



ICD-10-AM/ACHI/ACS Summary of Major Tenth Edition Changes

This document is a supplement to the ACCD's ICD-10-AM/ACHI/ACS Tenth Edition Education material; Tenth Edition FAQs Part 1, 2 and 3; and Addenda to Errata 2 – Issues identified in FAQs.

[This document was originally published in November 2017 and modified in December 2018 to correspond with ACCD advice post Tenth Edition implementation. See modified text on pages 5, 17, 18 and 22.](#)

Type 1 and Type 2 Exclusions and Conventions

- The concept of Type 1 and Type 2 *Excludes* notes has been removed.
- In Tenth Edition:
 - Some *Excludes* notes redirect users in the Tabular List from an incorrect code to a correct code (see Example 17 Intussusception of Appendix, in the *Introduction* of the Tabular List).
 - Some *Excludes* notes support single-condition coding (not relevant in Australia as we perform multiple condition coding). See Example 18 Osteoporosis due to vitamin D deficiency, in the *Introduction* of the Tabular List.
- Unnecessary or redundant *Excludes* notes at chapter level have been removed. Review of *Excludes* notes is ongoing with notes at the category and code level to be removed in Eleventh Edition.
- The concept “translate medical statement into code” has changed to “classify the clinical concept”.

Classifying a single clinical concept

If, by following the Alphabetic Index, all components of a single clinical concept are captured in the index pathway but result in a residual (i.e. “other” or “unspecified”) code being assigned, **do not assign an additional code to further classify the condition unless directed by any Instructional note in the Tabular List, Australian Coding Standard, or a Coding Rule.** It is unnecessary for conditions to be explicit in a code title or *Inclusion* term to be correctly classified.

Classifying multiple clinical concepts

In classifying a condition with an underlying cause, if the Alphabetic Index or an *Excludes* note results in a code for one of the clinical concepts not being assigned, follow the guidelines in ACS 0001 *Principal diagnosis, Problems and underlying conditions* and assign codes for both concepts i.e. the condition and the underlying cause.

Example 1: Hyperparathyroidism secondary to end stage renal failure (ESRF)

Alphabetic Index:

Hyperparathyroidism

- secondary

-- kidney = N25.8 *Other disorders resulting from impaired renal tubular function*

9 th Edition	10 th Edition
N25.8 Other disorders resulting from impaired renal tubular function	N25.8 Other disorders resulting from impaired renal tubular function
E21.1 Secondary hyperparathyroidism NEC	N18.5 Chronic kidney disease, stage 5
N18.5 Chronic kidney disease, stage 5	

All components of the clinical concept ‘secondary hyperparathyroidism’ are captured in the Index pathway (hyperparathyroidism, secondary, renal).

This pathway results in assignment of an “other” code: N25.8 *Other disorders resulting from impaired renal tubular function*. The condition ‘hyperparathyroidism’ is not explicit in the code title. In Tenth Edition **do not** assign an additional code (E21.1) to further translate the medical statement “secondary hyperparathyroidism”.

By following the Index pathway, one of the clinical concepts (ESRF) has not been coded. Therefore assign N18.5 *Chronic kidney disease, stage 5* as an additional diagnosis to classify the multiple clinical concepts (hyperparathyroidism due to ESRF) as per ACS 0001 *Principal diagnosis, Problems and underlying conditions*.

See also Example 2 Leg ulcer due to venous insufficiency and Example 18 Osteoporosis due to vitamin D deficiency, in the *Introduction* of the Tabular List.

Example 2: Exhaustion in pregnancy

Alphabetic Index:

Pregnancy

- complicated by

-- exhaustion = O26.88 *Other specified pregnancy-related conditions*.

9 th Edition	10 th Edition
O26.88 Other specified pregnancy-related complication	O26.88 Other specified pregnancy-related complication
R53 Malaise and fatigue	R53 Malaise and fatigue

Although the Index pathway contains all components of the clinical concept (exhaustion, pregnancy) an additional code is assigned due to the instruction in ACS 1521 *Conditions and injuries in pregnancy* to assign a code from another chapter if it adds specificity to a Chapter 15 code (‘O’ code).

Code assignment was the same in Ninth Edition, however the rationale for assigning R53 now differs. Ninth Edition rationale for adding R53 was to translate the medical statement. Tenth Edition rationale for adding R53 is because there is an ACS instruction to do so. ACS 1521 *Conditions and injuries in pregnancy* instructs that another chapter code (R53) is required if it adds specificity to a Chapter 15 code.

Example 3: Klebsiella meningitis

Alphabetic Index:

Meningitis

- Klebsiella = G00.8 *Other bacterial meningitis*

9 th Edition	10 th Edition
G00.8 Other bacterial meningitis	G00.8 Other bacterial meningitis
B96.1 Klebsiella pneumoniae as the cause of diseases classified elsewhere	B96.1 Klebsiella pneumoniae as the cause of diseases classified elsewhere

All components of the clinical concept are captured in the Index pathway (Meningitis, Klebsiella). The term ‘Klebsiella’ is not explicit in the code title, however it is listed as an Inclusion term at G00.8.

Although the Index pathway contains all components of the clinical concept, an additional code is assigned due to the Tabular List Instructional note at B95-B97:

Note: A code from these categories must be assigned if it provides more specificity about the infectious agent.

In addition, ACS 0002 *Additional diagnoses, Multiple Coding* instructs that multiple coding is applicable to identify organism(s) causing local infection.

Example 4: Acute viral bronchitis

Alphabetic Index:

Bronchitis

- acute or subacute

--viral NEC = J20.8 *Acute bronchitis due to other specified organisms*

9 th Edition	10 th Edition
J20.8 Acute bronchitis due to other specified organisms	J20.8 Acute bronchitis due to other specified organisms
B97.8 Other viral agents as the cause of diseases classified to other chapters	B97.8 Other viral agents as the cause of diseases classified to other chapters

Although the Index pathway contains all components of the clinical concept (bronchitis, acute, viral), an additional code is assigned due to the Tabular List Instructional note at B95-B97:

Note: A code from these categories must be assigned if it provides more specificity about the infectious agent.

In addition, ACS 0002 *Additional diagnoses, Multiple Coding* instructs that multiple coding is applicable to identify organism(s) causing local infection. B97.8 provides specificity by indicating a virus was the cause of bronchitis. See also WA Coding Rule *Viral URTI* (June 2017).

N.B. A Public Submission has been sent to ACCD for review of inconsistent listings of *Use additional code* notes in the Tabular List, particularly in Chapter 10 *Diseases of the Respiratory System*.

Same-day endoscopy

The following Australian Coding Standards have been replaced in Tenth Edition:

- ACS 0046 *Diagnosis selection for same-day endoscopy*
 - Replaced by ACS 0051 *Same-day Endoscopy – Diagnostic*
- ACS 2111 *Screening for specific disorders*
- ACS 2113 *Follow-up examinations for specific disorders*
 - Replaced by ACS 0052 *Same-day Endoscopy – Surveillance*

ACS 0051 *Same-day Endoscopy – Diagnostic*

The logic remains unchanged from Ninth Edition's ACS 0046: look for a causal link documented between the indication/symptom and any of the findings. Assign codes for all other symptoms and findings i.e. findings do **not** need to meet criteria in ACS 0002 *Additional diagnoses*.

There is a new instruction for the situation when no symptom/indication is documented as the reason for endoscopy, advising that incomplete documentation should be queried. If clarification is unavailable, assign Z01.8 *Other specified special examinations* (when no findings are documented) or code the findings alone.

ACS 0052 *Same-day Endoscopy – Surveillance*

This new standard combines the concepts 'follow-up' and 'screening', which previously had separate standards in Ninth Edition. In addition, other clinical concepts such as liver cirrhosis requiring surveillance to detect development of oesophageal varices, are now to be classified under this standard. Here is a summary of the types of clinical concepts to which ACS 0052 applies:

- Conditions previously treated and thought to be cured, requiring surveillance endoscopy looking for recurrence, for example:
 - Gastric ulcer
 - Malignancy
- Chronic incurable conditions, that cannot be eradicated, but require ongoing surveillance for treatment/management/monitoring, for example:
 - Coeliac disease
 - Crohn's disease
 - Ulcerative colitis
 - Diverticulitis (as per WA Coding Rule *Same-day endoscopy for follow-up of diverticulitis* (December 2015))
 - Liver cirrhosis (as per ACCD *Tenth Edition FAQs Part 3: Same-day endoscopy*)
 - Existing/known varices being monitored
- Diseases that have the potential for malignant transformation
 - Barrett's oesophagus
- Other diseases and pre-cursors (risk factors) where the individual is at risk for developing a condition, hence is undergoing surveillance to enable early diagnosis
 - Family history of cancer or gene mutation
 - Liver cirrhosis and/or portal hypertensive gastropathy
 - Familial adenomatous polyposis
 - Personal history of colonic polyp

Documentation of principal diagnosis

If principal and additional diagnoses are clearly documented in a discharge summary, apply ACS 0001 and ACS 0002 and **do not apply** ACS 0051 *Same-day Endoscopy – Diagnostic* or ACS 0052 *Same-day Endoscopy – Surveillance*.

However, if a diagnosis established after study (principal diagnosis) has not been documented or there is any ambiguity in the discharge summary, ACS 0051 and/or ACS 0052 apply instead. See also ACCD *Tenth Edition FAQ Part 1: ACS mutual exclusivity*.

Episode where both ACS 0051 and 0052 are applicable

Both ACS 0051 and 0052 may apply in the same admitted episode. For example:

- One endoscopy with multiple purposes
 - E.g. colonoscopy for anaemia (symptom – ACS 0051) and family history of bowel cancer (surveillance – ACS 0052).
- Two endoscopies each with different purpose
 - E.g. gastroscopy for epigastric pain (symptom – ACS 0051) and colonoscopy to check for recurrence of colonic polyp (surveillance – ACS 0052).
 - [Tenth Edition FAQs Part 3: Same day endoscopy clarified that codes from Z08/Z09 or Z11/Z12/Z13 can be assigned as additional diagnoses only when multiple endoscopies are performed in the same episode. Note: there is an error in the ACCD Coding Exercise answers, case scenario 15 \(presented at the NCCH Conference in 2017\) with unjustified assignment of Z09 as additional diagnosis.](#)

One endoscopy, multiple purposes i.e. diagnostic and surveillance

ACCD *Tenth Edition FAQ Part 2: Same day endoscopy* advises there is no hierarchy for assignment of principal diagnosis when both ACS 0051 and 0052 apply in the same episode, and advises that ACS 0001 and 0002 should be applied to determine sequencing of principal diagnosis. In practice, ACS 0001 and 0002 provide no assistance in sequencing these cases. WACCA proposes to retain a WA Coding Rule instructing that when sequencing principal diagnosis, a condition or symptom takes precedence over Z08/Z09 or Z11/Z12/Z13.

Example 1: Same-day colonoscopy. Indications on procedure report/record: family history colon cancer, change in bowel habit. Colonoscopy reported as normal.

9 th Edition	10 th Edition
R19.4 Change in bowel habit Z80.0 Family history of malignant neoplasm of digestive organs	R19.4 Change in bowel habit Z80.0 Family history of malignant neoplasm of digestive organs
WA Coding Rule <i>Endoscopy, symptom with screening/follow-up</i> (June 2010) advises a symptom takes precedence over surveillance Z code.	Continue to follow WA Coding Rule and sequence symptom as principal diagnosis rather than Z12. ACCD <i>Tenth Edition FAQs Part 3: Same-day endoscopy</i> clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses only when multiple endoscopies are performed in the same episode.

Two endoscopies, each with different purpose

Example 2: Same-day gastroscopy and colonoscopy. Indications on procedure report/record: dysphagia, family history colon cancer. Both endoscopies reported as normal.

9 th Edition	10 th Edition
<p>R13 Dysphagia Z12.1 Special screening examination for neoplasm of intestinal tract Z80.0 Family history of malignant neoplasm of digestive organs</p> <p>WA Coding Rule <i>Endoscopy, symptom with screening/follow-up</i> (June 2010) advises a symptom takes precedence over surveillance, and that because there are two endoscopies each should be coded out separately. The symptom is sequenced as principal diagnosis.</p>	<p>R13 Dysphagia Z12.1 Special screening examination for neoplasm of intestinal tract Z80.0 Family history of malignant neoplasm of digestive organs</p> <p>Continue to follow WA Coding Rule and sequence symptom as principal diagnosis rather than Z12.</p> <p>ACCD Tenth Edition FAQs Part 3: <i>Same-day endoscopy</i> clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses when multiple endoscopies are performed in the same episode.</p>

ACS 0052 Same-day Endoscopy – Surveillance examples

Example 3: Same-day gastroscopy for follow-up Barrett’s – stable.

9 th Edition	10 th Edition
<p>K22.7 Barrett’s oesophagus Z09.- Follow-up examination</p>	<p>K22.7 Barrett’s oesophagus</p> <p>ACCD Tenth Edition FAQs Part 3: <i>Same-day endoscopy</i> clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses only when multiple endoscopies are performed in the same episode.</p>

Example 4: Same-day gastroscopy for surveillance of Barrett’s – malignancy found and confirmed as adenocarcinoma biopsy.

9 th Edition	10 th Edition
<p>K22.7 Barrett’s oesophagus Z09.- Follow-up examination C15.9 Malignant neoplasm oesophagus, unspecified M8140/3 Adenocarcinoma NOS</p>	<p>K22.7 Barrett’s oesophagus C15.9 Malignant neoplasm oesophagus, unspecified M8140/3 Adenocarcinoma NOS</p> <p>The condition being screened for (malignancy) is found but not sequenced as principal diagnosis, in accordance with example 12 in ACS 0052. N.B. This logic is inconsistent with other examples within the same ACS, including malignancy found when screening due to family history; and varices found when screening due to liver cirrhosis.</p>

	<p>ACCD <i>Tenth Edition FAQs Part 3: Same-day endoscopy</i> clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses only when multiple endoscopies are performed in the same episode.</p>
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Example 5: Same-day gastroscopy. Indication: Liver cirrhosis. No varices found.

9 th Edition	10 th Edition
K74.6 Other and unspecified cirrhosis of liver	K74.6 Other and unspecified cirrhosis of liver

Example 6: Liver cirrhosis patient, no varices detected in the past. Same-day gastroscopy. Indication: Liver cirrhosis. Findings: Grade 1 oesophageal varices.

9 th Edition	10 th Edition
<p>K74.6+ Other and unspecified cirrhosis of liver I98.2* Oesophageal varices without mention of bleeding, in diseases classified elsewhere</p> <p>Endoscopy to further investigate a known condition (liver cirrhosis) is coded in accordance with ACS 0001 <i>Principal diagnosis</i> and ACS 0002 <i>Additional diagnoses</i>.</p> <p>Varices in liver cirrhosis are classified using the dagger/asterisk convention and both codes must be assigned as per the Alphabetic Index. Sequencing is in accordance with ACS 0001 <i>Principal diagnosis</i>.</p>	<p>I98.2* Oesophageal varices without mention of bleeding, in diseases classified elsewhere K74.6+ Other and unspecified cirrhosis of liver</p> <p>ACS 0052 provides classification advice for endoscopy surveillance to identify varices in liver cirrhosis patients. ACS 0001 and 0002 no longer apply unless there is a discharge summary.</p> <p>Documentation such as “surveillance”, “screening” etc. is not essential to apply ACS 0052.</p> <p>Varices in liver cirrhosis are classified using the dagger/asterisk convention and both codes must be assigned as per the Alphabetic Index. Varices are sequenced as principal diagnosis as per ACCD <i>Tenth Edition FAQs Part 3: Same-day endoscopy and Addenda to Errata 2</i>.</p>

Example 7: Patient with known oesophageal varices and liver cirrhosis. Same-day gastroscopy. Indication: follow-up varices. Findings: varices stable.

9 th Edition	10 th Edition
<p>I98.2* Oesophageal varices without mention of bleeding, in diseases classified elsewhere K74.6+ Other and unspecified cirrhosis of liver</p> <p>Endoscopy to further investigate a known condition (varices) is coded in accordance with ACS 0001 <i>Principal diagnosis</i> and ACS 0002 <i>Additional diagnoses</i>.</p> <p>Varices in liver cirrhosis are classified using the dagger/asterisk convention and both codes must be assigned as per the Alphabetic Index. Sequencing is in accordance with ACS 0001 <i>Principal diagnosis</i>.</p>	<p>I98.2* Oesophageal varices without mention of bleeding, in diseases classified elsewhere K74.6+ Other and unspecified cirrhosis of liver</p> <p>ACS 0052 provides classification advice for endoscopy for pre-existing conditions under surveillance (varices). ACS 0001 and 0002 no longer apply unless there is a discharge summary.</p>

Example 8: Same-day colonoscopy. Indication: family history of colon cancer. Caecal tumour found and histopathology revealed adenocarcinoma.

9 th Edition	10 th Edition
<p>C18.0 Malignant neoplasm, caecum M8140/3 Adenocarcinoma Z80.0 Family history of malignant neoplasm of digestive organs</p>	<p>C18.0 Malignant neoplasm, caecum M8140/3 Adenocarcinoma Z80.0 Family history of malignant neoplasm of digestive organs</p>

Example 9: Same day colonoscopy. Indication: follow- up tubular adenoma. A new tubular adenoma found in sigmoid colon and excised.

9 th Edition	10 th Edition
<p>D12.5 Benign neoplasm, sigmoid colon M8211/0 Tubular adenoma Z09.0 Follow-up examination after surgery for other conditions</p>	<p>D12.5 Benign neoplasm, sigmoid colon M8211/0 Tubular adenoma</p> <p>ACCD Tenth Edition FAQs Part 3: Same-day endoscopy clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses only when multiple endoscopies are performed in the same episode.</p>

Example 10: Same-day colonoscopy. Indication: follow-up tubular adenoma. Hyperplastic polyp found and excised.

9th Edition	10th Edition
Z09.0 Follow-up examination after surgery for other conditions Z86.0 Personal history of other neoplasms K63.58 Other polyp of colon	K63.58 Other polyp of colon As per ACS 0052, even if different morphology, code any new polyp as a recurrence. <i>ACCD Tenth Edition FAQs Part 3: Same-day endoscopy</i> clarifies that it is appropriate to assign codes from Z08/Z09 or Z11/Z12/Z13 as additional diagnoses only when multiple endoscopies are performed in the same episode.

Example 11: Same-day colonoscopy. Indication: follow-up rectal adenocarcinoma previously resected and cured. No recurrence detected. Sigmoid tubular adenoma found and excised.

9th Edition	10th Edition
Z08.0 Follow-up examination after surgery for malignant neoplasm Z85.0 Personal history of malignant neoplasm of digestive organs D12.5 Benign neoplasm of sigmoid colon M8211/0 Tubular adenoma NOS	Z08.0 Follow-up examination after surgery for malignant neoplasm Z85.0 Personal history of malignant neoplasm of digestive organs D12.5 Benign neoplasm of sigmoid colon M8211/0 Tubular adenoma NOS As per ACS 0052, assign as additional diagnosis any condition found at endoscopy that meets the criteria in ACS 0002 <i>Additional diagnoses</i> .

ACS 1807 Acute and Chronic Pain

The ACCD identified that chronic pain patients in acute care settings may be under reported. Chronic pain is considered a significant condition in its own right, with distinct signs and symptoms. As such it is to be classified **in addition to its underlying cause and/or site** (when documented). Amendments include:

- R52.1 *Chronic intractable pain* has been deleted
- R52.2 *Other chronic pain* has changed to *R52.2 Chronic pain* and classifies all forms of chronic pain
- A new instructional note at R52.2 *Chronic pain* to *Code first the underlying cause and/or site of chronic pain if applicable*. R52.2 is assigned as additional diagnosis as a flag code for chronicity of pain.
- ACS 1807 *Pain diagnoses and pain management procedures* has been renamed ACS 1807 *Acute and chronic pain*.

- Simplified instructions for assigning R52.0 *Acute pain NEC*. R52.0 is to be assigned when there is **no** documented underlying cause and/or site for the acute pain.
 - R52.2 *Chronic pain* can be assigned as principal diagnosis if there is no documentation of an underlying cause and/or site of pain.
 - Documentation of the following terms is synonymous with chronic pain:
 - Neoplastic pain
 - Neuropathic pain
 - Nociceptive pain
 - Terms **not** synonymous with chronic pain are:
 - Recurrent pain
 - Long standing pain
 - Nerve pain
- Clinical coders cannot use definitional information in ACS 1807 (for neoplastic, neuropathic and nociceptive pain types) for classification purposes. If documentation is lacking specific detail, seek clinical clarification.

Example 1: Patient admitted for treatment of chronic low back pain due to bone metastases secondary to lung cancer. Patient was given morphine to control pain. Principal diagnosis: Bone metastases

9th Edition	10th Edition
C79.5 Secondary malignant neoplasm of bone and bone marrow M8000/6 Neoplasm, metastatic C34.9 Malignant neoplasm of bronchus or lung, unspecified M8000/3 Neoplasm, malignant	C79.5 Secondary malignant neoplasm of bone and bone marrow M8000/6 Neoplasm, metastatic C34.9 Malignant neoplasm of bronchus or lung, unspecified M8000/3 Neoplasm, malignant M54.5 Low back pain R52.2 Chronic pain ACS 1807 instructs that for chronic pain with a documented underlying cause and/or site, code first the underlying cause and/or site and assign R52.2 as additional diagnosis.

Example 2: Patient admitted with recurrent pain due to osteoarthritis of hip.

9th Edition	10th Edition
M16.1 Other primary coxarthrosis	M16.1 Other primary coxarthrosis R52.2 is not assigned as there is no documentation of 'chronic pain'. The term 'recurrent' is not synonymous with the term 'chronic'.

ACS 1904 *Procedural complications*

New guidelines for applying ACS 0002 *Additional diagnoses* criteria have been added to ACS 1904 to assist coders to differentiate between *Routine postoperative care* and *Care beyond routine intraoperative/postoperative care*.

A condition is now considered a **procedural complication**, where:

- Documentation clearly states it arose as a complication of a procedure.
 - 'Secondary to' or 'due to' infer a causal relationship.
- The relationship is inherent in the diagnosis.
 - E.g. infection/bleeding of surgical wound/stoma/anastomosis; wound dehiscence; Transfusion Related Acute Lung Injury (TRALI).
- It is classified to blocks T82-T85 for complications of prosthetic devices, implants and grafts.
 - E.g. mechanical complication/haematoma/pain/stenosis following insertion of prosthetic device, implant or graft.
- It is a direct consequence of a procedure, resulting in an unintended injury/illness.
 - E.g. accidental puncture/laceration of an organ/structure during a procedure; retained instruments/swabs; mismatched blood transfusion.

Unintentional event (previously 'misadventure') is now defined as:

- Injury/harm caused during medical/surgical care. It may be identified at the time of; or after completion of the procedure. Examples:
 - foreign body accidentally left during a procedure
 - infusion of contaminated medical/biological substances
 - mismatched blood transfusion
 - failure of sterile precautions during surgical /medical care
 - inadvertent exposure of patient to radiation
 - unintentional cut/puncture/perforation during surgical/medical care

Classification instructions

ACS 1904 classification instructions have been revised:

- For complications **specific to prosthetic devices, implants or grafts** (complications explicitly Indexed to T82-T85) e.g. mechanical complication, infection, haemorrhage or haematoma, thrombosis, pain, stenosis etc. assign:
 1. A code from T82–T85 (except where directed by an Includes note or the Alphabetic Index e.g. dehiscence T81.3 or infection of operation wound T81.4); and
 2. An additional code from Chapters 1-19 where it provides further specificity.

- For general complications, **non-specific to prosthetic devices, implants or grafts** but documented as 'secondary to' or 'due to' prosthetic devices, implants or grafts (complications not explicitly Indexed to T82-T85) assign:
 1. A code from T82–T85 *Complications of prosthetic devices, implants and grafts* by following the Index: 'Complication(s); ...; device, implant or graft; ...; specified NEC');
 - and
 2. An *Intraoperative and postprocedural disorders...* block code from the body system chapters.

E.g. as per ACCD *Tenth Edition FAQs Part 2: Procedural complications*: Lymphocele due to cannulation of the femoral vein:

- T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*
 I97.83 *Postprocedural lymphocele, lymphoedema and chylothorax*

- For complications **not related to prosthetic devices, implants or grafts**, but:
 - related to a body system, assign:
 1. An *Intraoperative and postprocedural disorders...* block code from the body system chapters.
 2. An additional code from Chapters 1-19 where it provides further specificity.
 - not related to a body system, assign:
 1. A code from T80–T81 or T86–T88.
 2. An additional code from Chapters 1-19 where it provides further specificity.

There has been clarification that **obstetric procedural complications** not classified to a Chapter 15 *Pregnancy, childbirth and the puerperium* code are to be classified as per the instructions in ACS 1904.

Peritonitis in a peritoneal dialysis (PD) patient is considered PD-related peritonitis unless another cause of the peritonitis is specified as per ACCD *Tenth Edition FAQs Part 2: Procedural complications*.

Postoperative pain codes (i.e. T8x.83 *Pain following ...*) are only assigned when no underlying cause of pain is documented. If the cause of pain is documented, assign a code for the underlying cause, not a 'T8x.83 *Pain following ...*' code as per ACCD *Tenth Edition FAQs Part 2: Procedural complications*.

Place of occurrence

Y92.22 *Place of occurrence, health service area* has been replaced with Y92.23 and Y92.24.

Assign Y92.23 *Place of occurrence, health service area, not specified as this facility* when:

- The facility in which the external cause occurred is not documented.
- The external cause occurred in a facility with an establishment number different to the facility where the current episode is being coded.
 - Patient movement between these facilities is treated as discharge and admission.

Assign Y92.24 *Place of occurrence, health service area, this facility* when:

- The external cause occurred in any unit with the same establishment number as the facility where the current episode is being coded.
 - Y92.24 Tabular Note: '*This facility*' includes satellite units managed and staffed by the same health care provider. These units may be located on the hospital campus or off the hospital campus and treat movements of patients between sites as ward transfers.'

ACS 1908 *Open wound with artery, nerve and/or tendon damage*

For open wounds with artery, nerve and/or tendon damage, diagnosis code sequencing is now determined by:

Step 1

The instructions in ACS 0001 *Principal diagnosis* and ACS 1907 *Multiple injuries*.

Step 2

Where the principal diagnosis cannot be determined by referring to ACS 0001 and ACS 1907, the clinician should be asked to identify the principal diagnosis.

Step 3

Where clinician consultation is not possible, sequence the diagnosis codes using the following hierarchy:

1. artery injury
2. nerve injury
3. tendon injury
4. open wound

Mental health interventions

The Mental Health Intervention Classification (MHIC) has been incorporated into ACHI and ACS 0534 *Specific interventions related to mental health care services* has been created. Some of these specific MHIC codes will only be applicable to ambulatory and residential mental health care settings and are included in the revised Chapter 19 *Interventions not elsewhere classified* (Blocks 1820-1922).

For admitted episodes of care it is not mandatory to assign code(s) for mental health interventions with the exception of electroconvulsive therapy (ECT). However their use is encouraged in specialist mental health care facilities/units to better represent care provided to these patients. These interventions are not exclusive to mental health and may be assigned outside of this context. If the same mental health intervention is performed more than once during an episode of care, assign the code once only. For ECT follow ACS 0533 *Electroconvulsive therapy*.

As per ACS 0534 and ACS 0042 *Procedures normally not coded*, do not assign the following new codes in admitted episodes of care:

- 96241-xx [1922] *Prescription of psychotherapeutic agent*
- Codes from block [1920] *Administration of pharmacotherapy* with extension -10 *Psychotherapeutic agent*

Electroconvulsive therapy

- Ninth Edition ACHI codes for ECT have been deleted.
- Six new codes (14224-00 to 14224-05 [1907]) have been created to denote laterality (unilateral/bilateral) of electrode placement and duration of ECT pulse (ultrabrief/unspecified) delivered. These codes are assigned as many times as performed (up to 20 ECT treatments in an episode).
- 14224-06 [1907] *Electroconvulsive therapy [ECT] ≥ 21 treatments* is assigned when more than 20 ECT treatments are performed, irrespective of documented laterality or pulse duration.
- Coders cannot use definitional information in ACS 0533 *Electroconvulsive therapy* regarding pulse width (such as percentages and duration periods) for classification purposes. If documentation is lacking specific detail, seek clinician clarification.

The *Western Australian Mental Health Act 2014* defines ECT as:

... "*Electroconvulsive therapy is treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent.*"

ECT is always performed under general anaesthesia.

As per ACS 0031 *Anaesthesia* assign one anaesthetic code for each visit to theatre. If the same anaesthetic is administered more than once during different visits to theatre, it should be coded as many times as performed.

Example 1: Patient was admitted for a course of 25 unilateral ultrabrief ECT treatments, each performed under general anaesthesia.

9th Edition		10th Edition	
93341-25 [1907]	Electroconvulsive therapy [ECT], 25 treatments	14224-06 [1907]	Electroconvulsive therapy [ECT], ≥21 treatments
92514-99 [1910] x25	General anaesthesia, ASA 9, nonemergency	92514-99 [1910] x25	General anaesthesia, ASA 9, nonemergency
Assign anaesthetic code 25 times as per ACS 0031.		Assign anaesthetic code 25 times as per ACS 0031.	

Obstetrics

ACS 1500 *Diagnosis sequencing in delivery episodes of care*

ACS 1500 is a new standard providing guidelines for code assignment for delivery episodes. It includes instructions previously located in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

A list of additional diagnoses that must be assigned for antenatal or delivery episodes, when applicable, are also included in ACS 1500.

ACS 1505 *Delivery and assisted delivery codes*

WA Coding Standard 05 *Spontaneous vertex delivery* has been deleted in line with the creation of ACS 1505 *Delivery and assisted delivery codes*. The table in ACS 1505 shows valid code combinations of ICD-10-AM delivery (O80-O84) and ACHI delivery/other procedures to assist delivery.

This standard now ensures national consistency as a corresponding ACHI code must be assigned for all delivery episodes.

Delivery of baby prior to an admitted episode of care

For delivery of baby prior to an admitted episode with delivery of placenta in the episode, assign:

- A code from O80-O84 *Delivery* as the principal diagnosis
- **Do not assign codes from:**
 - DELIVERY PROCEDURES blocks [1336] to [1340]; or
 - PROCEDURES ASSISTING DELIVERY blocks [1341] to [1343].

Note: ACCD did not clarify whether this instruction from the Tenth Edition Education applies to manual removal of placenta, or only to spontaneous delivery of placenta. WACCA interpret it to apply to all methods of delivery of placenta.

Example 1: Spontaneous delivery of healthy term (single) infant in the ambulance on the way to hospital; spontaneous delivery of placenta following admission to Birthing Unit.

9th Edition	10th Edition
<p>Mother:</p> <p>O80 Single spontaneous delivery</p> <p>Z39.03 Postpartum care after unplanned, out of hospital delivery</p> <p>Z37.0 Single live birth</p> <p>90467-00 [1336] Spontaneous vertex delivery (as per instruction in WACS 05)</p> <p>Baby: Z38.1 Singleton, born outside hospital</p>	<p>Mother:</p> <p>O80 Single spontaneous delivery</p> <p>Z37.0 Single live birth</p> <p>No ACHI delivery code is assigned. The omission of an ACHI delivery code for these rare cases indicates that delivery of the baby did not occur within the episode.</p> <p>Baby: Z38.1 Singleton, born outside hospital</p>

Multiple delivery

If babies in a **multiple delivery** are delivered by different methods, assign ACHI codes for each different delivery method. Do not assign an ACHI delivery code for any delivery that occurred prior to the admitted episode e.g. in ambulance on way to hospital.

If the babies are delivered by the same method, assign only **one procedure code**. See *ACCD Tenth edition FAQs Part 2: Obstetrics*.

Example 2: Vaginal delivery of healthy term twins.

9th Edition	10th Edition
<p>O84.0 Multiple delivery, all spontaneous</p> <p>O30.0 Twin pregnancy</p> <p>Z37.2 Twins, both liveborn</p> <p>90467-00 [1336] Spontaneous vertex delivery</p> <p>90467-00 [1336] Spontaneous vertex delivery (as per instruction in WACS 05)</p>	<p>O84.0 Multiple delivery, all spontaneous</p> <p>O30.0 Twin pregnancy</p> <p>Z37.2 Twins, both liveborn</p> <p>90467-00 [1336] Spontaneous vertex delivery</p>

Failed procedures

When ACHI codes for **failed delivery procedures** are assigned (e.g. failed forceps/vacuum extraction/version), assign O83 *Other assisted single delivery* **unless** the delivery proceeds to forceps or vacuum extraction (O81), or caesarean (O82).

Example 3: Vaginal delivery of healthy term (single) infant following failed forceps.

9th Edition	10th Edition
O80 Single spontaneous delivery	O83 Other assisted single delivery
O66.5 Failed application of vacuum extractor and forceps, unspecified	O66.5 Failed application of vacuum extractor and forceps, unspecified
Z37.0 Single live birth	Z37.0 Single live birth
90467-00 [1336] Spontaneous vertex delivery	90468-05 [1337] Failed forceps
90468-05 [1337] Failed forceps	Note: 90467-00 [1336] <i>Spontaneous vertex delivery</i> was originally assigned in ACCD Tenth Edition Education material. However, it is not to be assigned as per ACCD <i>Tenth Edition FAQs Part 2: Obstetrics</i> which advises that once a delivery is 'assisted' it is no longer 'spontaneous'.

ACS 1521 Conditions and injuries in pregnancy

ACS 1521 *Conditions and injuries in pregnancy* has been revised. A condition is classified as complicating pregnancy when it is associated with an increased risk of adverse fetal or maternal outcome.

For conditions exclusive to pregnancy, assign codes as per ACS 0001, 0002 and 1500.

A nonobstetric condition is a condition that may occur in any patient; these conditions may or may not complicate pregnancy. Nonobstetric conditions are classified as complicating pregnancy when the condition meets the criteria in ACS 0001, 0002 or 1500 [in an antepartum episode](#) and documentation specifies the condition is complicating pregnancy.

In the absence of specific documentation, a nonobstetric condition is classified as complicating pregnancy as indicated by the presence of **two or more** of the following criteria:

- Patient admitted to an obstetric unit.
- Patient supervised/evaluated by an obstetrician, midwife and/or neonatologist
Note: evaluation may be performed remotely. That is, the clinician is located in another facility and consults via electronic methods (e.g. video/telephone conferencing).
- Fetal evaluation and/or monitoring performed.
- Patient transferred to another facility for obstetric and/or neonatal care.

WA Coding Rule ACS 1521 *Conditions and injuries in pregnancy* (October 2017) [was superseded by ACCD Coding Rule Q3265 *Additional diagnoses in delivery episodes of care* \(effective 01/04/2018\).](#)

[In antepartum episodes, once an 'O' code is assigned, all other conditions are coded with 'O' codes for that episode. This same logic should also be applied in delivery episodes. See](#)

[ACCD Coding Rule Q3265 Additional diagnoses in delivery episodes of care \(effective 01/04/2018\) which advises that codes may be assigned from other chapters if they add specificity to the 'O' code.](#)

ACS 1521 also provides instruction on:

- Coding **conditions not complicating pregnancy** (i.e. assign Z33 *Pregnant state, incidental* as an additional diagnosis); and
- **Injuries/poisonings in pregnancy** (i.e. assign Z34 *Supervision of normal pregnancy* as an additional diagnosis).

Example 4: Pregnant patient admitted with fractured shaft of 2nd metacarpal bone (jammed hand in door). Patient also has gestational diabetes mellitus (GDM) which did not meet any ACS 1521 criteria for 'complicating pregnancy'.

Codes:

S62.32	Fracture of shaft of other metacarpal bone(s)
W23.0	Caught crushed, jammed or pinched in or between door
Y92.9	Unspecified place of occurrence
U73.9	Unspecified activity
O24.49	Diabetes mellitus arising during pregnancy, unspecified

GDM must be assigned following ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*. ACS 1521 states: Z33 should never be assigned when a code from Chapter 15 Pregnancy, childbirth and the puerperium is assigned in the same episode of care.

Example 5: Pregnant patient admitted with fractured shaft of 2nd metacarpal bone (jammed hand in door). Patient also has pre-existing type 2 Diabetes Mellitus (DM) which did not meet any ACS 1521 criteria for 'complicating pregnancy'.

Codes:

S62.32	Fracture of shaft of other metacarpal bone(s)
W23.0	Caught crushed, jammed or pinched in or between door
Y92.9	Unspecified place of occurrence
U73.9	Unspecified activity
E11.9	Type 2 diabetes mellitus without complication
Z33	Pregnant state, incidental

DM must be assigned following ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia*. ACS 0401, DM and Intermediate Hyperglycaemia (IH) in pregnancy, childbirth and the puerperium states: If DM or IH is documented in pregnancy but does not meet the criteria for a pregnancy complication, assign a code for DM or IH (E09-E14) and Z33 Pregnant state, incidental.

Example 6: Pregnant patient admitted with fractured shaft of 2nd metacarpal bone (jammed hand in door). She was transferred to the obstetric unit for observation by midwifery team. No complications of her pregnancy were identified; therefore she was discharged home following treatment of her fracture.

Codes:

S62.32	Fracture of shaft of other metacarpal bone(s)
W23.0	Caught crushed, jammed or pinched in or between door
Y92.9	Unspecified place of occurrence
U73.9	Unspecified activity
Z34.9	Supervision of normal pregnancy, unspecified

If a pregnant patient with a nonobstetric injury/poisoning meets the criteria for a pregnancy complication, but there is no condition that qualifies for assignment of a code from Chapter 15, assign a code from Z34 as additional diagnosis.

ACS 1548 Puerperal/Postpartum Condition or Complication

ACS 1548 classification instructions have been revised:

Postpartum Care and Examination Immediately After Delivery

Z39.0- *Postpartum care and examination immediately after delivery* may be assigned as principal diagnosis, or additional diagnosis, but is **never assigned in a delivery episode**.

Z39.0- *Postpartum care and examination immediately after delivery* is only assigned for episodes **within the puerperal period** which is defined as the period of 42 days following delivery.

Example 7: Patient admitted three months post hospital delivery with an infected caesarean wound requiring intravenous antibiotics.

9th Edition	10th Edition
O86.0 <i>Infection of obstetric wound</i> Z39.01 <i>Postpartum care after hospital delivery</i>	O86.0 <i>Infection of obstetric wound</i> The infection did not occur within 42 days of delivery, therefore Z39.01 is not assigned.

Conditions Relating to Lactation

Ninth Edition ACS 1501 *Definition of puerperium* stated that beyond twelve months post delivery, conditions related to lactation should be assigned a code for the condition outside of Chapter 15 *Pregnancy, childbirth and the puerperium*.

In Tenth Edition, ACS 1501 was deleted and coders are now guided by ACS 1548 for classification of conditions relating to lactation. Where a patient has a condition relating to lactation:

- Assign a code from O91 *Infections of breast associated with childbirth* or O92 *Other disorders of breast and lactation associated with childbirth* regardless of duration since delivery.

- Assign Z39.0- *Postpartum care and examination immediately after delivery* **only** in the puerperal period (within 42 days following delivery).

Note: This section of ACS 1548 has been amended in the Addenda to Errata 2.

Example 8: Breastfeeding patient admitted 18 months post-delivery with mastitis. No documentation of attachment difficulty.

9th Edition		10th Edition	
N61	<i>Inflammatory disorder of breast</i>	O91.20	<i>Nonpurulent mastitis associated with childbirth, without mention of attachment difficulty</i>
Z39.1	<i>Care and examination of lactating mother</i>		

Elective versus Emergency Caesarean Delivery

A new note has been added to block [1340] *Caesarean section* which states: Assignment of codes for ‘elective’ or ‘emergency’ caesarean section is based on documentation of these terms in the medical record. Where neither of these terms is documented, assign an appropriate code for ‘elective’. Where there is conflicting documentation (that is, both of these terms are documented), assign an appropriate code for ‘emergency’.

Cataract procedures

The coding of cataract procedures now requires assignment of a code from block [193] *Insertion of intraocular prosthesis* **and** a code from block [200] *Extraction of crystalline lens*.

Example 1: Patient admitted for phacoemulsification extraction of cataract and insertion of artificial intra-ocular lens.

9th Edition		10th Edition	
H26.9	Cataract, unspecified	H26.9	Cataract, unspecified
42702-04 [197]	Extracapsular extraction of crystalline lens by phacoemulsification and aspiration of cataract with insertion of foldable artificial lens	42698-07 [200]	Phacoemulsification of crystalline lens
		42701-00 [193]	Insertion of intraocular lens

Thrombolytic therapy

ACS 0943 *Thrombolytic therapy* has been created. Thrombolytic agents may be administered systemically or locally (also known as transcatheter thrombolytic therapy or catheter direct thrombolytic therapy).

Codes have been created at block [741] *Peripheral arterial or venous catheterisation* and are split based on type of agent administered.

When transcatheter thrombolysis is employed as an adjuvant therapy during another endovascular intervention such as angioplasty, mechanical embolectomy or thrombectomy, do not assign an ACHI code for transcatheter thrombolytic therapy, as it is inherent in the other interventions.

ACS 0042 *Procedures not normally coded* has been amended to include thrombolytic therapy classified to block [741] as an exception to point 5 *Catheterisation*.

Obesity and Body Mass Index (BMI)

- Creation of code E66.3 *Overweight*.
- Deletion of codes E66.0 *Obesity due to excess calories* and E66.8 *Other obesity*.
- Removal of 'morbid' from Tabular List inclusion terms.
- Creation of fifth characters at E66.1 *Drug-induced obesity*, E66.2 *Obesity with alveolar hypoventilation* and E66.9 *Obesity, not elsewhere classified* to classify degrees of obesity based on clinically documented BMI values.

5th character	Descriptor	Obesity class
Patients under 18: assign 5th character 0. (BMI is not an accurate measure of obesity in those under 18 years)		
Patients 18 and above: assign 5th characters 0, 1, 2 or 3.		
0	<i>body mass index [BMI] not elsewhere classified</i>	
1	<i>body mass index [BMI] ≥ 30 kg/m² to ≤ 34.99 kg/m²</i>	Obese class I
2	<i>body mass index [BMI] ≥ 35 kg/m² to ≤ 39.99 kg/m²</i>	Obese class II
3	<i>body mass index [BMI] ≥ 40 kg/m²</i>	Obese class III Clinically severe obesity Extreme obesity

New Index pathways have been created for obesity and Body Mass Index:

- BMI (body mass index)
- Body, bodies; - mass index (BMI)
- Pre-obese

Classification instructions

Obesity documented in adult. No BMI value documented:

- Assign E66.90 *Obesity, not elsewhere classified, body mass index [BMI] not elsewhere classified*.

BMI value only documented:

- Follow the Index pathways: 'BMI (body mass index)' and 'Body, bodies; - mass index (BMI)' to assign a code from E66 *Obesity and overweight*.
 - [A documented BMI value can be used to inform coding of conditions such as diabetes mellitus.](#)
 - [A documented BMI value can be used to assign U78.1 Obesity.](#)

'High BMI' or '↑BMI' documented:

- Documentation of 'high BMI' or '↑BMI' cannot be used for code assignment. A BMI value must be documented to follow the Index pathways: 'BMI (body mass index)' and 'Body, bodies; - mass index (BMI)'.
 - See ACCD Coding Rules: *ACS 0003 Supplementary codes for chronic conditions, Ninth Edition Education FAQs* (September 2015) and *Use of abbreviations, symbols and test result values to inform code assignment for abnormal pathology results* (September 2009).

Patient's height and weight documented. No BMI value documented:

- A patient's BMI should not be calculated to inform code assignment.

R64 Cachexia

- In Tenth Edition ICD-10-AM R64 *Cachexia* is classified as a condition in its own right with an accompanying code for the underlying cause e.g. cancer.
- Cachexia in certain conditions (such as malnutrition and hypopituitarism) remains classified to the underlining condition as per the Alphabetic Index at lead term '*Cachexia*'.
- There is a new Alphabetic Index entry: 'Failure, failed; - to; -- thrive; --- adult → R64.

ACS 0303 *Abnormal coagulation profile due to anticoagulants*

ACS 0303 *Abnormal coagulation profile due to anticoagulants* has been revised:

- If patients on long term anticoagulants require anticoagulant level monitoring and the INR level is within the target therapeutic range (i.e. no suprathereapeutic/subtherapeutic INR documented), assign Z92.1 *Personal history of long term (current) use of anticoagulants* as an additional diagnosis.
 - Z92.1 would only be assigned when it meets ACS 0002 *Additional diagnoses* or ACS 0303 criteria. It is not routinely assigned as a 'flag' code to indicate a patient is on long term anticoagulants.

- If the INR value is outside the patient's normal/usual therapeutic range (i.e. supratherapeutic/subtherapeutic INR documented) but no bleeding occurs, assign R79.83 *Abnormal coagulation profile* together with appropriate external cause codes to indicate the abnormal coagulation profile is related to the administration of an anticoagulant.
- If bleeding occurs as a result of anticoagulant use, assign D68.3 *Haemorrhagic disorder due to circulating anticoagulants*. The causal relationship between the bleeding and anticoagulant use must be documented before D68.3 *Haemorrhagic disorder due to circulating anticoagulants* is assigned.

In Sixth Edition, the code sequencing for Example 2 (now Example 5) in ACS 0303 was amended to be consistent with the international consensus of the WHO Update and Revision Committee. The ACCD Tenth Edition Coding Exercise Workbook (Exercise 10.21) sequenced D68.3 as principal diagnosis, followed by a code for the manifestation. Clinical coders should instead follow ACS 0303 for code sequencing.

Example 1: Patient admitted with a haematoma of the abdominal wall due to warfarin. The patient's INR was monitored during the episode. The haematoma resolved without intervention.

Codes:	S30.1	Contusion of abdominal wall
	D68.3	Haemorrhagic disorder due to circulating anticoagulants
	Y44.2	Anticoagulants causing adverse effects in therapeutic use
	Y92.23	Place of occurrence, health service area, not specified this facility
	U73.8	Other specified activity

ICD-10-AM does not have specific codes for non-traumatic haematomas of all individual sites. Follow Alphabetic Index: Haematoma (*see also Contusion*).

Trial of Void (TOV)

ACS 1436 *Admission for Trial of Void* has been deleted. For admission for TOV, assign:

- Z46.6 *Fitting and adjustment of urinary device* as principal diagnosis following Index pathways:
 - Trial of void; - admission for
 - Admission (for); - trial of void
- Additional diagnosis code/s for urinary retention (so documented) when it meets ACS 0002 *Additional diagnoses* criteria for assignment.
 - Note: 'Unable to void' is assigned R39.1 *Other difficulties with micturition* as per WA Coding Rule *Unable to void* (August 2009).
- Procedure codes in accordance with ACS 0042 *Procedures normally not coded*.

See also: ACCD *Tenth Edition FAQs Part 1: ACS deleted for Tenth Edition*.

Phlebitis and thrombophlebitis

Fifth character codes have been created at I80.2 *Phlebitis and thrombophlebitis of other deep vessels of lower extremities* to specify iliac, popliteal and tibial veins.

I80.4 *Phlebitis and thrombophlebitis of vessels of upper extremities, not elsewhere classified* was created, with fifth digits to specify superficial and deep veins.

ACCD Tenth edition FAQs part 1: *Deep venous thrombosis (DVT)* states multiple codes from category I80 can be assigned. Where the site of a DVT is documented as extending inferiorly into the popliteal and posterior tibial veins, assign:

I80.22 *Phlebitis and thrombophlebitis of popliteal vein*; and
I80.23 *Phlebitis and thrombophlebitis of tibial vein*

ACS 0002 Additional diagnoses

Classification instructions for incidental findings and abnormalities noted on newborn examination have been added to ACS 0002.

Documentation of abnormal findings or conditions (i.e. on clinical assessment, discharge summary, diagnostic test report) should be assessed on their own merits to determine if they meet ACS 0002 criteria for coding.

Example 1: Clicking hips documented by clinician in newborn examination. Newborn referred for hip ultrasound to be performed post discharge.

9th Edition	10th Edition
<p>Inconsistent practices between coders and jurisdictions due to differing interpretation of ACCD Coding Rule ACS 0002 <i>Additional diagnoses and newborn conditions</i> (retired 1 July 2017).</p> <p>Some coders assigned: R29.4 Clicking hip Z38.- Singleton</p> <p>Other coders assigned only Z38.- Singleton</p>	<p>Z38.- Singleton</p> <p>As per examples 6 and 7 in ACS 0002 <i>Additional diagnoses/Abnormalities noted on examination of the newborn</i>, clicking hips would not be coded as it does not meet ACS 0002 criteria in this episode.</p>

Example 2: Reduction mammoplasty for breast hypertrophy. Histopathology reveals breast cancer. No investigation or treatment of cancer in this episode. Discharge summary notes the cancer finding and patient is referred to a specialist for further management post discharge.

Codes:	N62	Hypertrophy of breast
	45522-01 [1754]	Reduction mammoplasty, bilateral
	92514-xx [1910]	General anaesthesia, ASA 9, nonemergency
<p>As per Examples 2 and 3 in ACS 0002 <i>Additional diagnoses/Incidental findings and conditions</i>, breast cancer would not be coded as it does not meet ACS 0002 criteria in this episode.</p>		

ACS 0012 *Suspected conditions*

The definition of suspected condition has been clarified. For classification purposes, a suspected condition is one for which there is uncertainty about the final diagnosis **at discharge** (as expressed by qualifying terms), and where the suspected condition has **not been confirmed nor ruled out**.

- Examples of qualifying terms include ‘?, probable, suspected, possible, likely, query’.
- The suspected condition may be principal diagnosis or additional diagnosis.
- Where documentation indicates uncertainty about a final diagnosis at discharge; and:
 - a **single condition is suspected**, assign:
 - A code for the suspected condition.
 - E.g.: Patient discharged with diagnosis of ‘?lower respiratory tract infection (LRTI).’ Assign J22 *Unspecified acute lower respiratory infection*.
 - **more than one condition is suspected**, assign:
 - Codes for the suspected conditions.
 - E.g.: Patient transferred to district trauma hospital with discharge diagnoses of ‘?head injury and ?multiple rib fractures.’ Assign S09.9 *Unspecified injury of head*, S22.40 *Multiple rib fractures, unspecified* and Z75.6 *Transfer for suspected condition*.
 - **more than one condition is suspected as the differential diagnosis**, assign:
 - Codes for the symptom(s).
 - E.g.: Patient admitted with shortness of breath and wheezing. Patient discharged with diagnosis of ‘?asthma ?bronchiectasis.’ Assign R06.0 *Dyspnoea* and R06.2 *Wheezing*.

The code Z75.6 *Transfer for suspected condition* has been created for assignment as additional diagnosis to flag patients transferred between facilities with a suspected condition.

- Replaces Ninth Edition Z57.3 *Unavailability and inaccessibility of health care facilities*.
- Z75.6 is sequenced directly after the diagnosis code to which it relates.
- Z75.6 is **only** assigned as an additional diagnosis to flag patients transferred with a suspected condition.

Classification instructions for observation for suspected diseases and conditions (Z03.0-Z03.9) have been removed from ACS 0001 *Principal diagnosis* and relocated to ACS 0012.

ACS 0048 *Condition onset flag (COF)*

Inclusion of the new COF assignment rules:

- Where multiple conditions/sites are classifiable to a single ICD-10-AM code that meets the criteria for different COF values, assign COF 1 (e.g. two pressure injuries classified to the same ICD-10-AM code but qualify for different COFs).
 - The exception to this is when the condition is sequenced as the principal diagnosis and must be assigned COF 2.

ACS 2118 *Exposure to tobacco smoke*

Assign Z58.7 *Exposure to tobacco smoke* when exposure to secondhand tobacco smoke is documented by a clinician, except if the patient is a current or ex-smoker.

- **Z58.7 is not required to meet ACS 0002 *Additional diagnoses* criteria for code assignment.**
- Secondhand/Environmental Tobacco Smoke (ETS) is defined as:
 - Exhaled mainstream smoke: smoke exhaled by a smoker; and
 - Sidestream smoke: smoke that drifts from the smouldering tip of a cigarette.
- Exposure to secondhand tobacco smoke:
 - Includes passive smoking, involuntary smoking and breathing it in; and exposure to smoke from cigarettes, cigars, pipes and waterpipes (hooka, shisha, narghile).
 - Does not include exposure to smoke from Electronic Nicotine Delivery Systems (ENDS, i.e. e-cigarettes). ENDS do not deliver tobacco.

Reference:

Mental Health Act 2014, WA [Internet]. 2017 [cited 2017 Jul 5].

Available from:

https://www.slp.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13537_homepage.html