

Queensland Coding Committee February to June 2010 Queries

QCC_ID	Query summary	Query	QCC response
0709-03	Use of Z35.5x as PDx	<p>Could the QCC please provide clarification on the use of Z35.x and if using it as a principal diagnosis is acceptable in the following scenario:</p> <p>Patient was admitted for induction of labour due to maternal age (multigravida). Medical induction was performed. There were no other conditions.</p> <p>Would Z35.52 be an acceptable code allocation as a principal diagnosis? The rationale for this is because in the index the word (supervision of) is a nonessential modifier.</p> <p>There seems to be a reluctance to use a "Z" code as an obstetric principal diagnosis. Common practice seems to be to code O80 as the principal diagnosis plus Z35.52 as an additional code. This then places the case into DRG O60C. Whereas If coded with Z35.52 as principal it goes to DRG O60B.</p> <p>There is the ruling on social admissions where O80 can be used along with the induction code to show that there were no other reasons for induction but in this type of case the maternal age was the reason for admission.</p>	<p>QCC Response: The QCC advises that Z35.52 <i>Supervision of multigravida with advanced maternal age</i> should be coded as the principal diagnosis in the scenario given.</p> <p>The QCC notes that significant changes to the coding of obstetric admissions in 7th Edition will occur.</p> <p>Please see response to QCC query 1109-05 for additional information regarding applying the above advice in other scenarios.</p> <p>The DRG outcome of this advice has been forwarded to the Activity Based Funding Unit for their information.</p>
1109-05	Further Clarification of 0709-03	<p>Query 0709-03 - the answer was yes to the case in question, however, the Z35 codes are often used to accompany a PDx of O80. Can we take it from this advice that whenever there is a Z35 code it can replace the O80?</p> <p>See example in the string below as there is a significant change up from a C to a B DRG</p> <p>O80 Z37.0 Z35.52 groups to O60C</p> <p>Z35.52 Z37.0 groups to O60B</p>	<p>QCC Response: The QCC response to query 0709-03 to code Z35.52 <i>Supervision of multigravida with advanced maternal age</i> as principal diagnosis in the scenario was given by applying ACS 0001 Principal Diagnosis for that particular scenario and considering the particular information given by the enquirer.</p> <p>It should not be interpreted that a Z35 code should, or can, always replace an O80 code.</p> <p>The QCC notes that significant changes to the coding of obstetric admissions in 7th Edition will occur.</p> <p>The DRG outcome of this advice has been forwarded to the Activity Based Funding Unit for their information.</p>

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1109-07	Ankle Fracture transferred	<p>Our patients are usually elderly and cannot go home because they are non weight bearing so they stay with us until XXX ORTH team say it is ok for them to either go home or to REHAB.</p> <p>So therefore I guess they are really convalescent care. The patients are placed in a general ward. They are admitted with an acute care type from the big hospital XXX. Sometimes a member of the allied health team sees the patient. Sometimes not. If I find the words rehabilitation anywhere I ask for the care type to be changed to rehab clinical intent.</p> <p>These types of patients come either after surgical intervention for #'s or with no surgical intervention.</p> <p>In my quest for uniformity in the coding of these scenarios I have found that coders are allocating various PD's and OD's so in an endeavour for some consistency I would hope that the QCC can come up with some answers for us.</p> <p>I know my initial query asked for the PD but it would be great if you might be able to include OD's as well.</p>	<p>QCC Response: The QCC recommend consulting with the clinician regarding the intent of care to establish whether it should be a sub-acute or non-acute (SNAP) admission care type such Rehabilitation, Maintenance or Geriatric Evaluation and Maintenance (refer to Queensland Hospital Admitted Patient Data Collection [QHAPDC] Manual for Care Type definitions and/or to Codefile Care Type Supplement 2005).</p> <p>These episodes should be coded according to the documentation and ACS 0001 Principal Diagnosis.</p> <p>If the patient was transferred for aftercare, apply ACS 2103 Admission for Convalescence/Aftercare.</p> <p>If the patient was admitted for rehabilitation, please refer to ACS 2104 Rehabilitation.</p> <p>The QCC believe better definitions are required within the Australian Coding Standards for aftercare and convalescence and will send a suggestion to the NCCC to publish an article with advice related to these types of scenarios.</p>
0210-01	ProOsteon bone graft substitute	Can the QCC advise what the correct procedure code for ProOsteon bone graft is?	<p>QCC Response: As per the ACHI interventions table, a bio-implant is included in internal fixation as per the start of Chapter 15.</p> <p>Chapter 15 PROCEDURES ON MUSCULOSKELETAL SYSTEM (Blocks 1360–1579)</p> <p><i>Internal fixation – Includes:</i> bio-implant cerclage intramedullary nail nonsegmental fixation (Harrington rod) pin plate ring fixator rod screws (facetal) segmental fixation (CD)(Dwyer)(Luque)(Zielke) sliding nail wire</p> <p>Therefore an additional code to identify the ProOsteon bone graft is not required.</p>

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0210-03	Full thickness Squamous dysplasia limbus	Can the QCC advise on what is the correct code for full thickness squamous dysplasia of the limbus?	<p>QCC Response: Reference: Coding Matters Vol 14 no 3. The QCC considers that the terminology "severe dysplasia" does not always equate to "carcinoma in situ". Therefore D09.2 M8077/2 would not be appropriate to use based on the description of 'dysplasia' alone.</p> <p>Consequently, the QCC recommends that clinical clarification is sought to ensure that, where necessary, the correct histological and morphological type is selected.</p> <p>Additionally, clinical clarification is required to ascertain whether HPV is involved with this lesion.</p> <p>Based on the documented diagnosis of the above 'full thickness squamous dysplasia of the limbus' and in the absence of this information, the QCC recommends coding H11.8 -<i>Other specified disorders of conjunctiva</i> as a last option.</p>
0210-04	Ventilation for multiple procedures	<p>Should we use two different ventilation codes for separate incidences and duration of ventilation in a single episode of care?</p> <p>Do we need to assign a code for sedation with ventilation support?</p>	<p>QCC Response: The QCC directs the enquirer to ACS 1006 Ventilatory Support which states that all hours for the same type of ventilation are cumulative only one code is required that reflects the total cumulative hours.</p> <p>According to Coding Matters Volume 16 no 2 FAQs Q20: <i>"Q20: Does sedation need to be coded with ventilation when it is administered? A: As per ACS 0031 Anaesthesia, a code is assigned for any form of anaesthetic except local anaesthesia and oral sedation, when administered for anaesthetic purposes to perform a procedure i.e. for intubation/ventilation."</i></p> <p>Therefore, the QCC recommends that intravenous sedation is coded.</p> <p>QCC will seek clarification with NCCC as to whether ongoing sedation for ventilation is considered to be anaesthesia for a procedure, or whether sedation for ventilation should only be coded when associated with the initiation of ventilation.</p>
0210-05	ACS 1513 Induction - IUFD	<p>ACS 1513 Induction Page 222 <i>"Example 1: Patient admitted at 21 weeks gestation with a diagnosis of fetal death in utero (FDIU). Medical and surgical induction of labour.</i> <i>Codes:</i> <i>O36.4 Maternal care for intrauterine death</i> <i>O60.1 Preterm labour with preterm delivery</i> <i>O09.3 Duration of pregnancy 20-25 completed weeks</i> <i>Z37.1 Single stillbirth</i> <i>90465-05 [1334] Medical and surgical induction of labour"</i></p> <p>Why is O60.1 Preterm labour with preterm delivery used in this example rather than O60.3 Preterm delivery without spontaneous labour?</p>	<p>QCC Response: The QCC recommends that since there was no spontaneous labour, the correct code allocation is O60.3 <i>Preterm delivery without spontaneous labour</i>.</p> <p>The QCC will send a public submission to the NCCC recommending that this component of ACS 1513 Induction is updated for the next edition.</p> <p><u>QCC Review 2010</u> Updated as required in 7th Edition.</p>

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0210-06	Intravascular ultrasound (IVUS) performed in cardiac catheterisation lab	Do we need to code Intravascular ultrasound (IVUS) imaging of the coronary arteries if performed along with coronary angiography, cardiac catheterisation or Percutaneous transluminal coronary angioplasty (PTCA), and if so which code(s) should be used?	<p>QCC Response: The QCC recommends that the code 55054-00[1949] <i>Intraoperative ultrasound of other sites</i> is the appropriate code in this instance.</p> <p>Note that in accordance with NCCH 7th edition training material coronary angiography is still coded but 55054-00 [1949] <i>Intraoperative ultrasound of other sites</i> is deleted.</p> <p>The QCC recommends that a public submission is made to the NCCC for the creation of a new group of procedure codes representative of the advances in PCI. (This is in line with similar previous queries and submissions e.g. 0309-01).</p>
0210-07	Right heart catheterisation	<p>Can the QCC advise on the appropriate procedure code for:</p> <ol style="list-style-type: none"> 1. Cardiac catheterisation right heart where Swan Ganz catheter is documented. 2. Right Heart Catheterisation procedure where Swan Ganz is listed as technique. 	<p>QCC Response: The QCC acknowledges that the Swan Ganz catheter can be used to carry out right heart catheterisation.</p> <p>Therefore, the QCC recommends that an excludes note is provided at the following code: 13818-00 [657] <i>Insertion of right heart balloon catheter for monitoring</i></p> <p>Excludes where done for coronary angiography with right heart catheterisation.</p> <p>The QCC also recommends that an includes note is provided at the following code: 38218-01 [668] <i>Coronary angiography with right heart catheterisation</i></p> <p>Includes: Insertion of catheter (Swan Ganz)</p> <p>In the scenarios provided:</p> <ol style="list-style-type: none"> 1. The QCC recommends that the correct code allocation is: 38218-01[668] <i>Coronary angiography with right heart catheterisation</i> 2. The QCC recommends that the correct code allocation is: 38200-00 [667] <i>Right heart catheterisation</i>

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0210-08	Optical Coherence Tomography performed in cardiac cath lab	Can the QCC advise on how to code a Optical Coherence Tomography procedure?	<p>QCC Response: <i>"Optical coherence tomography (OCT) is a light-based imaging modality that can be used in biological systems to study tissues in vivo with near-histologic, ultrahigh resolution."</i> http://www.ncbi.nlm.nih.gov/pubmed/15321058</p> <p>In accordance with NCCH 7th Edition training material those radiological procedures listed in ACS 0042 will no longer be coded, even when performed in conjunction with surgery.</p> <p>The QCC recommends that a public submission is made to the NCCC for the creation of a new group of procedure codes representative of the advances in PCI. The QCC recommends that until a new code is created the most appropriate code to allocate is: 60100-00 <i>Tomography</i></p>
0210-09	Aspiration of peritonsillar abscess	Can the QCC confirm whether 41807-00 [409] is the correct procedure code for aspiration of peritonsillar abscess?	<p>QCC Response: The QCC recognises that the code 41807-00 [409] <i>Incision and drainage of peritonsillar abscess</i> is not representative of the procedure that has been carried out.</p> <p>The QCC recommends that in the absence of a better code that 41807-00 <i>Incision and drainage of peritonsillar abscess</i> is allocated.</p> <p>The QCC will put together a public submission to the NCCC for the creation of a new code or to have an Includes note under 41807-00 <i>Incision and drainage of peritonsillar abscess</i>.</p>
0210-10	Laparoscopic Sleeve Gastrectomy for obesity	<p>Can the QCC advise on the correct procedure code to use for a Laparoscopic Sleeve Gastrectomy for obesity?</p> <p>If 30518-00 [875] <i>Partial distal gastrectomy with gastroduodenal anastomosis</i> is assigned the result DRG is 901Z.</p> <p>Could 30511-00 [889] <i>Gastric reduction</i> be assigned?</p>	<p>QCC Response: The QCC does not consider 30511-01 [889] <i>Laparoscopic gastric reduction</i> appropriate as the procedure performed is actually removal of the stomach, not a reduction.</p> <p>Therefore the QCC suggests the assignment of the following codes: 30523-00 [879] <i>Subtotal gastrectomy</i> 30390-00 [984] <i>Laparoscopy</i></p> <p>Please note that the assignment of 30523-00 [879] <i>Subtotal gastrectomy</i> with a principal diagnosis of E66.8 <i>Other obesity</i> will result in DRG 901Z Extensive O.R. Procedure Unrelated To PDX.</p> <p>According to the Victorian Coding Committee query database, this issue has been previously been referred to the Commonwealth for investigation.</p>

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0210-11	Chronic Diarrhoea	What is the correct code for chronic diarrhoea? Is it A09.9 or K52.9?	QCC Response: The QCC considered that diarrhoea specified as either non infective or chronic should be coded to K52.9 <i>Noninfective gastroenteritis and colitis, unspecified</i> . However, diarrhoea NOS should be coded to A09.9 <i>Other gastroenteritis and colitis of infectious origin</i> . Coders should not infer diarrhoea to be non infective or chronic from documentation of duration (e.g. stated recurrent presentations over a period of time) or the 'clinical picture' only. If the diarrhoea is not specified, and the Coder suspects the diarrhoea may be chronic or non infective, the Coder should clarify with the clinician (supported by documentation) before coding to K52.9 <i>Noninfective gastroenteritis and colitis, unspecified</i> .
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0210-13	ACS Reference Symbol Procedures	<p>Could the QCC review the application of the ACS reference symbol (ACS 0028 Para-Aortic Lymph Node Biopsy) to the codes specified in this standard?</p> <p>The symbol can be found attached to 35723-02 [810] <i>Laparoscopic para-aortic lymph node sampling for staging of gynaecological malignancy</i> and 35723-03 [810] <i>Para-aortic lymph node sampling for staging of gynaecological malignancy</i></p> <p>but not to 37607-00 [811] <i>Radical excision of retroperitoneal lymph nodes</i> or 30075-00 [805] <i>biopsy of lymph node.</i></p> <p>We are requesting that the ACS 0028 symbol be applied to these codes as well.</p>	<p>QCC Response: The QCC considered the following when reviewing this query:</p> <p>ACS 0028 refers to biopsy and sampling of para-aortic lymph node.</p> <p>Under biopsy the following is listed for lymph node: lymphatic structure (node) 30075-00 [805] -- for staging of malignancy 35726-01 [985] --- gynaecological ---- intra-abdominal (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] ---- para-aortic (laparoscopic) 35723-02 [810] -----via laparotomy 35723-03 [810] ---- pelvic cavity (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] ---- retroperitoneal (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] --- lymphoma 30384-00 [985] -- axilla 30332-00 [808] --- sentinel 30300-00 [808] -- scalene 30096-00 [805]</p> <p>Under sampling the following is listed for lymph node: lymph node -- for staging of malignancy 35726-01 [985] --- gynaecological ---- intra-abdominal (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] ---- para-aortic (laparoscopic) 35723-02 [810] -----via laparotomy 35723-03 [810] ---- pelvic cavity (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] ---- retroperitoneal (laparoscopic) 35723-00 [810] -----via laparotomy 35723-01 [810] --- lymphoma 30384-00 [985] -- axillary 30332-00 [808]</p> <p>It is the opinion of the QCC members that the indent level of para-aortic lymph node biopsy should be decreased to the same level as "gynaecological" with the appropriate code provided, as this procedure is not only carried out for gynaecological procedures.</p> <p>This index suggestion has been sent to the NCCC for their consideration.</p>
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0210-14	EBUS (Endobronchial Ultrasound)	<p>Can the QCC please confirm that the procedures coded for EBUS (Endobronchial Ultrasound) are:</p> <p>41898-00 <i>Fibreoptic Bronchoscopy</i> 30075-00 <i>Biopsy of lymph node</i> 55054-00 <i>Intra-operative ultrasound of other site</i></p> <p>Does the QCC agree with these codes for 6th Edition?</p> <p>We understand that in 7th Edition the ultrasound will not be coded.</p>	<p>QCC Response: The QCC agree that for the EBUS (Endobronchial Ultrasound) that the suggested codes best represent the procedure carried out (where biopsy is performed).</p> <p>41898-00 <i>Fibreoptic Bronchoscopy</i> 30075-00 <i>Biopsy of lymph node</i> 55054-00 <i>Intra-operative ultrasound of other site</i></p> <p>Note that in accordance with NCCH 7th edition training material, 55054-00 [1949] <i>Intraoperative ultrasound of other sites</i> is deleted in 7th Edition.</p>
0210-15	Optic nerve compression	<p>Does the QCC agree with the following codes for Optic nerve compression secondary to thyroid eye disease/ thyroid ophthalmopathy?</p> <p>H47.0 <i>Disorders of optic nerve, NEC</i> E05.0+ <i>Thyrotoxicosis with diffuse goitre</i> H06.2* <i>Dysthyroid exophthalmos</i></p> <p>Also, we are finding it difficult to classify Thyroid eye disease or thyroid ophthalmopathy as these terms are not recognised in ICD-10-AM.</p>	<p>QCC Response: The QCC considers that the suggested codes best represent the condition discussed.</p> <p>H47.0 <i>Disorders of optic nerve, NEC</i> E05.0+ <i>Thyrotoxicosis with diffuse goitre</i> H06.2* <i>Dysthyroid exophthalmos</i></p> <p>The QCC also considers that there needs to be index improvement to assist in correctly allocating codes for this condition. This index improvement has been sent as a suggestion to the NCCC to consider including an index entry for thyroid eye disease e.g. disease - thyroid -- with eye involvement.</p>
0310-01	Mesh Erosion of vaginal wall mesh	<p>Mesh erosion is a complication associated with surgical mesh devices used to repair Pelvic Organ Prolapse and Stress Urinary Incontinence where the mesh erodes through the vaginal epithelium.</p> <p>What is the correct diagnosis code to assign for the diagnosis of Mesh Erosion?</p> <p>What is the correct procedure code for excision of mesh?</p>	<p>QCC Interim Response: In answering this query, the QCC considered the following: The mesh device is neither a genital or urinary implant, but rather a pelvic peritoneal implant. Therefore, the QCC considers that in the scenario provided that the appropriate code allocation is as follows:</p> <p>PDT85.6 <i>Mechanical complication of other specified internal prosthetic devices, implants and grafts</i> (not genital or urinary) Y83.1 and Y92.22 (external cause codes) S31.4 <i>Open wound of vagina and vulva</i> (any specific injury – in this case erosion through) Y83.1 and Y92.22 (external cause codes) 35572-00 [1280] <i>Colpotomy</i> (based on logic for code for r/o abdominal prosthesis/mesh and not being a vaginectomy) 90449-00 [1286] <i>Other repair of vagina</i> (oversew of erosion)</p> <p>The QCC will send this query to NCCC for ratification.</p>

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0310-02	Clinical Liaison Psychiatry	Can the code for allied health psychology 95550-10 [1916] be used for Clinical Liaison Psychiatry consults?	<p>QCC Response: The QCC advises that the disciplines of Psychology and Psychiatry are different.</p> <p>Psychology is considered a component of allied health, whilst Psychiatry is a medical specialty.</p> <p>QCC members suggested that a new range of Z codes or procedure codes could be introduced to specifically capture specialty consultations that would be used only where there is no condition or symptom identified.</p> <p>The QCC will send this suggestion to the NCCC to create a new range of Z codes that could be introduced into the classification to specifically capture specialty consultations.</p>
0310-03	Metastatic colorectal adenocarcinoma	<p>Is it correct to assign the procedure code 3041500 [953] <i>segmental resection of liver</i> once only as per Coding standard 0020 Bilateral/Multiple Procedures, Multiple Procedures, point 2?</p> <p><i>"The same procedure repeated during a visit to theatre involving one entry point/approach and similar/same lesions. Assign one code for these procedure types."</i></p> <p>Our uncertainty stems from lack of clarity regarding whether the entry point /approach would be considered to be the single abdominal incision, or whether the three separate areas of the liver excised are regarded as separate entry points.</p>	<p>QCC Response: The QCC considers that the correct code to use in this scenario would be: 30421-00 [953] <i>Trisegmental resection of liver</i></p> <p>QCC members, after reviewing the current available codes for liver resection, will consider suggesting improved and extended codes at block 953. These new suggested codes would include new codes for resection for particular types of segmentectomy e.g. segmental resection of segment 4 (utilising Couinaud's liver segments).</p>
0310-05	Principal diagnosis in Obstetrics	<p>Can the enquirer assume from the advice previously given in QCC 0709-03, that whenever there is a Z35 code that it can replace the O80 code?</p> <p>Refer also to query 1109-05</p>	<p>QCC Interim Response:</p> <p>Refer to response for query 1109-05</p> <p>The QCC will send this query to the NCCC for ratification.</p>

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0310-06	Management of tracheostomy	<p>We would like the QCC/NCCC to clarify in what circumstances it is appropriate to assign code 90179-06 [568] <i>Management of tracheostomy</i>.</p> <p>ACS 1006 Ventilatory Support at p.179 includes this code amongst the list of codes under the section "Intubation without ventilation" stating that: <i>"In cases of intubation without ventilation, no matter what the age of the patient, a code from the list below should be assigned.</i></p> <p>However coders here are confused as to when 90179-06 [568] can be assigned.</p> <p>Scenario 1: Where a patient has a tracheostomy performed during the episode of care.</p> <p>Scenario 2: Where a patient requires endotracheal or other intubation without ventilation during the episode of care.</p> <p>Scenario 3: Where a patient is admitted specifically for removal or replacement of their tracheostomy tube.</p> <p>Scenario 4: Where a patient is admitted specifically for closure of a tracheostomy.</p> <p>We are uncertain about whether a non-transferred patient who receives some care or attention to their tracheostomy (e.g. suctioning) while in hospital should be assigned either 90179-06 [568] and/or Z93.0.</p>	<p>QCC Response: The QCC members consider that the only time to utilise the code 90179-06 [568] <i>Management of tracheostomy</i> is when following advice from ACS 1006 Ventilatory support pg179 pt 2.</p> <p>The QCC agrees with the coding in the following scenarios:</p> <p>Scenario 1: Where a patient has a tracheostomy performed during the episode of care, a code from block [536] is assigned for the tracheostomy procedure only. Do not code 90179-06 [568] <i>Management of tracheostomy</i>.</p> <p>Scenario 2: Where a patient requires endotracheal or other intubation without ventilation during the episode of care. Code only the appropriate intubation code. Do not code 90179-06 [568] <i>Management of tracheostomy</i>.</p> <p>Scenario 3: Where a patient is admitted specifically for removal or replacement of their tracheostomy tube, the principal diagnosis allocated would be Z43.0 <i>Attention to tracheostomy</i>. Procedure codes would include either 92047-00 [568] <i>Removal of tracheostomy tube</i> or 92046-00 [568] <i>Replacement of tracheostomy tube</i>. Do not code 90179-06 [568] <i>Management of tracheostomy</i>.</p> <p>Scenario 4: Where a patient is admitted specifically for closure of a tracheostomy, the principal diagnosis is Z43.0 <i>Attention to tracheostomy</i>. Procedure codes would include 41879-02 [539] <i>Closure of external fistula of trachea</i>.</p> <p>There was discussion within the QCC regarding the scenario about a non transferred patient who receives some care or attention to their tracheostomy. Some members would consider coding 90179-06 [568] <i>Management of tracheostomy</i> whilst others would not.</p> <p>QCC members considered when the status codes Z93.0 and Z43.0 should be allocated.</p> <p>When considering this issue, the QCC considered that Z43 <i>Attention to artificial openings</i> includes: Closure passage of sounds or bougies reforming removal of catheter toilet or cleansing</p>
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0310-06 cont.			<p>QCC members consider that Z43.0 <i>Attention to tracheostomy</i> should be used when the above care is given to the tracheostomy and initiation has not occurred in the same episode of care.</p> <p>QCC members have asked that a query is sent to the NCCC regarding when a coder would allocate the code Z93.0 <i>Tracheostomy status</i>.</p> <p>In addition, the QCC will suggest to the NCCC that a Coding Matters article is written regarding the use of 90179-06 [568] <i>Management of tracheostomy</i>, Z43.0 <i>Attention to tracheostomy</i> and Z93.0 <i>Tracheostomy status</i>.</p> <p>The QCC will send a query to the NCCC enquiring what the definition of management means. In what circumstances should this procedure code and Z condition code be used.</p>
0310-07	Intrathecal administration of chemotherapy	<p>Intrathecal administration of chemotherapy under General Anaesthetic performed on more than one occasion during an admission.</p> <p>Under ACS 0044 Chemotherapy <i>"When a patient receives pharmacotherapy a number of times during an episode of care and the same procedure code applies; assign the procedure code only once."</i></p> <p>Under ACS 0042 / 0031 Procedures normally not coded / Anaesthesia <i>"The listed procedures (procedures normally not coded) should be coded if anaesthesia (except local) is required for the procedure."</i></p> <p>Do we code the intrathecal chemotherapy as many times as there is a general anaesthetic or do we just code it once according to the standard?</p>	<p>QCC Response: The QCC recommend coding the procedure once and the General Anaesthetics as many times as they occur.</p> <p>When coming to the above decision, the QCC considered the following:</p> <p>1. ACS 0031 Anaesthesia indicates at Classification point 2. that: <i>"If the same anaesthetic is administered more than once during different 'visits to theatre', within the total episode of care (eg two general anaesthetics), it should be coded as many times as performed."</i></p> <p>In addition, ACS 0044 Chemotherapy states that: <i>"When a patient receives pharmacotherapy a number of times during an episode of care and the same procedure code applies, assign the procedure code only once."</i></p> <p>Where a lumbar puncture or a bone marrow aspiration are carried out as separate procedures to the chemotherapy (i.e. they are not considered an approach), these procedures should be coded out as many times as they occur.</p>

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0310-08	Same Day Oncology patient - Planning for radiotherapy	<p>Same Day Oncology patient - Planning for radiotherapy – moulding performed under GA.</p> <p>What is the principal diagnosis in this scenario?</p> <p>We are not sure whether to code the malignancy or Z51.4 <i>Preparatory care for subsequent treatment, not elsewhere classified</i>.</p> <p>The DRG is also different according to which principal diagnosis code is chosen.</p> <p>If we follow the same logic as coding renal dialysis we should code the Z51.4.</p> <p>The moulding for radiotherapy is captured with the procedure code.</p>	<p>QCC Response:</p> <p>In March 2010 Coding Matters Volume 16 no. 4 the following advice was given: <i>“Brachytherapy planning</i> <i>Is it acceptable to assign Z51.4 Preparatory care for subsequent treatment as the principal diagnosis when a patient is admitted for brachytherapy planning or should the principal diagnosis be the cancer?</i></p> <p><i>The NCCC advises that coders should assign the condition as the principal diagnosis for brachytherapy planning, as ‘planning’ is considered part of the treatment of the neoplasm. Z51.4 Preparatory care for subsequent treatment, not elsewhere classified is a non-specific code and the data collection is better served by coding the condition with the intervention code specifically describing the reason for admission.”</i></p> <p>The QCC Considers that the same logic should be applied to the scenario given and would advise that the condition for which the radiotherapy is given should be allocated as the principal diagnosis.</p>
0310-09	Renal Conditions with hypertension	<p>ACS 0928 states that we must use a Chronic kidney disease (CKD) code with I15.0 or I15.1.</p> <p>The ACS 1438 definition of CKD is not met in these cases.</p> <p>We only see an acute admission, there is no CKD documented nor have they met the 3 month criteria documented in the standard.</p> <p>We are unsure about the intended use of I15.0 or I15.1 codes - are they based on the assumption that the patients have chronic hypertension due to chronic kidney disease?</p> <p>If so, how do we capture secondary hypertension in acute cases of kidney disease?</p> <p>How do we work around the ‘use additional code’ instruction in ACS 0928?</p>	<p>QCC Response:</p> <p>The QCC considers that the intent of the note in the tabular at I15.0 and I15.1 “use additional code to identify presence of CKD” is to be interpreted as code CKD in addition to secondary hypertension where CKD is present.</p> <p>The QCC agrees that ACS 0928 Secondary hypertension seems to imply that CKD must always be coded in conjunction with I15.0 <i>Renovascular hypertension</i> and I15.1 <i>Hypertension secondary to other kidney disorders</i>.</p> <p>The QCC believes that I15.0 <i>Renovascular hypertension</i> and I15.1 <i>Hypertension secondary to other kidney disorders</i> can also be caused by acute kidney disease.</p> <p>The QCC will ask that the NCCC consider whether I15.0 <i>Renovascular hypertension</i> and I15.1 <i>Hypertension secondary to other kidney disorders</i> can also be caused by acute kidney disease. If so, it will be recommend this logic be incorporated into ACS 0928 Secondary Hypertension.</p>

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0310-10	Laminectomy with debulking of tumour	<p>Laminectomy with debulking of tumour.</p> <p>The procedure can be adequately captured with 40309-00 [53] <i>Removal of spinal extradural lesion</i> (which includes laminectomy).</p> <p>However this tumour is a neuroblastoma and the removal/excision of neuroblastoma has their own set of codes: 43987-00 <i>Excision of intrathoracic neuroblastoma</i> (563 Excision procedures on chest wall, mediastinum or diaphragm) 43987-02 <i>Excision of neuroblastoma NEC</i> (80 Removal of lesion of nerve) 43987-01 <i>Excision of intra-abdominal neuroblastoma</i> (989 Other excision procedures on abdomen, peritoneum or omentum)</p> <p>The tumour in question is an intrathoracic neuroblastoma but the excision of intrathoracic neuroblastoma codes implies the excision is performed via a thoracotomy or from the front.</p> <p>This code gives no indication that the surgery is spinal.</p> <p>Similarly, if we code 43987-02 <i>excision of neuroblastoma NEC</i> – this code gives no indication that the surgery is spinal.</p> <p>The above case of intrathoracic neuroblastoma with a spinal excision groups to a 901Z. If we use the intrathoracic neuroblastoma with excision of neuroblastoma NEC as the principal procedure, it also groups to 901Z.</p> <p>However if we use the excision of intrathoracic neuroblastoma, this groups to EO2C Other respiratory system OR procedures without catastrophic or severe cc.</p>	<p>QCC Response: In responding to this query, the QCC considered the index for the ACHI.</p> <p>Index: Excision - neuroblastoma NEC</p> <p>Not elsewhere classified (NEC) in the ACHI: <i>"is used in the context of a warning to users that certain specified variants of the listed procedures may appear in other parts of the classification. Codes including 'NEC' within their description are only to be assigned when the user lacks the information necessary to assign the procedural term to a more specific code."</i></p> <p>Therefore the QCC recommends that the code allocated in the scenario quoted is as follows: 1. Laminectomy with excision of extradural tissue and debulking 40309-00 [53] <i>Removal of spinal extradural lesion</i></p> <p>The QCC will query the NCCC as to the requirement of the codes in the ACHI for excision of neuroblastoma.</p>
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0310-11	Paravertebral or Paraspinal Neuroblastoma – primary site code	<p>Paravertebral or Paraspinal Neuroblastoma – primary site code.</p> <p>How should you code the primary site when documentation and radiological reports state paravertebral or paraspinal neuroblastoma?</p> <p>Clinical advice stated to code it to spinal.</p> <p>The neuroblastoma arises in the sympathetic nervous system and in the case of paravertebral in the paraspinal ganglia.</p> <p>http://www.acrf.com.au/page/neuroblastoma.html: <i>"Neuroblastoma can occur anywhere in the body, In some children, neuroblastoma is found in the neck in nerve tissue in the chest, and also around the spinal cord. (C72.9 or spinal cord C72.0)"</i></p> <p>The Mosby's Dictionary of Medicine, Nursing and Health Professions state: <i>"A very rare, highly malignant tumour composed of primitive ectodermal cells derived from the neural plate during embryonic life. The tumour may originate in any part of the sympathetic nervous system but is most common in the adrenal medulla."</i></p> <p>Dorland's Illustrated Medical Dictionary state: <i>"Sarcoma consisting of malignant neuroblasts, usually arising in the autonomic nervous system or (in the adrenal medulla.)"</i></p> <p>This neuroblastoma was also referred to as a thoracic tumour.</p> <p>The DRG changes according to what principal diagnosis is assigned.</p>	<p>QCC Response: QCC members discussed the difference between paravertebral and paraspinal, and spinal. The QCC believes that currently these locations should be coded to "spinal" when coding neoplasms.</p> <p>The QCC considers that it would be valuable to have these terms indexed.</p> <p>The QCC will send an index enhancement suggestion to the NCCC.</p>
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0310-12	Neoplastic patient admitted for administration of radiotherapy	<p>Neoplastic patient admitted for administration of radiotherapy under general anaesthetic and IV administration of chemotherapy in a one day stay.</p> <p>What is the principal diagnosis – Z51.1 or Z51.0?</p> <p>Which standard overrides – ACS 0044 Chemotherapy or ACS 0229 Radiotherapy?</p> <p>ACS 0044 Chemotherapy <i>"For episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the patient is discharged on the same day as admission, Assign: Z51.1 as the principal diagnosis, a code for the neoplasm being treated as the first additional diagnosis, additional diagnosis code(s) for any neoplasm related condition(s) being treated"</i></p> <p>ACS 0229 Radiotherapy <i>"Should there be any same-day radiotherapy admissions, Z51.0 Radiotherapy session will be the principal diagnosis followed by the malignancy and procedure codes."</i></p> <p>Which one takes precedence?</p> <p>Should the Z51.0 take precedence because the radiotherapy is being performed under GA?</p> <p>If Z51.0 is chosen as the principal diagnosis, seemingly the other Z51.1 would be deleted and vice versa. Is this correct?</p> <p>The assignment of principal diagnosis also affects the DRG – R63Z (Chemotherapy) or R64Z (Radiotherapy) which have different cost weights.</p>	<p>QCC Interim Response: According to ACS 0001 Principal Diagnosis, the principal diagnosis is defined as <i>"The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code."</i> (Health Data Standards Committee (2006), National Health Data Dictionary, Version 13, AIHW).</p> <p>ACS 0001 Principal Diagnosis also states that: <i>"When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition."</i></p> <p><i>"If no further information is available, code as the principal diagnosis the first mentioned diagnosis."</i></p> <p>The QCC notes that there are current validation edits against using either Z51.0 <i>Radiotherapy session</i> or Z51.1 <i>Pharmacotherapy session for neoplasm</i> in any other position than the principal position.</p> <p>Where it is necessary to code one of these codes as an additional diagnosis, it will be necessary to request that the validation error is "mapped".</p> <p>This query will be sent to NCCC for further clarification.</p> <p>In addition this query and QCC response has been forwarded to the Activity Based Funding Unit for their information.</p>
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0310-13	Suicidal Ideation	<p>When suicidal ideation R45.81 is used as the principal diagnosis under the current grouper version it groups to 961Z Unacceptable Principal Diagnosis.</p> <p>Under the Casemix Funding Model (CFM) this DRG attracts \$0.00 (refer appendix 2 CFM Technical Paper 09/10).</p> <p>Can we highlight this issue (and similar issues) with the Casemix Unit?</p>	<p>QCC Response: This issue needs to be highlighted as hospitals are not being funded on valid coding due to the fact that AR-DRG V5.0 is currently being used within the Casemix Funding Model.</p> <p>There needs to be a procedure for hospitals to follow to highlight these cases and ensure that remuneration is correctly allocated.</p> <p>The QCC recommends that hospitals that have these types of queries should also identify this issue with their appropriate portfolio contact within Business Analysis & Management. (http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/forams/bam_phone_list.pdf)</p> <p>The QCC will forward this episode to the Activity Based Funding Unit for their information.</p> <p>QCC Update: A new national governance system is being established to guide future AR-DRG System development. Part of this governance system is the DRG Technical Group (DTG) who: "<i>Advice in regard to the change and development of AR-DRGs in Australia</i>". Any Queries submitted to the QCC that have not been addressed by the current or a future version of AR-DRGs will be sent to the DTG for clarification/advice via the NCCC portal. (http://nccc.uow.edu.au/about/governancemodel/index.html).</p>
0310-15	Failed Trial of Labour	Should we only code the 'Failure to progress 1st stage' or the 'Failed Trial of Labour' or both?	<p>QCC Response: The QCC recommends consulting with the clinician in regards to the documented trial of labour.</p> <p>Clarification needs to be sought on whether the Clinician meant trial of labour or trial of scar.</p> <p>If the clinician clarifies that the patient was admitted for trial of labour, which consequently "failed", code to O66.4 <i>Failed trial of labour, unspecified</i>.</p> <p>If the clinician clarifies that the patient was admitted for a trial of scar, which consequently "failed", code to O34.2 <i>Maternal care due to uterine scar from previous surgery</i></p> <p>The QCC will send a query to the NCCC asking for clarification on the definition and time limitations of 'Failed trial of labour'.</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p>

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0310-17	Polypectomy - Endoscopic mucosal resection	In a day surgery setting, can QCC advise what code should be used for a procedure labelled as a polypectomy when the documentation of procedural technique for this states "endoscopic mucosal resection"?	<p>QCC Response: The QCC recommends that the enquirer seeks clinical input from the treating clinician.</p> <p>In the absence of clinical advice, the QCC recommends that the enquirer follows the index:</p> <p>Resection - mucosa, endoscopic -- large intestine 90297-02 [914] - <i>Endoscopic mucosal resection of large intestine</i></p> <p>Additional information indicates that this procedure is submucosal rather than mucosal</p> <p>The QCC will ask if a change can be made to the index that will allow for the resection code to lead to the polypectomy code if appropriate.</p> <p>Resection - mucosa, endoscopic -- large intestine 90297-02 [914] - <i>Endoscopic mucosal resection of large intestine</i> -- submucosa, endoscopic – See Polypectomy -- for polypectomy</p> <p>Polypectomy - colon -- via --- colonoscopy (beyond hepatic flexure) (fiberoptic) (flexible) (long) (to caecum) 32093-00 [911] ---- by ----- forceps biopsy (cold)(hot) ----- mucosal resection ----- snare (cold) (hot) ----- submucosal resection (dissection) ---- to hepatic flexure (ascending colon) (short) 32087-00 [911]</p>
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0310-18	Glottitis vs Glossitis	<p>In the index when you look up Glottitis you are told to see Glossitis.</p> <p>This does not make sense as: Glottitis is an inflammation of the glottic portion of the larynx and should be coded to some type of laryngitis Whilst Glossitis is inflammation of the tongue.</p> <p>Can the QCC recommend that an index improvement occur to appropriately reflect this difference?</p>	<p>QCC Response: Brief research indicates that the glottis is “the vocal apparatus of the larynx; the true vocal folds and the space between them where the voice tone is generated”. (wordnetweb.princeton.edu/perl/webwn)</p> <p>Also that glottitis is defined as “Inflammation of the glottic portion of the larynx”. (http://medical-dictionary.thefreedictionary.com/glottitis)</p> <p>Alternately, glossitis is defined as “inflammation of the tongue”. (wordnetweb.princeton.edu/perl/webwn)</p> <p>Currently, the following index look up applies for Glottitis Glottitis — see Glossitis</p> <p>Therefore, the QCC will recommend to the NCCC that an index improvement occur to appropriately reflect this difference between Glottitis and Glossitis.</p>
0410-01	PACI (Partial anterior circulation infarct) secondary to AF	<p>PACI (Partial anterior circulation infarct) secondary to Atrial Fibrillation</p> <p>As Atrial Fibrillation is mentioned as the underlying cause can we assume embolic infarct in this instance, I63.4?</p>	<p>QCC Response: In the absence of further clarification, QCC recommends assignment of I63.9 <i>Cerebral infarction, unspecified</i> for the scenario described.</p> <p>However, the QCC feels that consultation with the clinician is recommended to determine whether the infarct was of an embolic nature.</p> <p>If the infarct was of an embolic nature, further clarification is need to determine if the embolism is of a cerebral artery or a precerebral artery.</p> <p>This further clinical information may change the code allocation required.</p>
0410-02	Basilar Thrombectomy	<p>Can the QCC please advise the correct code for Basilar Artery Thrombectomy?</p> <p>This ‘mechanical embolectomy’ procedure involves inserting a catheter into the femoral artery, directing it into the cerebral circulation, and deploying a corkscrew-like device to ensnare the clot, which is then withdrawn from the body.</p>	<p>QCC Response: The QCC suggests assigning 35320-00 [741] <i>Other peripheral arterial or venous catheterisation with administration of thrombolytic or chemotherapeutic agents</i> and 90230-00 [702] <i>Embolectomy or thrombectomy of other artery</i>.</p> <p>These codes can be reached by following the ACHI index (respectively): Thrombectomy - artery -- specified site NEC Embolectomy - artery -- peripheral --- by surgical catheterisation and infusion (open)</p>

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0410-03	Posterior Circulation Infarct (POCI) with haemorrhagic transformation	<p>Patient presents with POCI. Discharged. Re-admitted with haemorrhagic transformation as a result of anticoagulant therapy.</p> <p>Our query is around the application of ACS0605. What can be considered an extension of an old stroke and when should we follow ACS0605 and code the infarct again I63.9? Do we also code the haemorrhage I61.9 to reflect the new bleed?</p> <p>Does the QCC consider these codes acceptable to this scenario? And are we using ACS0605 correctly?</p>	<p>QCC Response: Based on the clinical information provided in the query, and in line with ACS 0001 Principal Diagnosis, the QCC recommends that the enquirer code the haemorrhagic transformation as the principal diagnosis.</p> <p>The QCC recommends that the enquirer seek clarification from the treating clinician about whether the previous POCI is still being treated as acute in this admission.</p> <p>If it is, then the QCC recommends that the enquirer follow ACS 0604 Stroke and adopt the advice that: <i>"While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign a code from categories I60-I64 (cerebrovascular diseases) with any applicable deficit codes (eg hemiplegia)."</i></p>
0410-04	Spontaneous Rupture of Membranes	<p>In 10-AM Commandments in Coding Matters Volume 7 number 2, there is advice that states: <i>"Codes from category O42 should be assigned when spontaneous rupture of membranes occurs before the start of labour."</i></p> <p>In the index: membranes (spontaneous) --artificial ---delayed delivery following O75.5 ----affecting fetus or newborn P01.1 --delayed delivery following O75.6 ---affecting fetus or newborn P01.1 --premature O42.9 [Extracted from NCCC eBook, July 2008, R.]</p> <p>Spontaneous is a non-essential modifier. Is it necessary for a premature rupture of membranes (PROM) to be documented as spontaneous prior to coding out PROM?</p>	<p>QCC Response: According to ACS 1531 Premature Rupture of Membranes, PROM should be coded when:</p> <ul style="list-style-type: none"> • <i>This condition should be coded when documented by an obstetrician/clinician/midwife.</i> • <i>If the criteria for the specific obstetric diagnosis is met but the relevant diagnosis is not documented, consult the clinician before assigning a code."</i> <p>As a result of the above advice, the QCC recommends that PROM is to be coded where it is documented as such.</p> <p>Where it appears as if the specific obstetric diagnosis is met and it is not documented the clinician should be consulted prior to assigning the code.</p> <p>The added information regarding spontaneity of the PROM is not included in the standard.</p> <p>Consequently, the QCC will consult with the NCCC regarding the requirement of the word "spontaneous" prior to coding PROM as described in Coding Matters Volume 7 no. 2.</p>

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0410-06	Blood Alcohol levels	<p>We can now code what the Blood Alcohol Level/content is on patients who present intoxicated, if it's documented.</p> <p>However we have been informed that very rarely blood alcohol level/content is done and that what we thought was blood alcohol level/content documented in the patients chart was in fact just a breath test.</p> <p>We phoned pathology to get clarification on what to look for if/when blood alcohol level/content are recorded and find that in fact we have been doing the wrong thing from a coding viewpoint.</p> <p>We just wondered if any others may have been confused and whether the 3M Codefinder option to select whether the "Wish to code blood alcohol level?" is being followed correctly.</p>	<p>QCC Response: The QCC recommends that where alcohol levels are documented as blood alcohol levels it is permissible to allocate a code from the rubric Y90 <i>Evidence of alcohol involvement determined by blood alcohol level</i>.</p> <p>It is important for the enquirer to note that alcohol levels may be measured from the breath. This measurement is not to be allocated a code from the rubric Y90 <i>Evidence of alcohol involvement determined by blood alcohol level</i>.</p> <p>Please be aware that there are differences between the results given in serum alcohol analysis versus blood alcohol analysis. If you are unsure of the levels for coding, please consult with the clinician.</p> <p>It is also important to note that codes from the rubric Y91 <i>Evidence of alcohol involvement determined by level of intoxication</i> should not be used for inpatient morbidity coding.</p> <p>QCC Follow Up: Recommendation to be made to Codefinder Clinical Support Specialist that this difference should be included into 3M Codefinder.</p>
0410-07	Interposition graft of Right Fem-pop graft	Can the QCC advise what is the appropriate procedure code for interposition graft (vein) of a right fem-pop bypass graft that has stenosed?	<p>QCC Interim Response: The QCC recommend using [710] 33821-05 <i>Repair of popliteal artery by interposition graft</i>.</p> <p>The QCC will ask the NCCC for revision of the bypass code and index entries.</p>

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0410-08	Laparoscopic button insertion	<p>Failure to thrive with a laparoscopic button insertion in a cerebral palsy (CP) patient.</p> <p>Consider the following coding string, however it groups to 902Z. <i>R62.8 Other lack of expected normal physiological development</i> <i>G80.03 Spastic quadriplegic cerebral palsy</i> <i>30483-00 Insertion of percutaneous non endoscopic gastrostomy button</i> <i>30390-00 Laparoscopy</i> <i>92514-xx General anaesthesia</i></p> <p>This query is pertaining to Grouper logic.</p>	<p>QCC Response: The QCC advises that this is a grouper issue. This particular issue has been fixed in AR-DRG version 6.0.</p> <p>The QCC recognises that there needs to be a procedure in place to ensure that hospitals are not penalised for coding correctly in the current Casemix environment.</p> <p>The QCC recommends that hospitals that have these types of queries should also identify this issue with their appropriate portfolio contact within Business Analysis & Management. (http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/forams/bam_phone_list.pdf)</p> <p>In addition this query and QCC response has been forwarded to the Activity Based Funding Unit for their information.</p> <p>QCC Update: A new national governance system is being established to guide future AR-DRG System development. Part of this governance system is the DRG Technical Group (DTG) who: "<i>Advice in regard to the change and development of AR-DRGs in Australia</i>". Any Queries submitted to the QCC that have not been addressed by the current or a future version of AR-DRGs will be sent to the DTG for clarification/advice via the NCCC portal. (http://nccc.uow.edu.au/about/governancemodel/index.html).</p>
0410-09	TAP Blocks	<p>Can the QCC please advise if the following procedure should be coded as regional nerve block of trunk 92510*?</p> <p>Documentation of TAP block on the anaesthetic record under regional technique.</p> <p>Clinical literature states that Transversus abdominis plane (TAP) block is an ultrasound guided abdominal wall field block involving application of local anaesthetic solution into the plane between internal oblique and transversus abdominis muscles.</p>	<p>QCC Interim Response: The QCC recommends that where this procedure is administered for anaesthesia that the correct code allocation is: 92510-** <i>Regional block, nerve of trunk.</i></p> <p>The QCC also recommends that where this procedure is administered for pain management, that the correct code allocation is: 90022-00 [63] <i>Administration of anaesthetic agent around other peripheral nerve</i></p> <p>The QCC will send the above response to NCCC for ratification.</p>

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0510-01	Grouper Issue – Burns Scar	<p>Grouper Issue – Scar conditions and fibrosis of skin with revision procedure.</p> <p>Please consider the coding is as follows: L90.51 <i>Scar conditions and fibrosis of skin due to burn</i> T95.2 <i>Sequelae of burn and frostbite of upper limb</i> Y86 <i>Sequelae of other accidents</i> Y92- <i>Place of occurrence</i> 45519-00 <i>Revision of burn scar or burn contracture</i> 92514-xx <i>General Anaesthesia</i></p> <p>This scenario groups to 902Z – Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis.</p> <p>This is a relatively common scenario. Are we able to examine the Grouper logic and rectify this issue.....I believe it has been rectified in a previous version(s) of the grouper.</p>	<p>QCC Response: The QCC notes that this issue has been addressed in AR-DRG V5.2.</p> <p>QCC Follow Up: Due to the number of these issues that the QCC has referred to them and recommends that hospitals that have these types of queries should also identify this issue with their appropriate portfolio contact within Business Analysis & Management. (http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/forms/bam_phone_list.pdf)</p> <p>In addition, this query and QCC response has been forwarded to the Activity Based Funding Unit for their information.</p> <p>QCC Update: A new national governance system is being established to guide future AR-DRG System development. Part of this governance system is the DRG Technical Group (DTG) who: "<i>Advice in regard to the change and development of AR-DRGs in Australia</i>". Any Queries submitted to the QCC that have not been addressed by the current or a future version of AR-DRGs will be sent to the DTG for clarification/advice via the NCCC portal. (http://nccc.uow.edu.au/about/governancemodel/index.html).</p>
0510-02	Nutrition Assistant	<p>ACS 0032 provides Clinical Coders with 14 allied health interventions (as stated) represented in ACHI. For the purposes of Clinical Coding and Classification, codes are required to be assigned for the general allied health interventions in block [1916].</p> <p>In our clinical notes there are entries documented by 'Nutrition Assistant'. Essentially a nutrition assistant is akin to a therapy assistant in other allied health disciplines, however in this case these 'nutritional assistants' are solely involved in the area of Nutrition/Dietetics. Their roles are to undertake screening of patients and feedback to the dietician for further instruction. Where required, the dietician will review the patient</p> <p>Should we be capturing this data by assigning the dietician allied health intervention code? As these assistants are undertaking a body of work normally performed by a dietician, however in these scenarios they are delegated to undertake the body of work by the dietician?</p>	<p>QCC Response: ACS 0032 Allied Health interventions states that: "<i>A key principle of procedure classification development is that interventions should be 'provider neutral', that is, the same code should be assigned for a specific intervention regardless of which health professional performs the intervention.</i>"</p> <p>Therefore, where an allied health intervention is carried out by another health professional, a code from the block [1916] can be allocated.</p> <p>QCC members recommended that further investigation needs to be undertaken to determine if nutritional assistant is defined as a "health professional". The QCC response will change dependent upon this answer.</p> <p>Further information from the enquirer indicated that the nutrition assistants were not clinical health professionals. Consequently, no code would be assigned to reflect this procedure. Hospitals should ascertain on a case by case basis as to the professional capacity of nutritional assistants prior to adopting this advice.</p>

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0510-03	Mixed Bipolar affective disorder with psychotic features	<p>Can the QCC advise on how to code mixed bipolar affective disorder with psychotic features i.e. do we need to identify 'psychotic features' with another code or consider it part of the F31.6.</p> <p>There are codes for hypomania and depression under block F31 to distinguish with or without psychotic symptoms but not for mixed.</p> <p>Can we assume psychotic features are the same as psychotic symptoms?</p>	<p>QCC Response: At the rubric F31 Bipolar affective disorder the includes note states: Includes:</p> <ul style="list-style-type: none"> • manic-depressive: • illness • psychosis • reaction <p>Therefore, the QCC suggests coding out F31.6 <i>Bipolar affective disorder, current episode mixed</i>.</p> <p>This recommendation is based on the assumption that there is documentation within the current episode of care of the "current" or "most recent" affective episode.</p> <p>Where there is no documentation in the current episode of care of the "current" or the "most recent" affective episode; then according to Coding Matters Volume 16 No. 3, the correct code allocation would be: <i>F31.9 Bipolar affective disorder, unspecified</i></p>
0610-01	Plasmapheresis	<p>If a patient receives plasmapheresis more then once during their episode of care (not same day) do you code it once or as many times as performed?</p>	<p>QCC Response: The QCC recommends that plasmapheresis should be coded once per episode of care unless it is performed under a cerebral anaesthetic.</p> <p>Plasmapheresis follows a similar treatment protocol pathway as hemodialysis and blood transfusions and coders should therefore refer to ACS 0020 Bilateral multiple procedures (same procedure repeated during multiple episodes of care) when coding this procedure.</p>

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0610-02	Major depressive disorder	<p>Can QCC please advice the correct diagnosis code for Major depressive disorder – MDD? There are conflicting index entries in both 6th & 7th Edition.</p> <p>Under the index entry of Depression, major – the code assigned in F32.2x (severe).</p> <p>Under the index entry of Disorder, depressive, there is a change from 6th edition to 7th edition in that the term major is a non-essential modifier, but the entry under Depression, major has not changed between editions.</p> <p>Please also note the coding examples 3 & 5 in ACS 0505 Mental illness complicating pregnancy where descriptions of major depression are coded as F32.20 & F32.21 respectively.</p> <p>Depression F32.9- - major (without psychotic symptoms) F32.2-</p> <p>Disorder (of) — see also Disease - depressive (see also Depression) F32.9- -- major --- recurrent F33.9 --- single episode ---- mild F32.0- ---- moderate F32.1- ---- severe (without psychotic symptoms) F32.2- ----- with psychotic symptoms F32.3-</p> <p>Episode - affective, mixed F38.0 - brain (apoplectic) I64 - cerebral (apoplectic) I64 - depressive F32.9- -- major (see also Disorder, depressive, major) F32.9- -- mild F32.0- -- moderate F32.1- -- recurrent (see also Disorder, depressive, recurrent) F33.9 --- brief F38.1 -- severe (without psychotic symptoms) F32.2- --- with psychotic symptoms F32.3- -- specified NEC F32.8-</p>	<p>QCC Response: The QCC advise the correct code for “major depressive disorder” is F32.2 <i>Severe depressive episode without psychotic symptoms</i> by following the index pathway: Depression - major F32.2-</p> <p>The QCC note the index inconsistency in the following index pathway: Disorder - depressive (major) F32.9-</p> <p>The QCC will request the NCCC consider removing the nonessential modifier “major” in this pathway.</p>
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0610-03	Alcohol Withdrawal Scale	<p>What action should be initiated (code, don't code, seek clarification) if there is no statement of alcohol withdrawal however:</p> <p>1) There is documentation on an alcohol withdrawal chart, scores within this range are recorded and the corresponding area for medication indicates that medication was given on some days? OR 2) Alcohol, Tobacco and Other Drug Services (ATODS) review stages</p>	<p>QCC Response: The QCC advises that the coder seeks clarification from the clinician prior to assigning a code for withdrawal unless withdrawal is documented within the clinical record.</p>
0610-04	Oedema/swelling due to intravenous catheter	<p>Swelling of L) arm at IVC site post-op. Clinical documentation on review Oedema secondary to IVF – change IVC site.</p> <p>Should we be coding this? If so as oedema following infusion, transfusion and therapeutic injection?</p> <p><i>R60.0 Localised oedema</i> <i>T80.1 Vascular complications following infusion, transfusion and therapeutic injection</i> <i>Y84.8 Other medical procedures</i> <i>Y92.22 Health service area</i></p>	<p>QCC Response: QCC recommends that where the condition meets the criteria for coding under ACS 0002 Additional Diagnoses, codes should be allocated.</p> <p>The QCC recommends that the appropriate codes for the scenario are as follows: <i>T80.8 Other complications following infusion, transfusion and therapeutic injection</i> <i>R60.0 Localised oedema</i> <i>Y84.8 Other medical procedures</i> <i>Y92.22 Health service area</i></p> <p>Coders should note that normal care for intravenous therapy can include replacement and review of the intravenous line; these procedures should not be routinely coded.</p>
0610-05	IV Antibiotics pre-TURP surgery	<p>Can the QCC please provide guidance on the best way to code the following urology scenario?</p> <p>Patient presents day before surgery for IV antibiotics as prophylactic cover before Transurethral resection of the prostate (TURP) surgery. They are sent home and return the next day for the surgery. As the IV antibiotic is not actually treating the prostate condition we have chosen to code these as follows:</p> <p><i>Z29.2 Other prophylactic pharmacotherapy</i> <i>96199-02 Intravenous administration of pharmacological agent, anti-infective agent</i></p>	<p>QCC Response: The QCC considers the episode of care is for prophylactic care rather than for the treatment of the condition requiring surgery.</p> <p>The QCC considers that where the episode fulfils criteria for admission and no other conditions are listed, the correct codes for the scenario are: <i>Z29.2 Other prophylactic pharmacotherapy</i> <i>96199-02 Intravenous administration of pharmacological agent, anti-infective agent</i></p> <p>Note: This code string correctly groups to <i>Z62Z Follow Up After Completed Treatment W/O Endoscopy</i> (on AR-DRG v5.0).</p>