

Queensland Coding Committee Queries February 2009

QCC ID	Query summary	Query	QCC Response
0209-01	Incorrect drug given in hospital	<p>In cases where the incorrect drug is given, for example if a GTN patch is ordered but a Fentanyl Patch is given in error, and as a result the patient is observed closely for adverse effects and no adverse effects were noted. If observations were required to rule out any adverse effect it would meet criteria for coding as per ACS 0002 Additional Diagnoses, increased clinical care and/or monitoring</p> <p>Coded out to poisoning by the following index – Wrong drug (given in error) – which leads to: T40.4 Poisoning by other synthetic narcotics X42 Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified Y92.22 Place of occurrence at or in health service area</p> <p>ACS 1901 <i>POISONING</i> - Definition: '<i>Poisoning by drugs <u>includes drugs taken in error, suicide and homicide, adverse effects of prescribed drugs taken in combination with self-prescribed drugs and intoxication. Poisoning involves improper use.</u></i>'</p> <p>Can we request addition to ACS 1901 <i>POISONING</i> to read: '<u>Poisoning by drugs includes drugs taken or given</u> in error'</p>	<p>QCC Response: QCC recommend this query be sent to the NCCH for clarification to determine the definition of poisoning.</p> <p>QCC discussed different ideas for the coding of this scenario ranging from not coded at all (as there was no adverse effect noted), to coding Z03.6 to coding poisoning, Z03.6.</p> <p>QCC also noted that if poisoning was coded, why do the ACS direct the coder to use accidental external cause codes rather than misadventure external cause codes?</p> <p>Considering this, a query will be created from the above for the NCCH.</p> <p>NCCH Response: See ACS 2005 Poisonings and Injuries – Indication of Intent which states: 'X40–X49 Accidental poisoning by and exposure to noxious substances The 'includes' note at the beginning of this block in the Tabular List of Diseases specifies: • accidental overdose of drug • wrong drug given or taken in error • drug taken inadvertently • accidents in the use of drugs, medicaments and biological substances in medical and surgical procedures.'</p> <p>This is consistent with ICD-10, which classifies a</p>

Queensland Coding Committee Queries February 2009

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			<p>wrong drug given or taken in error, as an accidental poisoning.</p> <p>The NCCH will consider amending the definition of poisoning at ACS 1901 Poisoning to include 'drugs given/taken in error,' for a future edition of the ACS.</p>
0209-02	"Diabetes with" Index Issues	<p>Type 1 Diabetes Mellitus (IDDM) patients admitted with ketoacidosis and documentation of 'poorly controlled diabetic'. Further documentation of 'hypertension and fatty changes in liver'.</p> <p>QUERY: When you look up the index for the following: Diabetes, Diabetic (controlled) (mellitus) E1-.9</p> <p>Note: The three character subdivision for diabetes mellitus is:</p> <p>0 Type 1 (IDDM) 1 Type 2 (NIDDM) 3 Other Specified 4 Unspecified</p> <p>--with --acanthosis nigricans E1-.72 --fatty (changes in) (non-alcoholic) liver E1-.72 --features of insulin resistance E1-.72 --hypertension E1-.72 --increased intra-abdominal visceral fat deposition E1-.72 --insulin resistance E1-.72 --non alcoholic fatty (change in) liver E1-.72 or Fatty – See also condition -liver (non-alcoholic) NEC K76.0 --with diabetes mellitus E1-.72</p> <p>I know that fatty liver is <u>not</u> associated with Type 1 diabetes and therefore don't code as ADx. I also know to code the</p>	<p>QCC Response: The QCC agreed that coders may misconstrue the indexing of E1-.72, especially for features of insulin resistance, as it appears that the classification could allow the use of E10.72. However, there is no code E10.72 and this is discussed in ACS 0401.</p> <p>It may be difficult to present all allowable diabetes with insulin resistance options separately in the index however a suggestion will be made to NCCH to consider review of the index.</p> <p>A query will also be sent to the NCCH to investigate correct coding for T1 diabetes with insulin resistance (double diabetes). Possibilities were to code T1 diabetes and the conditions indicative of insulin resistance (current practice) or T1 and T2 with insulin resistance and indicative conditions (this would require enhancement to ACS 0401).</p> <p>The Committee also recommended that Coders exercise caution when IDDM is documented as this may imply T1 DM or T2DM requiring insulin.</p>

Queensland Coding Committee Queries February 2009

QCC ID	Query summary	Query	QCC Response
		hypertension out as an additional diagnosis as per ACS 0401 page 94 Classification . However, new coders are very confused as there is no E10.72 code in the Tabular List.	On occasion, it is possible that Clinicians may see documentation of IDDM and construe it to be type 1 and then write T1. If the Coder has any doubt about the diabetes type, clarification should be sought.
0209-03	Fournier's Gangrene	<p>The following query was sent to 3M for their progression into Codefinder.</p> <p>“When coding Fournier's gangrene of the scrotum with Type 2 DM, the Codefinder has different prompts giving different codes depending on which lead term and pathway is chosen.</p> <p>Using Diabetes or Fournier's the codes E11.69 and N49.8 are provided. If the spell option is utilised (scrotum) via the gangrene lead term pathway all the options aren't made available as per the index and therefore incorrect codes may be assigned.</p> <p>Where using gangrene as a lead term, an option exists prompting the user to spell the site of gangrene (in this case scrotum)...in this example the user does not get an opportunity to view the options available to them, as per the index (please refer to attached). Suggestions would be to add to the gangrene clinical pathway or alternatively provide an option to spell "type" of gangrene...for example Fournier's.</p> <p>In the second example where gangrene is used as the lead term and the option for diabetes is chosen, no option exists for Fournier's gangrene and the codes derived in the second example are incorrectly assigned.”</p> <p>3M are reluctant to do anything at this stage due to the deficiencies of the classification, namely the index in this area. We believe Codefinder is following the index and given the current state of diabetes and the issues around diabetes 'with', we would like to</p>	<p>QCC Response: The QCC initially recommended that this 3M Codefinder enhancement request should be closed.</p> <p>The reasoning is that the Coding pathway for Fournier's as per the index is as follows:</p> <p>Diabetes -with --gangrene ---Fournier's E1*.69</p> <p>or</p> <p>Gangrene -Fournier's N49.8 --with diabetes E-.69</p> <p>However after the meeting an additional issue was detected where an inappropriate pathway (diabetes without diabetic complication but with condition not in the above spell) was chosen (this might occur if the Coder did not know that Fournier's or gangrene were diabetic complications). This issue will be forwarded to 3M for clarification.</p> <p>3M Codefinder Response:</p>

Queensland Coding Committee Queries February 2009

QCC ID	Query summary	Query	QCC Response
		seek clarification via the QCC for approval from the NCCH before we make any changes.	This issue was discussed with 3M and it was decided that this is a coding education issue rather than an issue with the Codefinder pathway.
0209-04	Hereditary non-polyposis colon cancer	<p>Consider an example, where the diagnosis is Hereditary Non Polyposis Colon Cancer (HNPCC) and the procedure is total colectomy with ileorectal anastomosis.</p> <p>HNPCC is documented as the reason for the procedure on both the operation report and the principal diagnosis on the discharge summary. The gene mutation has been identified.</p> <p>Would ACS0247 continue to be effective in classifying this condition, if the option of colectomy is being used prior to the pt developing a colon cancer?</p> <p>The ACS was developed for ICD-10-AM 2nd edition, so the classification advice from the clinicians would be 9-10 years old by now.</p> <p>Please advise whether ACS 0247 Classification advice should be followed if the patient has not had carcinoma.</p> <p>Histology results and histology results from previous polypectomies, report tubular adenoma with high grade dysplasia and hyperplastic polyps. An option of close colonoscopic surveillance or total colectomy is given.</p> <p>ACS 0247 states to assign documentation of HNPCC: C18.- <i>Malignant neoplasm of colon + Z80.0 Family history of malignant neoplasm of digestive organs.</i></p> <p>Persons who are at risk for HNPCC due to a family history of the</p>	<p>QCC Response: As the diagnosis was stated as HNPCC, the QCC recommends that malignant neoplasm should be assigned as the principal diagnosis in accordance with ACS 0247.</p> <p>The QCC recommends that this query is sent to the NCCH for ratification as it was considered that prophylactic colectomy seemed to be an extreme measure that would be rare and the standard may not have been written accounting for this scenario.</p> <p>A suggestion will be made to the NCCH that if the Clinician confirms prophylactic intent that Z40.08 be coded additionally to show that while the patient has a gene mutation; no actual malignant neoplasms have yet been confirmed and that the intent of surgery is prophylactic.</p> <p>NCCH response The guidelines in ACS 0247 Hereditary non-polyposis colon cancer state: 'If hereditary non-polyposis colon cancer (HNPCC) is documented assign the following codes: C18.- Malignant neoplasm of colon Z80.0 Family history of malignant neoplasm of</p>

Queensland Coding Committee Queries February 2009

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		<p>disease will be screened at regular intervals (see ACS 2111 <i>Screening for specific disorders</i>).¹ There is no documentation of the procedure being “prophylactic” in the record.</p> <p>ACS 1204 Plastic Surgery has instructions for diagnosis codes under the heading Prophylactic Mastectomy.</p> <p>We believe that 1204 should not be applied to conditions outside prophylactic mastectomy, and that ACS 2111 does not apply as the intent was not for screening. Should we use C18. - as the principal diagnosis as per ACS 0247?</p>	<p>digestive organs</p> <p>Therefore, C18.- should only be assigned if there is documented evidence of HNPCC. In the scenario cited there is NO documented evidence of the patient having HNPCC, only a family history of HNPCC.</p> <p>The patient is undergoing colonoscopic surveillance due to this family history and current histology reports tubular adenoma with high grade dysplasia and hyperplastic polyps. For code assignment follow the guidelines in ACS 2111 Screening for specific disorders and ACS 0010 General abstraction guidelines.</p> <p>For the second scenario cited, where the patient with a family history of HNPCC elects to have a colectomy without documented evidence of HNPCC, it is reasonable to assume that the procedure, though extreme, is being performed prophylactically.</p> <p>In this instance assign Z40.08 Other in category Z40.0 Prophylactic surgery for risk-factors related to malignant neoplasms and Z80.0 Family history of malignant neoplasm of digestive organs, following the index pathways:</p> <p>Prophylactic - surgery</p>

Queensland Coding Committee Queries February 2009

QCC ID	Query summary	Query	QCC Response
			<p>- - for risk factors related to malignant neoplasm</p> <p>- - - specified NEC Z40.08</p> <p>and</p> <p>History</p> <p>- family, of</p> <p>- - malignant neoplasm (of) NEC</p> <p>- - digestive organ Z80.0</p> <p>If there is any doubt, the coder should verify code assignment with the clinician.</p>
0209-05	Alcohol Related Disease	<p>When you are coding alcohol related disease (eg alcoholic cirrhosis liver) is it necessary to code the alcohol dependence as a separate code or can this be assumed to be included in the alcohol related disease code?</p> <p>For example, in cases where alcohol dependant persons are admitted with alcoholic cirrhosis of the liver, can you code K70.3 Alcoholic Cirrhosis of the liver alone or do you need to add the F10.2 Alcoholism?</p>	<p>QCC Response:</p> <p>The QCC advises that a code F10.X should be coded additionally to the condition stated as “Alcoholic” even where “Alcoholic” is included in the code title of this condition.</p> <p>Please note “Alcoholic” in the code title does not necessarily imply alcoholism and F10.1 should be used if the actual alcohol use disorder is not stated.</p> <p>However at the 4th character level, harmful use, cannot be assigned if a more specific alcohol related disorder is documented. Therefore if alcoholism or alcoholic psychosis etc is stated, these codes (F10.2 or F10.7) would be used instead.</p>

Queensland Coding Committee Queries February 2009

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			<p>To formulate this response, the QCC has considered the advice from NCCH queries 893 and 2090 and the advice implied in the 6th Edition ACS 0503 example 2, a code F10.X should be coded additionally to the condition stated as alcoholic even where “alcoholic” is included in the code title.</p>
0209-06	Coding PROM	<p>Consider cases where Principal diagnosis is uterine inertia and principal procedure of LUSCS is documented. The patient is term and admission is for Trial of Scar and 'losing pink fluid PV' is noted. If the doctor notes 'SR0M, not in labour' for LUSCS does this indicate a diagnosis: 1. Premature rupture of membranes? 2. Previous LUSCS?</p> <p>This is referred to in ACS 1531 PREMATURE RUPTURE OF MEMBRANES and Coding Matters Vol 7, No. 2, Sept 2000 regarding coding PROM, however in the above scenario there was no labour just the PROM.</p> <p>This cannot really code to O42.X range as they all refer to onset of labour within a given time frame.</p> <p>A Coding Matters article advises 'O75 is a NEC category and should be used rarely as there will usually be other conditions documented which cause delay of delivery, eg uterine inertia. Such conditions should be coded in preference to a code from O75.</p> <p>O75.6 should be assigned rarely and only where there is delayed delivery NOS (either onset of labour is delayed or the labour itself may be long).'</p> <p>Is it acceptable to code to O75.6 <i>Delayed delivery after spontaneous or unspecified rupture of membranes</i> to reflect the PROM (along with O62.2 <i>Other Uterine Inertia</i> and O34.2 <i>Maternal</i></p>	<p>QCC Response: QCC members recommended coding O42.9 because premature rupture of membranes is documented and is indexed to O42.9. This code does not refer to “onset of labour”.</p> <p>Committee members agreed that in this scenario premature rupture of membranes would be the Principal Diagnosis and Uterine Inertia would be coded additionally.</p> <p>Some QCC members advised they would seek clarification where uterine inertia was documented and the QCC agreed to prepare a paper on inertia for discussion.</p>

Queensland Coding Committee Queries February 2009

QCC ID	Query summary	Query	QCC Response
		<p><i>care due to uterine scar from previous surgery)?</i></p> <p>If only the Uterine Inertia is coded it does not reflect that a PROM occurred and IV antibiotics were commenced prior to the LUSCS.</p>	
0209-07	Standards - Coding Test Results	<p>Can you use the x-ray report as further site specification and to allocate additional codes?</p> <p>For example, in cases where lower respiratory tract infection is documented by a doctor throughout admission notes, and there is consolidation (usually lower lobe) recorded on the x-ray report. Can you use the x-ray report as further site specification and to allocate code for pneumonia?</p> <p>Terms encountered on x-rays include consolidation, pneumonic consolidation, consolidation consistent with aspiration, etc.</p> <p>There is understanding that if there are other co-morbidities such as pulmonary oedema, CCF, or trauma, further clarification from the doctor is required (coding matters Vol 7 No2).</p>	<p>QCC Response:</p> <p>The QCC noted that as there is no documentation of pneumonia in the notes, the coder should code the condition as LRTI (see also ACS 0010). However where coders have reason to believe that a diagnosis of pneumonia has been made but not specifically documented clarification should be sought.</p> <p>Where there is documentation of LRTI and pneumonia in the same episode of care, the QCC recommends that the coder assign a code for pneumonia only, unless it is clear that these are two separate infections.</p>
0209-08	Complication of Pregnancy	<p>Pregnancy complicated by obesity was flagged as a bug in 3M Codefinder as well as 3M Codefinder for Pregnancy complicated by dehydration.</p> <p>Have also noticed that in the Alphabetic Index of Diseases, page 338: Pregnancy (single) (uterine) -complicated by --conditions in</p> <p>There is no code range for conditions in E00-E89 (except specifically E40-E46) Is this a classification error?</p>	<p>QCC Response:</p> <p>The QCC recommends that as dehydration is a metabolic disorder; the correct pathway to follow for pregnancy complicated by dehydration is pregnancy complicated by metabolic disorder NEC but agree indexing for common metabolic conditions would be of value.</p>
0209-09	Coding Intrathecal Pump Refill	<p>In situations where Intrathecal pump was refilled for chronic back pain, can the QCC clarify whether the correct code for this same day procedure is:</p>	<p>QCC Response:</p> <p>The QCC recommend that this should be coded as loading of a pump - [1920] 92609.xx .</p>

Queensland Coding Committee Queries February 2009

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		<p>a) 96198-** intrathecal administration of pharmacological agent b) 96199-** I.V administration code, as the notes for this include administration via a reservoir, which an intrathecal pump is.</p> <p>The confusion seems to be that the procedure is just for a pump refill, (internal), not actually injecting intrathecally. But the reservoir is not connected IV.</p>	<p>Although [1920] excludes administration of pain management, in this case the procedure that has been described is intrathecal pump refill and there is no administration of pain management, only loading.</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
0309-01	Preterm delivery without spontaneous labour O60.3	<p>Consider the following two scenarios: Scenario 1. Medical termination of pregnancy at over 20 weeks for prolonged rupture of membranes. There is a Breech delivery, baby born alive, cord snapped with retained placenta without haemorrhage.</p> <p>The suggested codes following ACS 1511 part 2: PD <i>O42.11 Premature rupture of membranes, onset of labour between 1-7 days later</i> O04.44 <i>Medical abortion , incomplete, without complication</i> (incomplete used as placenta retained) O69.8 <i>Labour and delivery complicated by other cord complications</i></p> <p>Question 1. Is it necessary to code the snapped cord and is O69.8 'Labour and delivery complicated by other cord complications' the correct code? (this would show the reason for the retained placenta as other causes could be morbidly adherent placenta) O73.0 <i>Retained placenta without haemorrhage</i></p> <p>Question 2. Is it necessary to code O73.0 'Retained placenta without haemorrhage' to specify that the placenta was retained without haemorrhage? (this was manually removed in OT with</p>	<p>QCC Response: Answer to question 1: The QCC recommend coding the snapped cord. O69.8 would be the correct code in this instance.</p> <p>Answer to question 2: The QCC recommend coding the retained placenta. O73.0 would be the correct code in this instance.</p> <p>Answer to question 3: The QCC agree that O60.3 is the correct code to use if the labour is preterm and has been induced (i.e. not spontaneous)</p> <p>Answer to question 4: The QCC agree that O60.3 is the correct code because there was not labour.</p> <p>NCCH Response: As a follow-up to your submission regarding the code title of O60.1 in ACS 1530, I am pleased to advise that the error has been amended in Sixth Edition errata 4, June 2009.</p>

Queensland Coding Committee Queries March 2009

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		<p>GA) <i>O60.3 Preterm delivery without spontaneous labour</i> (code used as the labour was induced and therefore not spontaneous) <i>Z37.0 single live birth</i> Plus procedure codes.</p> <p>Question 3. Is <i>O60.3 'Preterm delivery without spontaneous labour'</i> the correct early delivery code to use if the labour has been induced? This is a new code for sixth edition which was like the change to the diarrhoea coding and tucked away in the WHO changes.</p> <p>Index <i>Delivery (single) O80</i> - <i>early onset (with spontaneous labour) NEC O60.1</i> - - <i>without spontaneous labour O60.3</i> - <i>premature or preterm (with spontaneous labour) NEC O60.1</i> - - <i>without spontaneous labour O60.3</i></p> <p>Scenario 2: 2. Emergency LSCS for APH due to placental abruption at K34 with no labour. Suggested codes- <i>O45.9 Abruptio placenta NOS</i> <i>O60.3 Preterm delivery without spontaneous labour</i> <i>Z37.0 single live birth</i> Plus procedure codes</p> <p>Question 4. Again is <i>O60.3 'Preterm delivery without spontaneous labour'</i> the correct early delivery code? It seems that the changes have been made to the index and tabular but not ACS 1511 example 2 and 3 (In both examples labour would have been induced). Both have <i>O60.1 'Preterm labour with preterm delivery'</i> (this is the fifth edition code descriptor). However</p>	<p>Once again, thank you for initiating this proposal and for your interest in the continued development of ICD-10-AM/ACHI/ACS.</p>

Queensland Coding Committee Queries March 2009

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		<p>sixth edition states <i>O60.1 'Preterm spontaneous labour with preterm delivery, Preterm labour with delivery NOS'</i>.</p> <p>As this is also '<i>Preterm labour with delivery NOS</i>' code, the decision to use <i>O60.3 'Preterm delivery without spontaneous labour'</i> for labour that is induced is a bit confusing.</p> <p>Also: ACS 1530 Premature delivery When coding 'premature delivery' or delivery (spontaneous, induced or caesarean) with onset before 37 completed weeks gestation, assign code <u><i>O60.1 Preterm labour with preterm delivery</i></u>.</p> <p>This doesn't seem to be updated with the new sixth edition code changes.</p>	
0309-02	Adhesions in pregnancy	<p>Scenario: Consider situations where patient had Elective LSCS for previous caesarean. Pelvic adhesions found and lysis performed (no mention of post procedural).</p> <p>There is no index entry for "adhesions in pregnancy" or "delivery complicated by adhesions".</p> <p>Option 1. Pelvic adhesions are classified to <i>N73.6 Female pelvic peritoneal adhesions</i>. This has been further clarified in Coding Matters: Volume 14, Number 1, June 2007, 10 Commandments page 6.</p> <p>Following ACS 1521 example 3 advice to follow the index: <i>Pregnancy</i> <i>-complicated by</i> <i>--conditions in</i> <i>---N13-N99, O99.8</i> <i>----N70-N73, N76, O23.5</i></p>	<p>QCC Response: The QCC recommend Option 1: Pelvic adhesions are classified to <i>N73.6 Female pelvic peritoneal adhesions</i>.</p> <p>This has been further clarified in Coding Matters Volume 14 Number 1 June 2007, 10 Commandments page 6. Following ACS 1521 example 3 advice to follow the index <i>Pregnancy</i> <i>-complicated by</i> <i>--conditions in</i> <i>---N13-N99, O99.8</i> <i>----N70-N73, N76, O23.5</i> <i>O23.5 'Infections of the genital tract in pregnancy'</i> plus use the <i>N73.6 Female pelvic peritoneal</i></p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
		<p>O23.5 'Infections of the genital tract in pregnancy' plus use the N73.6 Female pelvic peritoneal adhesions Previous NCCH Query 2293 supports the above codes</p> <p>or</p> <p>Option 2. Should we assume the adhesions are an abnormality of pelvic organs or tissues and follow the index- <i>Pregnancy</i> <i>-complicated by</i> <i>--abnormal, abnormality</i> <i>---pelvic organs or tissue</i> <i>----affecting</i> <i>-----labour or delivery O65.5</i> O65.5 Labour and delivery affected by abnormality of maternal pelvic organs Plus use the N73. 6 Female pelvic peritoneal adhesions</p> <p>This is what the Codefinder assigns if you use the Spell option following the pathway: Pregnancy, D. continue list, 2. other complications related to or affecting management of pregnancy, childbirth, delivery or puerperium, 6. SPELL other complication or condition commonly related to or associated with pregnancy, childbirth, delivery or puerperium, Enter key word-Adhesions 2.Adhesions 3. pelvic 2.other /unspecified 2. affecting/in/during labour and/or delivery/intrapartum With prolonged labour 1. no, or already coded</p>	<p><i>adhesions</i></p> <p>Previous NCCH Query 2293 supports the above codes</p> <p>Additionally, the QCC recommends referring to Coding Matters Vol 14 Number 1 June 2007, 10 Commandments page 6.</p>

Queensland Coding Committee Queries March 2009

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		<p>Eventually getting to <i>O65.5 Labour and delivery affected by abnormality of maternal pelvic organs</i> <i>N73. 6 Female pelvic peritoneal adhesions</i></p> <p>Note this was in the August 3M Codefinder 6th Edition Pathway Defect List: *Adhesions, pelvic complicating delivery The below path assigns O235 and N736, should assign O348 or O655 with N736. KWP: deli...delivery...other comps...other....current condition...spell... ad...adhesion ...pelvic...other/unspecified...no...No...No... Do not wish to code...any assigns O235 and N736.</p> <p>With the January Upgrade this has now caused coding inconsistencies.</p>	
0309-03	Neonatal Jaundice	<p>Query regarding: Neonatal Jaundice</p> <p>ACS 1615 <i>Specific interventions for the sick neonate</i> states 'A diagnosis code for jaundice of the newborn should only be assigned when > 12 hours of phototherapy is provided.'</p> <p>Could an ACS symbol be added at the tabular entry for P58 or P59 to highlight that ACS 1615 is relevant to these codes?</p>	<p>QCC Response: The QCC agree there should be an ACS symbol next to the code for Feeding Difficulty referring to codes P58 and P59.</p> <p>The QCC also recommended incorporating the advice published in Coding Matters: Vol 5, No.1 into the ACS that, 'where admitted specifically for jaundice, that the jaundice may be coded even though phototherapy is given for < 12 hours.'</p> <p>The QCC also queries whether jaundice should be coded if identified as contributing to feeding difficulty (coded) when no phototherapy required (e.g. sunlight treatment, phototherapy for < 12 hours etc , increase feeds).</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>An NCCH request will be prepared to update the standard along with previous advice regarding jaundice.</p> <p>NCCH response: The current guidelines in ACS 1615 Specific interventions for the sick neonate state that:</p> <p>'A diagnosis code for jaundice of the newborn should only be assigned when > 12 hours of phototherapy is provided.'</p> <p>The exception to this guideline (previously published in Coding Matters Vol 5 No 1) is where a neonate is admitted specifically for jaundice. In this instance jaundice may be coded even if the phototherapy is given for less than 12 hours.</p> <p>The ACS symbols and amendments to ACS 1615 Specific interventions for the sick neonate will be considered for a future edition of ICD-10-AM/ACS.</p>
0309-04	Anaemia Complication the Puerperium	<p>In situations where trial of scar precedes to caesarean delivery and the clinician notes: HB 81, plan: Iron tablets.</p> <p>Is it appropriate to code anaemia complicating puerperium when only iron tablets are administered, no transfusion?</p> <p>Is it appropriate to code anaemia complicating puerperium if iron tablets are not given during admission, but a script for same is given on discharge?</p>	<p>QCC Response: Anaemia needs to be documented by the clinician. It is not the coders' responsibility to translate whether HB 81 is anaemia or not.</p> <p>However, where there is an intervention and Coders suspect anaemia, the Coder should consult with the Clinician and request supporting documentation where appropriate.</p> <p>Where there is documentation of anaemia complicating the puerperium then the anaemia</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>should be coded.</p> <p>The Committee considered that:</p> <p>1) Rx was given therefore ACS 0002 was met</p> <p>2) The condition was monitored / assessed and it was decided that Rx was warranted therefore the Committee agreed that ACS 0002 was met in this instance.</p>
0309-05	Sequestration - Index issue	<p>When sequestration is used as a lead term in Codefinder, the coder is directed to osteomyelitis which is incorrect.</p> <p>How would QCC proceed with this?</p> <p>Additional Information: A disc sequestration occurs when the centre, gelatinous portion of the disc is not only squeezed out, but also separated from the main part of the disc. http://orthopedics.about.com/od/herniateddisc/q/discs.htm</p>	<p>QCC Response: The QCC members do not agree with the allocation of an osteomyelitis code when sequestration of the intervertebral disc rather than of the bone is documented.</p> <p>The QCC considers that disc sequestration should be coded as vertebral disc displacement.</p> <p>QCC Interim Advice: The QCC recommends that the Coder code disc displacement if sequestration is of intervertebral disc.</p> <p>NCCH response: Disc sequestration is synonymous with a ruptured or displaced disc. It is incorrect to select M86.6- Other chronic osteomyelitis... by following the pathway, Sequestrum, bone (see also Osteomyelitis), as a sequestered disc is not sequestered bone.</p> <p>The three classifications of herniated/displaced disc are disc protrusion, disc extrusion, and disc sequestration. Disc sequestration is where the</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>nucleus pulposus has leaked out of the disc entirely and has separated with the disc due to a breach of the posterior longitudinal ligament (PLL). Disc sequestration is often severely painful, exhibiting sciatica, or pain down the back and leg. Disc sequestration usually requires decompressive surgery.</p> <p>Clinical advice confirms that the correct code assignment for disc sequestration is determined by selecting the appropriate code from the index pathway, Displacement, displaced, intervertebral disc.</p> <p>Improvements to the ICD-10-AM Alphabetic Index will be considered for a future edition of the classification.</p>
0309-06	Fall code	Please advise on correct external cause code for a fall on same level while pushing a walker on wheels (Please note this query is in relation to an adult walker and has nothing to do with a stroller/pram).	<p>QCC Response: Correct code allocation is not clear. There is a question as to whether a walker on wheels is a pedestrian conveyance or if it is a support mechanism such as a walking stick.</p> <p>QCC Interim Advice: QCC interim response is to code W029 – <i>Fall involving other and unspecified pedestrian conveyance.</i></p> <p>NCCH response: ACS 2009 Mode of pedestrian conveyance states: “A pedestrian conveyance can be defined as 'something that serves as a means of transportation' and includes scooters,</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>rollerskates, wheelchairs, skateboards, etc.”</p> <p>An adult walker with wheels does not meet the above definition of a pedestrian conveyance. That is, it is not used as a means of transportation but rather as an aid to walking.</p> <p>Therefore, the correct external cause code for a fall, on the same level, while pushing an adult walker with wheels, is either W18.8 Unspecified fall on same level or the appropriate code from category W01 Fall on same level from slipping, tripping and stumbling, depending on the circumstances of the fall.</p>
0309-07	Pathway issue - sebaceous cyst - vulval or labial site	<p>Please review the pathway: index entry for the diagnosis of sebaceous cyst - vulval or labial site.</p> <p>There is a note at the index entry of Cyst saying to look up type of cyst first because if looking up site first there may not be an added indent for type.</p> <p>The trick here is that Cyst, vulva or Cyst, labia both have added indents for sebaceous cyst. But under Cyst, sebaceous, there is only an indent for genital organ, female which the coder would probably select, not knowing it is there are contradictory index entries under Cyst, vulva or Cyst, labia.</p>	<p>QCC Response:</p> <p>Following the directions at the top of the index entry for Cyst: the clinical coder when trying to code sebaceous cyst of the vulva and/or labia would follow the “look-up” for Cyst sebaceous genital organ <u>NEC</u>.</p> <p>Then, the coder should follow ACS 0034 which describes what to do when the index leads you to NEC code:</p> <p><i>NEC (not elsewhere classified) indicates that specified variants of the listed condition are classified elsewhere, and that, where appropriate, a more precise term should be looked for in the Index.</i></p> <p>Therefore following this advice, Coders should then check the site which would lead them to: Cyst</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>-labium (majus) (minus) N90.7 -- Sebaceous N90.7 and Cyst -vulva (implantation) (inclusion) N90.7 -- congenital --sebaceous gland N90.7</p> <p>NCCH response: The highlighted index entries have been amended for ICD-10-AM Seventh Edition.</p>
0309-08	Coding Underlying Conditions	<p>In cases where patients present for replacement of Pacemaker/AICD due to end of battery life:</p> <p>Do we need to code the underlying condition(s), such as arrhythmia, necessitating the pacemaker insertion? Especially in regards to coding the arrhythmia or cause in respect to ACS 0002.</p>	<p>QCC Response: The QCC recommend not coding the arrhythmia, as per 6th Edition education: page 65, Ex 4, Page 91.</p> <p>However, not all Committee members agreed with the 6th Edition education and would like a query to go to the NCCH regarding this issue. Some members felt that it would be hard to imagine a scenario where the arrhythmia would not meet ACS 0002 – Additional Diagnosis.</p> <p>NCCH Response: For replacement of pacemaker/AICD due to end of battery life, follow the guidelines in ACS 0936 Cardiac pacemakers and implanted defibrillators which states:</p> <p>'End-of-(battery) life is an indication for elective replacement of the pacemaker or defibrillator generator (device)...</p> <p>Admission for elective replacement of</p>

Queensland Coding Committee Queries March 2009

QCC ID	Query summary	Query	QCC Response
			<p>pacemaker or defibrillator is assigned code:</p> <p>Z45.0 Adjustment and management of cardiac device together with the appropriate procedure code(s).'</p> <p>A code for the underlying condition should only be assigned if it meets the criteria in ACS 0002 Additional diagnoses.</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
0409-01	Formalisation of gangrenous and osteomyelitic finger tip post traumatic amputation	<p>Can the committee please assist with the code allocation for cases where admission is for partial amputation of a finger and the site is infected? The procedure ended up being formalisation of gangrenous and osteomyelitic finger tip.</p> <p>Should the Principal Diagnosis be the Osteomyelitis or the amputation?</p>	<p>QCC Response:</p> <p>On review of notes provided, the Committee considered Clinician clarification was warranted in order to determine the appropriate principal diagnosis code.</p> <p>It is necessary to establish:</p> <ol style="list-style-type: none"> 1) The main reason (at the time of admission) for amputation and; 2) Whether the current infection and osteomyelitis are complications of the original amputation, <i>never actually fully healed</i> versus the amputation <i>had healed</i>, and osteomyelitis and related infection developed subsequently. <p>Options proposed by the Committee included:</p> <ol style="list-style-type: none"> 1) The injury <i>never fully healed</i> (notes 15/1 "healed with hypersensitivity symptoms" - interpretation may be that skin has healed but underlying damaged tissue has not and is now complicated by infection and osteomyelitis. The reason for the

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
			<p>amputation is formalisation and treatment of the infected traumatic amputation.</p> <p>Principal Diagnosis = traumatic amputation finger, Additional diagnoses = T89.02 <i>Open wound with infection</i>. T89.03 <i>Other complications of open wounds</i>, and osteomyelitis (with appropriate external cause codes). Smoking status and procedure codes would also be assigned;</p> <p>2) The injury <i>had healed</i> (notes 15/1 "healed", and "small sinus", and notes seem to indicate a gap between antibiotic treatment and current symptom of discharge) and the reason for the planned amputation is osteomyelitis (all current infection is attributable to the osteomyelitis). Principal Diagnosis = osteomyelitis (acute vs. chronic) Additional diagnosis = sequelae of amputation codes.</p>
0409-02	Repair of epigastric hernia	<p>Please consider a situation where admission is for an obstructed epigastric hernia. This is coded to K43.0 – Ventral hernia with obstruction without gangrene.</p> <p>When the hernia is repaired, the code allocated should be: 30403-01 [996] – Repair of other abdominal wall hernia (repair of incarcerated, obstructed or strangulated hernia) The “includes note” under this procedure includes epigastric hernia but not ventral hernia.</p> <p>Should repair of epigastric obstructed hernia be coded to 30615-00 or 30403-01?</p>	<p>QCC Interim Response: The QCC provided interim advice that repair of obstructed epigastric hernia should be coded as K43.0 and 30615-00 [997] on the basis of indexing of repair -hernia --obstructed (epigastric) giving the code 30615-00 [997], and the MBS code for repair of obstructed hernias being 30615-00.</p> <p>The QCC request NCCH ratification of this, and rectification or clarification/education in regards to the perceived inconsistencies/areas of confusion:</p> <ul style="list-style-type: none"> ◦ hernia descriptions ◦ hernia repair indexing

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
		<p>There is an “includes note” under 30615-00 for epigastric hernia and yet when you code epigastric hernia it is coded to ventral hernia – this makes it very hard for the coder to correctly allocate the repair code.</p>	<p>◦ instructional terms at [996] and [997]</p> <p>NCCH Response: ICD-10-AM, as per the parent classification ICD-10, classifies an obstructed epigastric hernia to K43.0 Ventral hernia with obstruction, without gangrene following the index pathway:</p> <p>Hernia, hernial - - epigastric — see Hernia, ventral - ventral - - with - - - obstruction K43.0</p> <p>Category K43 Ventral hernia, has an includes note for epigastric hernia.</p> <p>ACHI is based on the Medicare Benefits Schedule (MBS), where terminology for hernias differs to that in ICD-10.</p> <p>To assign a code for a hernia repair, follow the index pathways provided in ACHI, for the type of hernia documented, not the code assigned by ICD-10-AM.</p> <p>The correct code assignment for repair of an obstructed epigastric hernia is 30615-00 [997] Repair of incarcerated, obstructed or strangulated hernia, by following the index pathway: Repair - hernia - - epigastric (with graft) (with prosthesis) - - - incarcerated (obstructed) (with prosthesis)</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
			<p>30615-00 [997]</p> <p>Ventral hernia is excluded at block [997].</p> <p>A code from category [996] Repair of other abdominal wall hernia should only be assigned if a ventral or unspecified abdominal wall hernia is documented, which is not the case in the scenario cited.</p> <p>A review of hernia repairs will be considered for a future edition of ACHI.</p>
0409-03	Clinical documentation of ↑K+ or ↓K	<p>Please consider the following 2 coding scenarios:</p> <ol style="list-style-type: none"> 1. Clinical documentation of ↑K+ or ↓K+ and treatment is given to treat these conditions. 2. Another type of documentation seen: K 2.7 Correct K+ Plan: Spank K or 2x 10 mml KCl iv replacement. <p>We have been previously advised not to assign a diagnosis code for conditions documented with the use of arrows such as ↑K+ or ↓K+ even though it is clear that treatment were given for these conditions. We acknowledge this was based on NCCH #1918 advice stating that “coders should be aware that arrows might indicate a trend, rather than a high/low reading”.</p> <p>However in the recent Coding Matters: Volume 15, Number 2, September 2008, in the Frequently Asked Questions part 1:</p> <p>Q: If ↑ Lipids is documented with diabetes, and the diabetes meets ACS 0001 Principal diagnosis or</p>	<p>QCC Interim Response:</p> <p>The Committee advises until clarification is received from the NCCH, with the exception of those instances specifically cited in an Australian Coding Standard (e.g. ↑chol, eGFR), not to assign a diagnosis code solely on the basis of documentation of an abbreviation using an arrow or a value (regardless of whether there is an associated intervention).</p> <p>The QCC advises that until NCCH advice is provided, clinical clarification should be sought in all cases where it is likely that this would result in substandard capture of information (e.g. where there is an intervention such as treatment change or where documentation seems to imply the trend or value is problematic).</p> <p>NCCH Query: Please advise whether there are certain circumstances (and if so, exactly what these are,</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
		<p>ACS 0002 Additional diagnoses, what codes should be assigned?</p> <p>A: Documentation in the clinical record of hyperlipidaemia/↑ Lipids alone does not equate to features of insulin resistance in a patient with diabetes.</p> <p>It looks like NCCH has interpreted that ↑ Lipids means hyperlipidaemia.</p>	<p>providing examples) where it is permissible to code a condition that is described:</p> <p>1) using an arrow and abbreviation (e.g. ↑ K, ↑chol) or</p> <p>2) a value (e.g. Hb 70, GCS 3, BP 90/50).</p> <p>Over recent years there have been several queries relating to this e.g. NCCH database query 1918, VIC Coding Newsletter: Nov 2001, query 1735 and queries 1944, 2152 and 2310.</p> <p>http://www.serviceforip.webcentral.com.au/viccdb/VICC_querieslist.asp?psearch=1735&psearchtype=OR&Submit=Search.</p> <p>The QCC also notes ACS 0010 <i>General Abstraction Guidelines</i> has a heading 'Test Results' and under this a sub-heading 'Findings with an unclear, or no associated condition documented'. This section states: <i>Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded.</i></p> <p>Some Coders infer that, with the exception of ↑chol and eGFR, a condition should not be coded if trends and values are documented but there is no corresponding diagnosis <i>written in full</i>. Others interpret they can code trends and values without a corresponding diagnosis written in full, because they do not perceive the situation to be "unclear" (particularly when there is a related intervention). They construe trends and values to be legitimate abbreviations for conditions (therefore that the</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
			<p>condition <i>is</i> documented when these are used.)</p> <p>The QCC request clear advice from the NCCH regarding this, and suggest ACS 0010 also be enhanced accordingly.</p> <p>NCCH Response: A query has already been received from QLD (Q2506) regarding this issue, for which a response was published in Coding Matters Vol 16 No 2, September 2009:</p> <p>'Clinicians sometimes use abbreviations and symbols to document conditions in the clinical record. Each case should be assessed on its own merits to determine if the documentation sufficiently describes a condition that meets the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, in order to be coded.</p> <p>When ↓ Hb or ↓ K is documented as the indication for an intervention such as a blood transfusion or commencement of medication, a code for the condition can be assigned if the test result or clinician confirms that the patient's haemoglobin or potassium is below the normal range, as the criteria for code assignment in ACS 0001 or ACS 0002 has been met. See ACS 0010 General abstraction guidelines.</p> <p>So, where ↓ Hb is documented as the indication for a transfusion and the test results and/or clinician verifies the patient's haemoglobin is below the normal range - follow the index pathway, Low,</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
			<p>haemoglobin and assign D64.9 Anaemia, unspecified.</p> <p>Where ↓K is documented as the indication for commencement of medication and the test results and/or clinician verifies the patient's potassium is below the normal range, follow the index pathway, Deficiency, potassium (k), Depletion, potassium, Hypokalaemia, or Hypopotassaemia and assign E87.6 Hypokalaemia.</p> <p>However, if ICD-10-AM does not provide an index look up or there is uncertainty or ambiguity in relation to such abbreviated forms of documentation they should be confirmed with the clinician prior to code assignment. Coders should not assign codes on the basis of test results alone.'</p> <p>The FAQs in Coding Matters Volume 15 Number 2 September 2008 cited, correctly implies that documentation of ↑ lipids is synonymous with hyperlipidaemia.</p>
0409-04	Excisional debridement of skin and subcutaneous tissue of leg wound with wound suturing/closure	<p>Would 2 codes be assigned for this procedure? 90665-00 [1628] Excisional debridement of skin and subcutaneous tissue and 30026-00 [1635] Repair of wound of skin, other site, superficial.</p> <p>Or does this debridement code include wound suturing/closure?</p>	<p>QCC Interim Response: The Committee advise: 1) When both excisional debridement and suture of skin and subcutaneous tissue is performed assign codes for <u>both</u> the excisional debridement and the suture. 2) When both debridement and suture of soft tissue is performed assign a code for the debridement <u>only</u>.</p> <p>The Committee acknowledge this difference complicates the coding of these procedures, and</p>

Queensland Coding Committee Queries April 2009

QCC ID	Query summary	Query	QCC Response
			<p>the logic seems confusing. The Committee also discussed that it was confusing to have important information relating to different aspects of skin and subcutaneous tissue and soft tissue injury and repair in different standards. The QCC will make a submission to the NCCH asking whether changes can be made for the purposes of simplification and standardisation.</p> <p>NCCH Response: 30023-00 [1566] Excisional debridement of soft tissue has the following note: “Includes: suture of wound”</p> <p>This has led some coders to assume that as there is no similar note at 90665-00 [1628] Excisional debridement of skin and subcutaneous tissue, that any suture of the wound should be assigned as an additional code for this procedure as it does not contain the same includes note.</p> <p>However, in these circumstances the guidelines in ACS 0016 General Procedure Guidelines – Procedure Components apply and it is unnecessary to assign an additional code for suture of wound performed with excisional debridement. It is a component of the procedure.</p> <p>The includes note at 30023-00 [1566] will be reviewed for a future edition of ACHI.</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
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Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
0509-01	Gallstone pancreatitis requiring laparoscopic cholecystectomy	<p>Could the QCC please review the code sequencing and grouping of the following scenario:</p> <p>Patient admitted with epigastric pain and nausea. Bloods revealed elevated lipase and deranged LFTs. USS demonstrated cholelithiasis with mild GB thickening. Patient went on to have lap cholecystectomy after several days and was consequently discharged. Discharge summary stated: gallstone pancreatitis requiring laparoscopic cholecystectomy.</p> <p>Histo result noted cholelithiasis with chronic cholecystitis. Lap cholecystectomy was performed,</p> <p>Coding following ACS 0001 DRG H08B Lap Cholecystectomy without CC Cost wt=1.40 ALOS 1.72</p> <p>Pdx: K85.1 Biliary acute pancreatitis K80.10 Cholelithiasis with cholecystitis 30445-00 [965] Lap cholecystectomy</p> <p>However if the patient had presented with gallstone cholecystitis and had raised LFTs and lipase on second day then had Lap cholecystectomy on day 5 and discharged on day 6 then:</p> <p>DRG H08A Lap cholecystectomy with cat/severe CC Cost wt=2.62 ALOS 5.49</p> <p>Pdx: K80.10 Cholelithiasis with cholecystitis K85.1 Biliary acute pancreatitis 30445-00 [965] Lap cholecystectomy</p> <p>They are similar type patients receiving similar type care yet the grouping is different depending on presentation. This seems to</p>	<p>QCC Response: Code assignment and sequencing is dependent upon documentation of the Clinician's determination of the reason for admission after study and other conditions (meeting ACS criteria) should be considered on a case by case basis.</p> <p><i>ACS 0001 Principal Diagnosis states "the circumstances of inpatient admission will always govern the selection of principal diagnosis"</i></p> <p>The introduction section of the ACS states "<i>the responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder</i>".</p> <p>QCC members acknowledge the Clinician's concern regarding the average length of stay associated with DRG H08B where a patient has a principal diagnosis of biliary acute pancreatitis and note this DRG assignment does not change in Grouper version 6.0</p> <p>The QCC considers that this issue should be raised with the Casemix group at DoHA.</p> <p>QCC Interim Response: The QCC considers that coding should be carried out as appropriate.</p> <p>This is an issue with the DRG classification. It also appears as if this issue has not been fixed in AR-DRG v6.0.</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>be inconsistent and our clinician is of the opinion that an ALOS of 1.72 for a patient presenting with acute pancreatitis is unrealistic.</p>	<p>Submission for Casemix Group: A Clinician has raised concern that an average length of stay of only 1.72 days is allocated in some instances where a patient presents with acute pancreatitis. For example, DRG H08B (ALOS 1.72 days) is allocated where a patient has a principal diagnosis of biliary acute pancreatitis and a cholecystectomy during the same episode.</p> <p>QCC members noted:</p> <p>1) DRG assignment (and associated length of stay) is not influenced by whether a patient episode is elective or emergency, yet there may be distinct differences in these two groups</p> <p>2) Where DRG assignment is primarily based on a surgical partition, the grouper logic will consider a condition to be a 'cc' for that procedure if it is an additional diagnosis but not if it is the principal diagnosis. In some instances, the procedure driving the DRG may be for a condition that has been coded as an additional diagnosis, yet the principal diagnosis could be one that significantly complicates. For example –</p> <p><u>Scenario 1</u> - The patient is admitted for cholelithiasis and cholecystitis, develops biliary acute pancreatitis soon after admission and has a laparoscopic cholecystectomy</p> <p>Pdx: K80.10 Cholelithiasis with cholecystitis</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>Adx: K85.1 Biliary acute pancreatitis Proc: 30445-00 [965] Lap cholecystectomy</p> <p>DRG H08A <i>Lap cholecystectomy <u>with cat/severe CC</u></i> Cost wt=2.62 ALOS 5.49</p> <p><u>Scenario 2</u> – Patient is admitted for acute biliary pancreatitis and has a laparoscopic cholecystectomy as they are found to also have cholelithiasis with chronic cholecystitis.</p> <p>Pdx: K85.1 Biliary acute pancreatitis Adx: K80.10 Cholelithiasis with cholecystitis Proc: 30445-00 [965] Lap cholecystectomy</p> <p>DRG H08B <i>Lap Cholecystectomy <u>without CC</u></i> Cost wt=1.40 ALOS 1.72</p> <p>In scenario 1, biliary acute pancreatitis is considered to be a catastrophic/severe complicating co-morbidity for a laparoscopic cholecystectomy but in scenario 2, it is not considered as a complication at all because it is not coded as an additional diagnosis (but rather as the principal diagnosis). Would the Casemix group please consider addressing this anomaly?</p>
0509-02	Incidental finding: Menorrhagia for vaginal hysterectomy. Pathology result shows leiomyoma of uterus.	<p>Consider situations where admission is for vaginal hysterectomy for menorrhagia and the pathology result shows leiomyoma of uterus. If the principal diagnosis is menorrhagia, would you code the leiomyoma?</p> <p>Consider this question in situations where the pathology result shows leiomyoma with no documented connection as the cause of</p>	<p>QCC Response: The QCC has forwarded this query to the NCCH.</p> <p>NCCH Response: Clinical advice confirms that leiomyomas/fibroids may or may not be an incidental finding:</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>the menorrhagia and no documented connection in the record between the menorrhagia and the leiomyoma.</p> <p>This example was also in the NCCH 6th Edition workshop and the leiomyoma was not coded.</p>	<p>'Fibroids can be incidental within the uterus and may not be the reason for the uterus being removed. Such fibroids are often small and in the subserous or intramural position in the uterus.</p> <p>If, however, the uterus is massively enlarged, it can certainly cause menorrhagia and would be the reason for the hysterectomy.</p> <p>Small fibroids in the submucous position can cause severe menorrhagia and could be a reason for hysterectomy.</p> <p>For the above reasons, unless the fibroids are indicated to be the reason for the hysterectomy by the operating surgeon, the surgeon should be asked to advise whether the fibroids were the reason for the surgery, and if the answer was YES, code accordingly' Pepperell, Roger, O& G Clinician/O&G CCCG (personal communication).</p> <p>Therefore, coders should follow the guidelines in ACS 0010 General abstraction guidelines, Findings with an unclear, or no associated condition documented which states:</p> <p>'Unless a clinician can indicate that a test result is significant and/or indicates the relationship between an unclear test result and a condition, such test results should not be coded.'</p> <p>Where there is uncertainty, such as where histopathology indicates a subserous leiomyoma, which are known to cause menorrhagia, coders</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>should verify with the clinician whether the leiomyoma is significant to determine whether it should be coded.</p>
0509-03	<p>Incidental finding: Haematuria secondary to BPH. Pathology shows Adenocarcinoma prostate.</p>	<p>Consider cases where patients are admitted with haematuria secondary to BPH and TRUS biopsy is performed and pathology shows Adenocarcinoma prostate.</p> <p>If the documented principal diagnosis is BPH, would you code the Adenocarcinoma?</p> <p>Consider this query if there is no connection documented between the haematuria and adenocarcinoma and no treatment was commenced in this admission for the cancer.</p>	<p>QCC Response: The QCC has forwarded this query to the NCCH.</p> <p>NCCH Query: Male patient admitted with haematuria secondary to BPH. A TRUS biopsy was performed. Pathology shows Adenocarcinoma prostate.</p> <p>Documented principle diagnosis: BPH</p> <p>Would you code the Adenocarcinoma?</p> <p>No connection documented between the haematuria and adenocarcinoma. No treatment was commenced in this admission for the cancer.</p> <p>NCCH Response: This scenario is an example of poor documentation and so the guidelines below from ACS 0010 General abstraction guidelines should be followed in this instance:</p> <p>‘It is important to seek clinical advice where necessary for:</p> <ul style="list-style-type: none"> • verification of diagnoses recorded on the front sheet which are not supported in the clinical record, and • clarification of discrepancies between investigation results and clinical documentation.’

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>The following advice was received by the NCCH from the Nephrology CCG:</p> <p>'The only reason to perform a TRUS and biopsy is to diagnose a cancer. No one biopsies a prostate because they suspect BPH. A finding of cancer is significant but may still result in no change to a treatment plan.' Travis, Douglas, Urologist/Nephrology CCG (personal communication).</p> <p>Therefore, when presented with poor documentation as indicated in the scenario above, coders should seek advice from the treating clinician to determine the correct principal diagnosis.</p>
0509-04	<p>Incidental finding: Chronic ongoing pelvic pain for abdominal hysterectomy. Pathology result shows CIN III.</p>	<p>Consider situations where admission is for abdominal hysterectomy with chronic ongoing pelvic pain and pathology result shows CIN III.</p> <p>If the principal Diagnosis: Pelvic Pain would you code the CIN III as an additional diagnosis?</p> <p>Consider if the pathology result shows CIN III with no documented connection to the pelvic pain. Documentation does not indicate CIN III was an already known/suspected condition that was also the reason for the abdominal hysterectomy. Documentation stated that as the patient underwent TAH no follow up was required.</p>	<p>QCC Response: The QCC has forwarded this query to the NCCH.</p> <p>NCCH Response: Clinical advice confirms that CIN III in the scenario cited is an unexpected finding:</p> <p>'CIN III usually does not produce any symptoms at all, and certainly not pelvic pain. It results in an abnormal smear test, which then requires assessment by colposcopy and biopsy. It is usually treated by laser or cone biopsy, rarely by hysterectomy. In this instance it was likely to be an unexpected finding on histologic examination of the excised uterus, where the uterus was removed for pain not the CIN III.' Pepperell, Roger, O&G Clinician/O&G CCG (personal communication).</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			Therefore, in the scenario cited CIN III should not be coded as per the guidelines in ACS 0010 General abstraction guidelines.
0509-05	<p>Incidental finding: Hypertrophy of breast for reduction mammoplasty as a day only procedure.</p> <p>Post discharge pathology shows DCIS of breast.</p>	<p>Consider the situation where admission is for hypertrophy of breast for reduction mammoplasty as a day only procedure.</p> <p>If the Principal Diagnosis is Hypertrophy Breast but pathology came back 2 days post discharge showing DCIS of breast.</p> <p>What would be the most appropriate codes to allocate in this situation?</p>	<p>QCC Response: The QCC has forwarded this query to the NCCH.</p> <p>NCCH Response: In the scenario cited the finding of DCIS on pathology is an unexpected finding and should not be coded, as per the guidelines in ACS 0010 General abstraction guidelines.</p> <p>This scenario highlights an issue where coders may consider it necessary to assign a cancer code to generate a cancer notification for the cancer registry. Coders should be aware that the pathology department will do this automatically, irrespective of whether the condition is coded in the inpatient episode of care.</p>
0509-06	Diabetic foot ulcer with osteomyelitis	<p>Could the QCC consider the following scenarios:</p> <p>Scenario 1 Diabetic foot ulcer of toe from PVD, presents with fever and foot pain, investigations shows osteomyelitis of 4th toe. There was debridement of infection including bone for osteomyelitis, followed by toe amputation.</p> <p>Scenario 2 Diabetic foot ulcer of toe from PVD, presents with fever and foot pain, investigations shows osteomyelitis of toe. Followed by toe amputation. Discharge summary indicates osteomyelitis of toe, had amputation.</p> <p>Scenario 3</p>	<p>QCC Interim Response: The QCC considers that the coding of these scenarios should be based on a case-by-case assessment.</p> <p>It is possible that either the diabetic foot ulcer or the osteomyelitis could be the principal diagnosis. Consultation with the clinician is advised.</p> <p>QCC Meeting Response: A patient with diabetic foot and osteomyelitis may be admitted for either the diabetic foot or the osteomyelitis and the Committee advise that assignment of the principal diagnosis should be based on a case by case assessment, ACS</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>Diabetic foot ulcer of toe from PVD, presents with fever and foot pain, investigations shows osteomyelitis of toe. IV antibiotics given then discharged.</p> <p>Could the QCC please indicate what the principal diagnosis would be in each scenario – diabetic foot ulcer or osteomyelitis? We have had a lot of discussions amongst staff and cannot come to an agreement on what the principal diagnosis should be following ACS 0001. Should we be coding the underlying cause or the problem that was treated?</p>	<p>followed with clinical clarification sought as necessary.</p> <p>The introduction section of the ACS states “<i>the responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder</i>”.</p> <p>ACS 0001 <i>Principal Diagnosis</i> states</p> <ul style="list-style-type: none"> • The principal diagnosis is <i>the diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care</i> • <i>The circumstances of inpatient admission will always govern the selection of principal diagnosis</i> • <i>When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided, and the Alphabetic Index, Tabular List or the standard does not provide sequencing direction, <u>the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition.</u></i> <p><u>Scenario 1</u> Consult the clinician. PD not stated and two conditions could potentially meet criteria as being the reason for admission</p> <p><u>Scenario 2</u> Consult the clinician. The discharge summary is somewhat ambiguous - osteomyelitis is stated but</p>

Queensland Coding Committee Queries May 2009

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			<p>not specifically nominated as the principal diagnosis. It is difficult to know whether “osteomyelitis of toe –had amputation” was intended to be interpreted as ‘osteomyelitis is the principal diagnosis’ (in the absence of other conditions being listed) versus the discharge summary is incomplete. As two conditions could still potentially meet criteria as being the reason for admission</p> <p><u>Scenario 3</u> Consult the clinician. PD not stated and two conditions could potentially meet criteria as being the reason for admission. Investigations showed osteomyelitis and the patient was given IV antibiotics and discharged, but this does not preclude the possibility that the patient was admitted for diabetic foot and that this documentation refers to identification and management of osteomyelitis as an additional diagnosis. There is also no documentation that the IV antibiotics were actually given <i>for</i> treatment of the osteomyelitis as opposed to management of a condition associated with the diabetic foot (e.g. mild signs that might indicate potential for early infection of the ulcer).</p>
0509-07	Diabetes with hypoglycaemia. Uncontrolled blood sugar levels.	<p>Consider cases where the patient has diabetes with hypoglycaemia and uncontrolled blood sugar levels. In addition the patient has PVD and end stage renal failure. A previous renal transplant failed and the patient now requires dialysis.</p> <p>Considering: 1) If the patient was diabetic and had hypoglycaemia blood sugar levels were uncontrolled, should both hypoglycaemia and unstable</p>	<p>QCC Interim Response: 1) ACS 0401 <i>Diabetes for Stabilisation</i> classification box section states: <i>When there is documentation of 'unstable', 'for stabilisation', 'uncontrolled', 'poorly controlled' or 'poor control', the code E1-.65 *Diabetes mellitus with poor control should be assigned as principal or additional diagnosis as appropriate.</i></p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>diabetes be coded?</p> <p>2) If the patient had peripheral vascular disease not further specified, is it necessary to add the code I70.20 Atherosclerosis of arteries of extremities Unspecified?</p> <p>3) If the patient also had end stage renal failure. They had a failed renal transplant and now required dialysis.</p> <p>Should Z94.0 Kidney transplant status be coded to show that the patient has previously had a transplant, as opposed to not coded, or a code for failed transplant assigned even though this was not an issue due to dialysis management?</p>	<p><i>When patients in this category have recognised diabetic complications, assign additional appropriate code(s) from E10–E14.</i></p> <p>Using this instruction, the QCC recommends coding both.</p> <p>2) The QCC recommends that in this instance, I70.20 does not add any further information and should not be coded.</p> <p>3) The QCC considers that Z94.0 should be coded to reflect renal transplant status where it meets the requirements of ACS 0002.</p> <p>The QCC will consult with the NCCH regarding when kidney transplant failure is to be coded as opposed to kidney transplant status</p> <p>QCC Meeting Response: The QCC considers that the coding of these scenarios should be based on a case-by-case assessment.</p> <p><u>Question 1</u> Consultation with the clinician is advised. The Committee recommends that when both hypoglycaemia and unstable diabetes are documented, codes for both should be assigned.</p> <p>ACS 0401 <i>Diabetes mellitus and impaired glucose regulation, Diabetes for Stabilisation</i> classification box section states:</p>

Queensland Coding Committee Queries May 2009

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			<p><i>When there is documentation of 'unstable', 'for stabilisation', 'uncontrolled', 'poorly controlled' or 'poor control', the code E1-.65 *Diabetes mellitus with poor control should be assigned as principal or additional diagnosis as appropriate.</i></p> <p><i>When patients <u>in this category</u> have recognised diabetic complications, <u>assign additional appropriate code(s) from E10–E14.</u></i></p> <p><u>Question 2</u> The Committee advises that in this instance, I70.20 does not add any further information. The Committee recommends that I70.20 not be coded additionally to E1x.51 <i>Diabetes mellitus with peripheral angiopathy without gangrene.</i></p> <p><i>ACS 0401 Diabetes mellitus and impaired glucose regulation, General Classification Principals box section 3rd point states:</i></p> <p><i>In addition to the impaired glucose regulation and diabetes code(s) from E09–E14, assign codes from other chapters <u>when necessary, to fully describe the clinical diagnosis</u></i></p> <p><u>Question 3</u> The Committee considers that Z94.0 should be coded to reflect renal transplant status where it meets the requirements of ACS 0002.</p> <p>The QCC will consult with the NCCH regarding when kidney transplant failure is to be coded as opposed to kidney transplant status</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>ACS 1438 <i>Chronic kidney disease, Kidney Replacement Therapy</i> classification box section 3rd point states: <i>For patients who have received a kidney transplant and <u>documentation pertaining to this status satisfies criteria for coding under ACS 0002</u>, assign <u>Z94.0</u> Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR level.</i></p> <p>NCCH Response: Hyperacute rejections of transplanted kidneys are immediate and acute rejection is highest in the first three months after transplantation. However, acute rejection can also occur months to years after transplantation. Chronic transplant rejection is irreversible and cannot be treated effectively.</p> <p>When deciding whether to code kidney transplant failure or kidney transplant status the coder should attempt to determine, from the information in the clinical record, whether the failed transplant is chronic and irreversible or in an acute rejection phase. Acute rejections will likely be the focus of the admission with the objective being the treatment of the rejection. For chronic irreversible kidney transplant rejection, the patient is likely to be on maintenance dialysis to treat the CKD stage 5.</p> <p>Therefore, T86.1 Kidney transplant failure and rejection should only be assigned for acute kidney transplant rejections that meet the criteria for code assignment as per ACS 0001 Principal diagnosis</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>or ACS 0002 Additional diagnoses.</p> <p>Z94.0 Kidney transplant status should be assigned as per the following advice in ACS1438 Chronic kidney disease, Kidney replacement therapy which states: “For patients who have received a kidney transplant and documentation pertaining to this status satisfies criteria for coding under ACS 0002, assign Z94.0 Kidney transplant status together with N18.3 Chronic kidney disease, stage 3 or higher, as indicated by an eGFR level.”</p> <p>Therefore, for a patient with a failed kidney transplant who is now requiring dialysis, as per the scenario cited, assign Z94.0 Kidney transplant status in addition to N18.5 Chronic kidney disease, stage 5.</p> <p>If it is impossible to determine whether the transplant rejection is acute or chronic, then the coder should seek clarification from the clinician.</p>
0509-08	Infected full thickness sunburn	<p>Consider the scenario where admission is for infected full thickness sunburn. The sunburn was sustained weeks prior and the body surface area was not provided. The patient had a split skin graft.</p> <ul style="list-style-type: none"> •10-AM Commandments Volume 10 number 2 states that infected burns should be coded using: a code for the site of the burn (T20–T30), a code from T31 Burns classified according to extent of body surface area involved, T79.3 Post traumatic wound infection, NEC, and a code from B95–B97 Bacterial, viral and other infectious agents, to indicate the organism, if known. •ACS 1911 Sunburn states that the external cause is inherent in the 	<p>QCC Interim Response: In this issue the coding appears correct. This is an issue with the DRG classification. It also appears that this issue has not been addressed in AR-DRG v6.0.</p> <p>Code according to the standard L55.2 T79.3 X32 Y92.9 U73.2</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>codes L55.- Sunburn and therefore the assignment of an external cause code is unnecessary, but if the percentage body surface area is documented, codes from categories T31.- Burns classified according to extent of body surface involved and X32.- Exposure to sunlight should be assigned.</p> <p>•When this order of codes is assigned, but the sunburn is sequenced as the principal diagnosis rather than a code in the range T20-T30, the DRG allocated is 901Z Extensive OR procedure unrelated to the principal diagnosis. This is regardless of whether a code indicating the body surface area involved is assigned. If the same codes are used but T79.3 is sequenced as the principal diagnosis, the DRG allocated is T01C OR procedure infectious and parasitic diseases W/0 CC, or if the site of the burn was assigned as the principal diagnosis (contrary to direction provided in ACS 1911), and sunburn were coded additionally, the DRG would be Y02A Other burns W skin graft>64or W Cat/Sev CC or with complicating procedure.</p> <p>•Is this a DRG anomaly or should code assignment be revised?</p>	<p>QCC Meeting Response: The Committee agreed that the assignment of codes used by the enquirer was consistent with direction given in ACS 1911 <i>Burns</i>:</p> <p>Pdx: L55.2 <i>Sunburn, full thickness</i> T79.3 <i>Post traumatic wound infection, not elsewhere classified</i> X32 <i>Exposure to Sunlight</i> Y92.9 U73.2 45406-00 etc.</p> <p>The Committee acknowledges allocation of DRG 901Z <i>Ext O.R. PR unrelated to PDX</i> in this scenario is problematic as funding is not allocated to episodes with this DRG, yet coding is correct and the procedure was related to the principal diagnosis.</p> <p>A submission will be sent to the NCCH asking that this scenario be considered and that ACS 1911 be reviewed to allow code assignment and subsequent grouping that more fully reflects information provided.</p>
0509-09	Tumour lysis	<p>Consider the scenario where the patient was admitted with leukaemia and it is noted that the patient had acute renal failure secondary to sepsis and tumour lysis syndrome. However there is no clear documentation whether this was due to chemotherapy.</p> <p>• If Notes documented ↑K but there was not a written diagnosis of hyperkalaemia and tumour lysis was also documented in some other patients e.g. in a patient with Burkitt tumour.</p> <p>Considering there is no index entry for tumour lysis syndrome. What is the best code/s to assign for this? Should each</p>	<p>QCC Interim Response: The QCC recommends that components of the TLS should be coded out; clarifying where necessary with the clinician especially for trends and values.</p> <p>The QCC will send a query to the NCCH regarding the creation of a code for TLS.</p> <p>QCC Meeting Response:</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
		<p>complication such as hyperkalaemia, and other specific metabolic conditions, should be coded additionally?</p>	<p>The Committee recommends that as there is no specific code for tumour lysis syndrome indexed, the documented components should be coded.</p> <p>Where tumour lysis syndrome (TLS) has been documented and there is documentation of a 'value' or 'trend' that may reflect a component of TLS but this has not been written as a named condition (e.g. ↑ K, or K 6.5, but not "hyperkalaemia") clinical clarification should be sought</p> <p>In here we need to mention the FAQ response regarding values.</p> <p>Brief literature research by Committee members (e.g. http://emedicine.medscape.com/article/282171-overview and http://en.wikipedia.org/wiki/Tumor_lysis_syndrome) indicated TLS was a clinically significant condition, potentially occurring sufficiently frequently to warrant a specific code. The QCC will forward a submission to the NCCH requesting consideration be given to creation of a specific code for TLS.</p> <p>NCCH Response: As a follow-up to your public submission regarding tumour lysis syndrome, I am pleased to advise that a code for this condition (E88.3 Tumour lysis syndrome) has been added to ICD-10-AM Tabular List following ICD-10 WHO updates.</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>Consequently, it has been included in ICD-10-AM Seventh Edition, which will become effective from July 2010.</p>
0509-10	Intentional drug overdose	<p>Consider cases where patients are admitted following an intentional drug overdose.</p> <p>Activity does not have an index entry for self harm but there is a 'specified NEC' option.</p> <p>Most Clinical Coders assign U73.8 Other specified activity for suicidal activity, but it is not clear whether this is appropriate. Can the correct coding practice be made clear?</p>	<p>QCC Interim Response: Refer to CM: Vol 5, no. 1 which states that you should assign .8.</p> <p>QCC to suggest to the NCCH that this advice be incorporated into the index.</p> <p>QCC Meeting Response: Committee members advise, in accordance with NCCH advice published in Coding Matters: Vol 5, no. 1, page 13, the activity code that should be assigned for attempting self harm/ suicide is U73.8 <i>Other specified activity</i>.</p> <p>The QCC will suggest to the NCCH that this advice be incorporated into the index.</p>
0509-11	Pseudo-obstruction (e.g. Ogilvy syndrome) and mucosal colitis	<p>Summary documentation indicates principal diagnosis as Ogilvy Syndrome and mucosal colitis and notes state an acute abdomen after a knee replacement</p> <p>Ogilvy syndrome is an acute colonic pseudo-obstruction. Neither term is indexed in ICD-10-AM.</p> <p>What codes should be used for these conditions?</p>	<p>QCC Interim Advice; Pseudo-obstruction is indexed and the following index entry should be followed. K59.8.Colitis see also Enteritis. Enteritis, Mucous – see Syndrome Irritable Bowel.</p> <p>The QCC will send a request to the NCCH regarding the creation of a code for Ogilvy Syndrome in the index. The QCC will also suggest an index enhancement for colitis.</p> <p>QCC Meeting Response: 1) The code for Pseudo-obstruction is K59.8 and is indexed - Pseudo-obstruction</p>

Queensland Coding Committee Queries May 2009

QCC ID	Query summary	Query	QCC Response
			<p>- intestine K59.8 K59.8 is listed in the Tabular as <i>Other specified functional intestinal disorders</i></p> <p>A suggestion will be made to the NCCH that an index entry be created for Ogilvy syndrome.</p> <p>2) The code for mucosal colitis is K58.9 and is obtained by following the index pathway - Colitis (see also enteritis) <i>Then</i> Enteritis - mucous - see <i>Syndrome, irritable bowel</i>² <i>Then</i> Syndrome - irritable - - bowel K58.9 - - - with diarrhoea K58.0</p> <p>A suggestion will be made to the NCCH that a more direct index look up is created for mucosal colitis.</p>

Queensland Coding Committee Queries June 2009

QCC ID	Query summary	Query	QCC Response
0609-01	Prophylactic Surgery with reference to QCC query 0708-03	<p>Can the QCC please provide clarification in relation to the last paragraph of the QCC response to Query 0708-03. Specifically, does the explanation given by QCC in 0708-03 resolve the query or does the query need to go to the NCCH for advice.</p> <p>Original query for 0708-03: If Prophylactic surgery is reported and admission is for prophylactic</p>	<p>QCC Response: The QCC advise that ACS 1204 should be followed in this instance.</p> <p>ACS 1204 directs the coder to code the neoplasm as the PD and Z40.01 as an additional diagnosis identifies the organ being removed.</p>

Queensland Coding Committee Queries June 2009

QCC ID	Query summary	Query	QCC Response
		<p>bilateral oophorectomy - breast ca, lymph mets 2007, having chemo and radio - on text trial. What is the correct PD?</p> <p>Original response for 0708-03: The QCC recommends that the principal diagnosis is the breast cancer. Committee members were uncertain whether the appropriate code to reflect prophylactic ovary removal in management of breast carcinoma was Z74.00 Breast or Z74.01 Ovary and asked that this be submitted to the NCCH for clarification</p> <p>Further review has shown index entries: Prophylactic --organ removal (for neoplasia management) --breast Z40.00 --ovary Z40.01</p> <p>--surgery Z40.9 --for risk factors related to malignant neoplasm ---breast Z40.00 ---ovary Z40.01</p> <p>After reviewing the index, it appears that the code relates to the organ removed, rather than the site of the malignant neoplasm.</p>	
0609-02	Default code for Viral Hepatitis C (not further specified)	<p>For Viral Hepatitis Type C (not further specified), the index defaults to B17.1. However ACS 104 overrides this with the advice below. Should the default in the index be amended as per the advice in ACS 104 and default to B18.2?</p> <p>ACS 0104 Viral Hepatitis C states the following: "When ambiguous terms such as 'hepatitis C' or 'hepatitis C positive' are recorded and the patient has symptoms of hepatitis C, coders should check with the clinician to determine if the disease is at the acute or chronic stage. Where consultation is not possible,</p>	<p>QCC Interim Response: The QCC agree to forward this query to the NCCH. In the interim, QCC advise that coders continue to follow the ACS 0104.</p> <p>NCCH Response: The ICD-10-AM Alphabetic Index defaults viral hepatitis type C to B17.1 Acute hepatitis C as per ICD-10. However, this is not supported by Australian clinicians and ACS 0104 Viral</p>

Queensland Coding Committee Queries June 2009

QCC ID	Query summary	Query	QCC Response
		assign the code for chronic viral hepatitis C (B18.2)."	<p>hepatitis was created in Second Edition to provide guidance on the classification of viral hepatitis.</p> <p>Coders should follow the standard practice of searching for terms in the Alphabetic Index, and then verify code assignment by referring to the Tabular List and any applicable Australian Coding Standards.</p> <p>Therefore, symptomatic hepatitis C without specification of acuity (i.e. acute or chronic) is classified to B18.2 Chronic viral hepatitis C, by following the guidelines in ACS 0104.</p> <p>The indexing of viral hepatitis will be reviewed for a future edition of ICD-10-AM.</p>
0609-04	Dysphagia / Oesophageal Stricture	<p>In cases where admission is with dysphagia and stricture of oesophagus was found on the gastroscopy, which was dilated.</p> <p>Do you code the dysphagia as the PD or stricture as the PD? This is a one day admission for endoscopy.</p>	<p>QCC Response:</p> <p>If a causal relationship has been documented between the dysphagia and the stricture then the QCC recommend to code the stricture as the PD and do not code dysphagia as an AD as per ACS 0046.</p> <p>Alternatively, if no causal relationship is documented then the dysphagia is the PD with stricture as AD as per ACS 0046.</p>
0609-06	Coding of prosthesis BX260 ADEPT Adhesion Reduction Solution	<p>Consider a scenario where diagnosis is Endometriosis: N80.3, N80.8 and Chronic Cervicitis: N72. Procedures include: Insertion of ADEPT solution into peritoneal cavity</p> <p>Code used: 90347-02(983)</p>	<p>QCC Response:</p> <p>This is a similar query to a previous QCC query id 0407-07. This previous query was regarding seprafilm® as opposed to ADEPT. The query 0407-07 was forwarded to the NCCH and the response received from the NCCH still stands. The NCCH advice is as follows:</p>

Queensland Coding Committee Queries June 2009

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		<p>Following the main procedure, the surgeon used a new prosthesis product ADEPT Adhesion Reduction Solution (Prostheses No: BX 260) which is a single use fluid for intraperitoneal administration.</p> <p>ADEPT is intended to be used as an instillate for the reduction of adhesions following abdominal surgery. It only has a shelf life of 14 days. Would procedure code of 90347-02 (983) be sufficient coding for billing of this prosthesis use in the future? Should 30393-00(983) Division of Adhesions code also be used to give more description as to why the fluid was used, even though no adhesions were divided?</p>	<p>“Seprafilm®, which is composed of chemically modified sugars, acts as a physical barrier that separates tissue surfaces while the body’s natural healing process occurs. It is a prophylactic measure used during surgery to help prevent the formation of adhesions. It is completely absorbed into the body and does not require removal. The NCCH advises that it is unnecessary to assign a code for this procedure.”</p> <p>The QCC note that this NCCH advice can be applied in the case of QCC query 0906-06. The QCC recommend that it is not necessary to assign a code for the ADEPT.</p>
0609-07	Injury due to resuscitation	<p>In cases were patients go into cardiac arrest in ICU and are resuscitated and the resuscitation measures result in fractured ribs.</p> <p>What external cause codes are required? Examples are struck by other person, complication of medical care Y84, misadventure Y65.8.</p>	<p>QCC Response: The QCC recommend using Y65.8 as the injury occurred at the time of the medical procedure.</p>
0609-08	Coding Intrathecal Pump Refill – With reference to QCC Query 0209-09	<p>The following query is in response to QCC query response 0209-09</p> <p>This was the original query 0209-09: Intrathecal pump refill for chronic back pain.</p> <p>Can you clarify whether the correct code for this same day procedure is 96198-** intrathecal administration of pharmacological agent. Other suggestions for the code include 96199-** I.V. administration code, as the notes for this include administration via a reservoir, which an intrathecal pump is. The confusion seems to be that the procedure is just for a pump refill, (internal), not actually injecting intrathecally. But the reservoir is not connected IV.</p>	<p>QCC Interim Response: The QCC will forward this query to the NCCH for guidelines on coding these cases. QCC interim advice is to code the condition (pain) as the PD and not a Z code. Previous advice on this procedure still stands.</p>

Queensland Coding Committee Queries June 2009

QCC ID	Query summary	Query	QCC Response
		<p>This was the QCC ratified response to 0209-09: The QCC recommend that this should be coded as loading of a pump as [1920] 92609.xx.</p> <p>Although [1920] excludes administration of pain management, in this case the procedure that has been described is intrathecal pump refill and there is no administration of pain management - only loading.</p> <p>New Query In Relation To Ratified Response: I agree that it is not administration of pain management (query 0209-09). However, If this procedure is not a pain management admission, what is the principal diagnosis (Z code or pain)?</p> <p>Does it follow then that the PD should be the pain code? There is no pathway for admission for loading of pump, to use the z code.</p> <p>Should we assign iv infusion of morphine, if it is initiated in recovery room according to ACS 0031 (page 50) or we consider that is it for pain relief?</p>	