

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0710-01	Failure To Progress	<p>When "Failure To Progress in first stage" is documented as the reason for intervention (eg. Caesarean Section) should this be coded to O63.0 <i>Prolonged first stage (of labour)</i> or O62.9 <i>Abnormality of forces of labour, unspecified?</i></p> <p>Similarly, when "Failure To Progress in second stage" is documented should this be coded to O63.1 <i>Prolonged second stage (of labour)</i> or O62.9 <i>Abnormality of forces of labour, unspecified?</i></p>	<p>QCC Response: The QCC has sent a query to the NCCC asking for clarification as to which code should be used when failure to progress is documented.</p> <p>SSU will write a Codefile article in relation to the codes used on the Perinatal Data Collection Form (MR63d).</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p> <p>QCC Update: Please refer to the Codefile Issue 39 (October 2010) article titled "ICD-10-AM/ACHI codes documented upon the Perinatal Data Collection Form" for advice regarding using codes documented on the form.</p> <p>http://www.health.qld.gov.au/qcc/documents/newsletters/codefile_39.pdf</p>
0710-02	Laparoscopic gastric bubble	<p>How should a laparoscopic gastric bubble for morbid obesity be coded? E66.8 <i>Morbid Obesity</i> 90950-00 <i>Insertion of gastric bubble [balloon]</i> 30390-00 <i>Laparoscopy</i></p> <p>When coding the above scenario without the Laparoscopy the allocated AR-DRG is K62C <i>Miscellaneous Metabolic Disorders wo Catastrophic of Severe CCs</i>, which describes exactly the combination of disease and procedure codes.</p> <p>When the Laparoscopy is added it groups to AR-DRG 902Z <i>Non-Extensive Or Procedure Unrelated To Principal Diagnosis</i> as the AR-DRG is being driven by the Laparoscopy as opposed to the Insertion of the Gastric Bubble.</p>	<p>QCC Response: The QCC has forwarded this query to the NCCC for review of the DRG allocation.</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: The NCCC have proposed a revision of the procedure block [889] <i>Procedures for morbid obesity</i> for the ICD-10-AM 8th edition.</p>
0710-03	Diabetes with morbid obesity for lap gastric banding	<p>Can QCC please advise whether E11.72 <i>Diabetes with insulin resistance</i> should be coded in a patient with morbid obesity admitted for lap gastric banding?</p> <p>In some admissions for this procedure, the diabetes does not meet ACS 0002 <i>Additional Diagnosis</i> criteria, but according to ICD-10-AM 6th Edition ACS 0401 <i>Diabetes Mellitus And Impaired Glucose Regulation</i>, E11.72 is sequenced as the principal diagnosis (PD) with E66.8 <i>Other Obesity</i> as the additional diagnosis (AD).</p> <p>In ICD-10-AM 7th Edition we believe that E66.8 will be PD but we are unsure whether E11.72 should be coded as an AD when there is no reason to code the diabetes other than the entry of obesity in the index: Obesity (simple) E66.9 - with diabetes — see ACS 0401 <i>Diabetes Mellitus And Impaired Glucose Regulation, obesity</i></p> <p>(7th Edition) In the 7th Edition training package it was stated that all reverse indexing was deleted.</p>	<p>QCC Interim Response: The QCC recommend coding using the intent of the index and standard, which is to code Type 2 Diabetes with insulin resistance. PD Obesity AD Type 2 Diabetes mellitus with insulin resistance (where the diabetes meets the criteria for coding under ACS 0002 <i>Additional Diagnosis</i>)</p> <p>The QCC has sent a query to the NCCC regarding the index entry and have recommended that obesity should be coded as the PD in the scenario cited above.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0710-04	Choroid plexus carcinoma	There is no index entry in ICD-10-AM for Choroid plexus carcinoma. This condition is located in the Morphology of Neoplasms appendix with the code M9390/3 <i>Choroid plexus carcinoma</i> .	<p>QCC Response: The QCC has sent a public submission to the NCCC requesting an index entry for: Carcinoma - Choroid plexus</p>
0710-05	Inverted T-incision Caesarean Section	<p>Could the QCC please advise the best procedure code to assign to reflect T-incision caesarean section?</p> <p>A T or J incision caesarean section involves both a transverse incision (Lower Uterine Segment Caesarean Section (LUSCS)) and a longitudinal incision (classical caesarean section).</p>	<p>QCC Interim Response: The intention of the caesarean in this scenario needs to be determined as this would determine the correct code.</p> <p>In the index the following applies: Caesarean section - classical -- elective 16520-00 [1340] -- emergency 16520-01 [1340] - lower segment -- elective 16520-02 [1340] -- emergency 16520-03 [1340]</p> <p>Since classical caesarean section is higher in the statistical classification hierarchy, as an interim measure the QCC recommends coding the classical caesarean with an additional code to reflect the extra laparotomy 30373-00 <i>Exploratory laparotomy</i>.</p> <p>The QCC has sent a query to the NCCC for further clarification including request for additional index entry for similar cases.</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p>
0810-01	MS Chest Pain	Should musculoskeletal chest pain be coded to R07.3 by following pathway Pain(s) - chest - - specified NEC R07.3?	<p>QCC Interim Response: QCC advise coders to continue with current practice. Where practice is found to be varied within a hospital, the QCC would encourage the code R07.3 <i>Other chest pain</i> is used to represent musculoskeletal chest pain.</p> <p>According to ACS 0013 '<i>Other</i>' And '<i>Unspecified</i>' Codes, example 4, the coding of a subluxed cataract is coded to an unspecified cataract as there is no sub term 'subluxed' or 'specified NEC' entry under Cataract in the index.</p> <p>Using this logic, the index look up for musculoskeletal chest pain is as follows: Pain(s) - chest R07.4 - - specified NEC R07.3</p> <p>The QCC has sent this decision to the NCCC for ratification.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0810-02	Endoscopic ablation of Barrett's oesophagus	<p>Endoscopic ablation of Barrett's oesophagus</p> <p>We have been advised that the best fit code for this new procedure is 30478-13 [861] <i>Oesophagoscopy with excision of lesion.</i></p> <p>Can a new code be created to capture this procedure as research indicates that this is a new form of treatment for Barrett's oesophagus.</p>	<p>QCC Response:</p> <p>The QCC refers to the ICD-10-AM Commandments article regarding HALO ablation therapy of the oesophagus (Vol 16, no 4). <i>"If laser therapy was used in the scenario provided, the correct code is 30479-00 Endoscopic laser therapy to oesophagus. If the procedure was performed without laser therapy please follow the advice provided in the ICD-10-AM Commandments Vol 16, No 4.</i> <i>* Extract of Vol 16, No 4</i> <i>HALO ablation therapy</i> <i>What is the correct code to assign for HALO ablation therapy of the oesophagus?</i> <i>HALO ablation therapy is used in the treatment of Barrett's oesophagus -- a pre-cancerous condition caused by chronic acid reflux or gastro-oesophageal reflux disease (GORD). Traditionally Barrett's oesophagus has been managed with frequent endoscopic biopsy surveillance to detect progression to cancer. Ablation, the use of energy, to remove this diseased layer of cells from the oesophagus offers treatment of the disease before it has the opportunity to progress to cancer. For most patients healthy tissue replaces the ablated tissue in three to four weeks.</i> <i>The HALO system is a very specific type of ablation, in which heat energy is delivered in a precise and highly-controlled manner, to remove the layer of diseased oesophageal tissue, without damage to the normal underlying structures and allowing replacement by normal cells. Assign 30478-19 [856] Oesophagoscopy with other coagulation for HALO ablation therapy of the oesophagus.</i> <i>Improvements to the codes in block [856] Destruction procedures on oesophagus will be considered for a future edition of ACHI."</i></p>
0810-03	Dural tear spinal surgery	<p>What is the code for a dural tear during spinal surgery? The two examples that arise are:</p> <ol style="list-style-type: none"> 1. Incidental/iatrogenic dural tear during spinal surgery. 2. Accidental dural tear during resection of brain tumour. <p>We have been assigning: T81.2 <i>Accidental puncture and laceration during a procedure, not elsewhere classified</i> Y60.0 <i>During surgical operation</i> Y92.22 <i>Health service area</i></p> <p>But we are struggling to find an appropriate additional code to specify the injury site. In neurosurgery, sometimes there is documentation of dural leak but this is rarely the case in spinal surgery.</p> <p>What injury code would QCC recommend in these 2 different cases?</p>	<p>QCC Interim Response:</p> <p>The QCC considers that in the scenarios provided, the dural tears meet the criteria of a procedural complication.</p> <p>The correct codes for a dural tear are: T81.2 <i>Accidental puncture and laceration during a procedure, not elsewhere classified</i> Y60.0 <i>Unintentional cut, puncture, perforation or haemorrhage during surgical operation</i> Y92.22 <i>Health Service Area</i></p> <p>As per ACS 1904 <i>Procedural Complications</i>, an additional code from Chapters 1-19 may be assigned to provide further specification of the condition. The QCC advise that code S06.28 <i>Other diffuse cerebral and cerebellar injury</i> may be used to provide further specificity regarding the location of the dural tear of the brain.</p> <p>The QCC has sent this advice to the NCCC for ratification.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0810-04	Gastrostomy tube	<p>What code would the QCC recommend for Percutaneous insertion of gastrostomy tube/catheter via fluoroscopy?</p> <p>It seems more gastrostomy tubes are inserted by this method than the percutaneous endoscopic method.</p> <p>Would it be possible for a "percutaneous gastrostomy" code similar to "percutaneous nephrostomy" be created to differentiate it from the endoscopic procedure?</p>	<p>QCC Response:</p> <p>The QCC recommends that the correct code to use for an initial/unspecified insertion of a gastrostomy tube is: 30481-00 <i>Initial insertion of percutaneous endoscopic gastrostomy [PEG] tube.</i></p> <p>If the insertion of the gastrostomy tube is a repeat insertion of the gastrostomy tube then the following code should be used: 30482-00 <i>Repeat insertion of percutaneous endoscopic gastrostomy [PEG] tube.</i></p> <p>Whilst investigating this query, the QCC noted the inconsistencies of the non-essential modifier 'endoscopic' in the index.</p> <p>Insertion</p> <ul style="list-style-type: none"> - tube - - feeding - - - gastric 96202-07 [1920] - - - gastrostomy, percutaneous (endoscopic) (initial) (PEG) 30481-00 [870] - - - gastrostomy, percutaneous endoscopic (initial) (PEG) 30481-00 [870] <p>The QCC has sent a recommendation to the NCCC in regards to the inconsistency with regard to essential and non-essential modifiers is addressed in the index.</p>
0810-05	Procedure for Dropped Nucleus	<p>When we apply codes for dropped nucleus as advised by NCCH, this gives AR-DRG 902Z <i>Non-Extensive Or Procedure Unrelated To Principal Diagnosis.</i></p> <p>The codes are as follows: T81.2 <i>Accidental puncture and laceration during a procedure, not elsewhere classified</i> S05.8 <i>Other injuries of eye and orbit</i> Y60.0 <i>During surgical operation</i> Y92.22 <i>Health service area</i></p> <p>and assign procedure code 42731-01 [200] <i>Extraction of crystalline lens by posterior chamber sclerotomy with removal of vitreous.</i></p> <p>We would like to pick up the removal of lens fragment additionally by using 42569-00 <i>Nonmagnetic removal of intraocular foreign body posterior chamber or anterior chamber</i> which will group it to X06B <i>Other procedures for other injuries w/out CC.</i></p> <p>Can the QCC please advise.</p>	<p>QCC Response:</p> <p>The QCC considers that after reviewing the operative report that the code 42731-01 [200] <i>Extraction of crystalline lens by posterior chamber sclerotomy with removal of vitreous</i> sufficiently describes the procedure that was carried out.</p> <p>The QCC has sent notification of the grouping anomaly to the NCCC and awaits further advice.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0810-06	Frontal Lobe Dementia	<p>What code is used for Frontal Lobe Dementia? The only code we can find is F03 <i>Unspecified Dementia</i> or F07.0 <i>Frontal Lobe Syndrome</i>. Should we also be coding F07.0 <i>Frontal Lobe Syndrome</i>, as you cannot have one without the other?</p> <p>We queried the difference between Frontal Lobe Dementia and Frontal Lobe Syndrome with the clinician.</p> <p>We were told that all patients with Frontal Lobe Dementia would have Frontal Lobe Syndrome. You cannot have Frontal Lobe Dementia without having Frontal Lobe Syndrome. Not all patients with Frontal Lobe Syndrome will have Frontal Lobe Dementia.</p> <p>This has got some of the coders wondering should we be coding the Frontal Lobe Syndrome along with the Frontal Lobe Dementia code.</p>	<p>QCC Response: A specific look up for frontal lobe dementia has been added in 7th edition.</p> <p>Please refer to the look-up below: Dementia - Frontal lobe G31.0 <i>Circumscribed brain atrophy</i> + F02.0 <i>Dementia in Pick's disease</i></p>
0810-08	Drug treatment	<p>There is conflicting information in the coding of drug treatment.</p> <p>Please refer to point 8 in ACS 0042 <i>Procedures Normally Not Coded</i>: <i>".. Drug treatment should not be coded except if:</i> <i>* the substance is given as the principal treatment in same-day episodes of care</i> <i>* drug treatment is specifically addressed in a coding standard (see ACS 1316 Cement spacer/beads and ACS 1615 Specific interventions for the sick neonate)"</i></p> <p>Please refer to ACS 0044 <i>Chemotherapy</i>: <i>"Multi-day episodes of care for chemotherapy should have a principal diagnosis code for the condition requiring treatment by chemotherapy and the appropriate procedure code</i></p> <p><i>EXAMPLE 4: Patient admitted for course of chemotherapy for breast cancer over twelve days.</i></p> <p><i>Intravenous chemotherapy (5FU) was administered. Codes: C50.Malignant neoplasm of breast M8000/3 Neoplasm, malignant 96199-00 [1920] Intravenous administration of pharmacological agent, antineoplastic agent"</i> [Extracted from NCCH eBook, July 2010, General Standards for Interventions.]</p> <p>Why is ACS 0044 not referred to in ACS 0042 (along with ACS 1615 <i>Specific Interventions For The Sick Neonate</i> & ACS 1316 <i>Cement Spacer/Beads</i>)?</p> <p>Can you please confirm the correct coding?</p>	<p>QCC Response: ACS 0042 <i>Procedures Normally Not Coded</i> states: <i>"Note: Some codes on this list may be required in certain standards elsewhere in the Australian Coding Standards. In such cases, the standard overrides this list and the stated code should therefore be assigned as described in the relevant standard."</i></p> <p>The QCC has suggested to the NCCC that point 8 of ACS 0042 should also include a reference to ACS 0044.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0810-09	Pacemaker insertion	<p>In regards to pacemaker insertion, the Ten Commandments Volume 15 Number 2 documents:</p> <p><i>Q: If a patient is admitted for insertion of a Port-A-Cath, should Z45.2 Adjustment and management of vascular access device be assigned as the principal diagnosis or the reason for the insertion i.e. cancer codes?</i></p> <p><i>A: As per ACS 0002 Additional diagnoses:</i></p> <p><i>The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.</i></p> <p><i>If the admission is only for the insertion of a Port-A-Cath then Z45.2 is assigned as the principal diagnosis. Additional diagnosis codes for the neoplasm are only assigned if the condition meets ACS 0002 Additional diagnoses, i.e. if treatment of the neoplasm commences during the episode of care."</i></p> <p>In the sixth Edition Education Case #3 the following is documented: <i>"Patient admitted for insertion of a biventricular pacemaker</i> <i>Answer: 150.0"</i></p> <p>The index directs to Z45.0</p> <p>Could you please explain the difference between these 2 scenarios?</p>	<p>QCC Response:</p> <p>In the case of admissions for insertion of Port-A-Cath (POC), the POC is not treating the condition it is preparatory care for future delivery of treatment.</p> <p>In the case of admissions for insertion of Pacemaker the pacemaker is treating a condition and is not preparatory care for future delivery of treatment.</p> <p>The guiding principle for all the possible scenario's is the application of ACS 0001 <i>Principal Diagnosis</i>, which directs coders to assign the reason primarily responsible for admission, as the principal diagnosis (PD):</p> <p>Scenario 1 – Initial insertion Patient admitted for initial insertion of pacemaker (or automatic/artificial implantable cardioverter defibrillator (AICD)). The PD should be the condition for which the procedure is being performed/device is being inserted.</p> <p>The PD logic: In this scenario the reason for admission is to insert a pacemaker. Why is the procedure being performed? The device is being inserted to treat a condition therefore that condition is the PD. The admission is about the condition.</p> <p>Scenario 2 – Pacemaker maintenance Patient admitted for a routine/elective battery replacement of an existing pacemaker (or AICD) due to the battery approaching the end of its working life (end-of-life period). In this instance Z45.0 <i>Adjustment and management of cardiac device</i> should be assigned as the principal diagnosis. The reason for admission is primarily for the adjustment or management of the device.</p> <p>The PD logic: In this scenario the reason for admission is to perform maintenance on a pacemaker. The condition is stable and the device is functional. Why is the procedure being performed? It is being performed to provide preventative maintenance to a device that is treating a condition. The condition is not the reason for the procedure being performed therefore the PD will be Z45.0. The admission is about the device.</p> <p>Scenario 3 – Pacemaker complication Admission to review/replace a pacemaker due to a complication of pacemaker (or AICD). Regardless of what procedures are performed, the PD is the device complication.</p> <p>Scenario 4 – Pacemaker upgrade - no change in condition. Patient admitted for a pacemaker upgrade, without any change in the patient's condition for which the pacemaker was inserted. This may reflect a change in clinical practice (for example if congestive heart failure (CCF) was believed to increase the risk of certain arrhythmias developing and therefore it is deemed good practice to insert an AICD as a preventative measure). If the device insertion is purely preventative in nature then Z45.0 may be assigned as the PD.</p> <p>The PD logic: In this scenario the reason for admission is to upgrade a device. The condition is stable and the device is functional. Why is the procedure being performed? It is being performed as a preventative measure for complications/conditions that do not exist yet. Therefore the PD will be Z45.0. The admission is about the device.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0810-09 cont.			<p>Scenario 5 – Pacemaker upgrade – change in condition/new condition. Patient admitted for a pacemaker upgrade as there has been a deterioration of the condition which necessitated the original implantation or a new condition has presented requiring a different device. The condition should be assigned as the PD.</p> <p>The PD Logic: In this scenario the reason for admission is to insert a pacemaker. Why is the procedure being performed? The procedure is being inserted to treat a condition therefore that condition is the PD. The admission is about the condition.</p> <p>While acknowledging that the index entry: Admission - for insertion of device – see <i>Fitting</i></p> <p>Fitting (of) - pacemaker (cardiac) Z45.0</p> <p>leads to the Z45.0 code, you must consider what your PD condition is before selecting your lead term for index look up.</p>
0810-10	Diabetic retinopathy / maculopathy	<p>There appears to be no index entry in 7th edition for diabetic retinopathy and maculopathy.</p> <p>There are however index options under diabetes Diabetes/Diabetic: - with -- retinopathy Diabetes/Diabetic - with -- maculopathy</p> <p>Can the QCC request a review of these index entries: Maculopathy - diabetic</p> <p>Retinopathy - diabetic</p>	<p>QCC Response: The QCC advise as per ACS 0401 <i>Diabetes Mellitus And Impaired Glucose Regulation</i> Table: General classification principles in diabetes mellitus and impaired glucose regulation, conditions which occur commonly with diabetes mellitus are indexed under 'Diabetes - with'.</p> <p>The QCC agreed that it is not the intention of the classification to retain reverse type index entries under specific conditions in the index.</p> <p>The QCC has recommended to the NCCC that the identified reverse index pathways are removed.</p>
0910-01	Insufficiency fracture femoral head	<p>There is no term in the index for Insufficiency fracture. In this case it was documented as with +/- Avascular necrosis (AVN) with a history of rheumatoid arthritis and no history of osteoporosis or injury that may have caused the fracture.</p> <p>"Insufficiency" does not exist under the lead term "Fracture".</p> <p>Could you please clarify the correct code?</p>	<p>QCC Response: The QCC advises that as the insufficiency fracture in this scenario is described as pathological, M84.45 <i>Pathological fracture, not elsewhere classified</i> is the correct code. The AVN should also be coded if it meets the criteria for coding.</p> <p>The QCC has advised the NCCC that the term "insufficiency fracture" is frequently documented and that the QCC request consideration for the index to be updated to reflect the terminology being documented in the record.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0910-02	Diabetic Patients for Insertion of Insulin Pump	<p>Can you please clarify the correct codes for patients admitted as same day patients for connection of an insulin pump?</p> <p>These patients do not have unstable diabetes.</p> <p>QCC query 1208-03 advised using the diabetes code as the principal diagnosis (PD) in the circumstances submitted with the query.</p> <p>Would the QCC please confirm that this advice applies to the above situation taking into consideration that the patient receives education and "treatment" of his diabetes?</p> <p>Due to the changes with diabetes in 7th edition what would then be the PD in the following circumstances - Patient with diabetes and background retinopathy admitted for connection of insulin pump as described above.</p> <p>As only the diabetes is being treated we have used E11.9 <i>Type 2 diabetes mellitus without complication</i> as our PD as per the following: E11.9 <i>Type 2 diabetes mellitus without complication</i> E11.31 <i>Type 2 diabetes mellitus with background retinopathy</i> + Procedure codes</p> <p>Will the PD for all admissions for insulin pumps where the patient does not have unstable diabetes be E1x.9?</p>	<p>QCC Interim Response:</p> <p>The QCC agree with the enquirer that the diabetes does meet criteria for coding as the principal reason for the admission was to manage the diabetes (by inserting a device to treat the condition).</p> <p>The PD in the case described is E11.31 <i>Type 2 diabetes mellitus with background retinopathy</i></p> <p>The QCC notes that if the admission were for maintenance, replacement or adjustment of the device the diabetes would only be coded if the criteria in ACS 0001 <i>Principal Diagnosis</i> or ACS 0002 <i>Additional Diagnoses</i> were met. These episodes would have a PD reflecting the intent of the admission i.e. a z-code for device adjustment.</p> <p>The QCC will confirm this advice with the NCCC.</p>
0910-03	Definition of COPD	<p>We were advised that for a patient to be considered to have Chronic Obstructive Pulmonary Disease (COPD) they must fulfil 3 criteria i.e. the condition must be chronic, obstructive and the patient MUST have been, or is a smoker.</p> <p>This is in contrast to ACS 1008 <i>Chronic Obstructive Pulmonary Disease (COPD)</i>.</p> <p>An example of this is a patient who has never smoked and presents with chronic obstructive asthma.</p> <p>Following the index would lead to the code for COPD being assigned J44.8 <i>Other specified chronic obstructive pulmonary disease</i>.</p> <p>Coders were advised this should be coded as exacerbation of asthma or J45.9 <i>Asthma, unspecified</i>.</p> <p>Could the QCC please investigate further whether the criterion for COPD has changed and if so whether the index will need updating?</p>	<p>QCC Response:</p> <p>The QCC advise that clinical coders should apply ACS 1008 <i>Chronic Obstructive Pulmonary Disease (COPD)</i> and be guided by documentation in the clinical record.</p> <p>QCC acknowledge that smoking is a known precursor to COPD and note that smoking is only one of many possible precursors to COPD.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0910-04	Family History of Cancer	<p>Would the QCC please advise what they consider to be the principal diagnosis in the following scenario?</p> <p>A patient has upper abdominal pain and a family history of bowel cancer.</p> <p>The patient is admitted for endoscopy and during the procedure a colonoscopy is performed as well to check the family history of bowel cancer.</p> <p>Would the correct coding be – R10.1 <i>Pain localised to upper abdomen</i> Z12.1 <i>Special screening examination for neoplasm of intestinal tract</i> Z80.0 <i>Family history of malignant neoplasm of digestive organs</i> + Procedure codes</p> <p>Or is Z12.1 not coded?</p>	<p>QCC Response:</p> <p>The QCC note that it would be unusual for a colonoscopy to be performed without the appropriate clinical preparation.</p> <p>The correct coding for this scenario is: R10.1 <i>Pain localised to upper abdomen</i> Z12.1 <i>Special screening examination for neoplasm of intestinal tract</i> Z80.0 <i>Family history of malignant neoplasm of digestive organs</i></p> <p>The QCC advise that Z12.1 would be coded additionally to reflect the reason for the additional endoscopy.</p>
0910-06	Documentation Other than within patient records	<p>ACS Introduction states:</p> <p><i>"It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet and/or discharge summary (or a copy of same) but that analysis of the entire clinical record is performed before code assignment."</i></p> <p>Can electronically stored information relevant to the episode being coded be used to determine code assignment?</p> <p>A few examples encountered are:</p> <ul style="list-style-type: none"> • No clear documentation within obstetrical notes that a primary postpartum haemorrhage (PPH) has occurred (although a > 300ml blood loss is recorded) but on the electronic perinatal data collection form a PPH has been recorded (not filed in the patient record). • A full blood count (FBC) has been ordered (with a subsequent low HB found) and within AUSCARE database there is a copy of the Request Form (for the FBC) which has Dr documentation of the reason for the test as being PPH. • No documentation of degree of obstetrical tear within patient record but the degree of tear is recorded on the electronic perinatal data collection form (not filed in the patient record). <p>Can the QCC advise the policy in regards to the use of electronic information in the coding process?</p>	<p>QCC Interim response:</p> <p>The QCC acknowledge that records are increasingly of mixed format (electronic and paper) and may be sourced from a number of electronic systems. The QCC recommend health services develop protocols (that are ISO compliant) in regard to the use of clinical data for clinical coding purposes.</p> <p>Clinical Coders should be guided by ACS 0010 <i>General Abstraction guidelines</i> and seek clinical advice where necessary for verification of diagnoses and clarification of discrepancies.</p> <p>QCC update:</p> <p>Clinical Information Management, Information Division have advised QCC that the following QH policies contains definitions of a clinical record: Retention and Disposal of Clinical Records Policy http://gheps.health.qld.gov.au/policy/docs/pol/gh-pol-280.pdf and Records Management for Administrative, Clinical and Functional Records Policy http://gheps.health.qld.gov.au/policy/docs/pol/gh-pol-045.pdf</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
0910-08	Vaginal delivery with 'McRobert's Position/Manoeuvre'	Can the QCC please advise the correct principal diagnosis for a delivery episode where the mother has a delivery which is assisted via the McRobert's position/manoeuvre? O80 <i>Single spontaneous delivery</i> or O83 <i>Other assisted single delivery</i> ? Should a procedure code be assigned, i.e. 90477-00 [1343] <i>Other procedures to assist delivery</i> ?	<p>QCC Response: Where documentation of a McRobert's manoeuvre has been performed in a delivery episode, the QCC recommend coding O83 <i>Other assisted single delivery</i>. 90477-00 [1343] <i>Other procedures to assist delivery</i></p> <p>by following the index pathway: Procedure – to assist delivery NEC</p> <p>The QCC refers clinical coders to the NCCC document FAQ's from the 7th Edition Workshop (FAQ number 3) available via the following link http://nccc.uow.edu.au/productservices/casemixmatters/index.html#faq</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p>
0910-09	Haglund's Deformity	<p>Haglund's Deformity can also be an acquired condition (pump bump) and it is called the same as the congenital condition, but ICD only provides codes for congenital (M92.6 <i>Juvenile osteochondrosis of tarsus</i>).</p> <p>Can we ignore the lead term look up provided by the clinician (Haglund's) and use another lead term look up that will lead us to an acquired code, eg Deformity - ankle (acquired) M21.67 <i>Other acquired deformity of ankle and foot</i>.</p>	<p>QCC Interim Response: The QCC recommends that the enquirer seek clinical clarification to determine whether the patient has either a diagnosis of Haglund's Disease or Haglund's Deformity.</p> <p>If the clinical opinion is that the patient has Haglund's disease; please code accordingly.</p> <p>If the clinical opinion is that the patient has a Haglund's deformity, then the enquirer should ascertain if the patient has an underlying disease which has caused this issue to occur.</p> <p>Where there is no underlying cause identified for the deformity, the QCC recommends that the appropriate index pathway to follow is: Deformity -foot (acquired) NEC</p> <p>The QCC has sent a query to the NCCC regarding the coding of Haglund's disease and Haglund's deformity.</p>
0910-10	Coding of Neutropaenia based upon clinical care	Patient is admitted to hospital post chemotherapy with Anaemia and was transfused with packed cells. Should neutropaenia be coded as an additional diagnosis on the basis of being monitored daily and requiring isolation nursing/ increased clinical care?	<p>QCC Response: The QCC advise that coding of conditions that are not explicitly documented in the record is generally not supported.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1010-01	Excisional debridement and suturing	<p>Could the QCC please review the interim response provided in query 0409-04 <i>Excisional debridement of Skin and subcutaneous tissue of leg wound with wound suturing/closure</i> in light of advice published in Coding Matters Volume 16, Number 1 Jun 2009?</p> <p>Query 0409-04 advises: <i>"1) When both excisional debridement and suture of skin and subcutaneous tissue is performed, assign codes for both excisional debridement and the suture. 2) When both debridement and suture of soft tissue is performed, assign a code for the debridement only."</i></p> <p>Advice published in Coding Matters 16, 1, Jun 09 states: <i>"... excisional debridement of soft tissue with suturing requires a code for the debridement only, and advises that the guidelines in ACS 0016 General Procedure Guidelines – Procedure Components apply and it is unnecessary to assign a code for suture of wound performed with excisional debridement. Although the Coding Matters article is specifically answering the question with respect to excisional debridement of soft tissue and soft tissue involving bone and cartilage, the answer and reasoning provided would seem to also apply to cases of excisional debridement with suturing of skin and subcutaneous tissue. Therefore should excisional debridement of skin and subcutaneous tissue with suturing be coded as an excisional debridement only?"</i></p> <p>Additionally it is noted that in ACHI 7th Edition the includes note "Includes: suture of wound" at code 30023-00 <i>Excisional debridement of soft tissue</i> has been removed.</p> <p>This change does not seem to be included in the Seventh Edition Education list of changes. We presume it was intentionally removed as the Coding Matters article above suggested that the includes note was causing coders confusion because there was no similar note at 30023-01 <i>Excisional debridement of soft tissue involving bone or cartilage</i>.</p> <p>It would be less confusing if the includes note was included at the debridement codes where suturing was considered to be a procedure component.</p> <p>Is QCC able to provide any further background information on the history of the apparent removal of the includes note at code 30023-00?</p>	<p>QCC Response:</p> <p>The QCC refer to the Coding Matters article, Vol 16, Number 1: <i>Excisional Debridement</i> which states that it is unnecessary to assign an additional code for the suture of the wound when performed with excisional debridement. It is considered a component of the procedure.</p> <p>The QCC considers the advice "not to code the suture" should be applied to episodes of debridement for cases involving either skin or soft tissue.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1010-02	Silicone breast implants "gel bleed"	<p>When old implants are documented as being intact but with silicone gel bleed and the histopathology reveals "silicone granuloma", should the principal diagnosis be: T85.4 <i>Mechanical complication of breast prosthesis and implant</i> Y83.1 <i>Surgical operation with implant of artificial internal device</i> Y92.22 <i>Health service area</i></p> <p>Or: Z42.1 <i>Follow-up care involving plastic surgery of breast</i> with additional diagnosis codes of T85.4 <i>Mechanical complication of breast prosthesis and implant</i> Y83.1 <i>Surgical operation with implant of artificial internal device</i> Y92.22 <i>Health service area</i></p>	<p>QCC Response: The QCC advise that the reason for the admission must first be ascertained in order to correctly assign codes for the episode. As per ACS 0010 <i>General Abstraction Guidelines</i>, findings obtained from pathology notes may provide specificity to already documented conditions. Please also refer to ACS 1204 <i>Plastic Surgery</i>, ACS 0001 <i>Principal diagnosis</i> and ACS 0002 <i>Additional diagnoses</i>.</p> <p>In episodes where the breast implant/prosthesis is removed (+/- replacement) and there is documentation of:</p> <ul style="list-style-type: none"> • a complication of the implant (such as a leak or chronic infection) assign the appropriate code from category T85._ <i>Complications of other internal prosthetic devices, implants and grafts</i> as the principal diagnosis code. • a psychological condition (such as anxiety) assign <i>Z41.2 Follow-up care involving plastic surgery of breast</i> as the principal diagnosis code with an additional code for the psychological condition. • the surgery being performed for cosmetic reasons (without any other diagnosis documented); assign <i>Z41.1 Other plastic surgery for unacceptable cosmetic appearance</i>. • the surgery being performed for prophylactic reasons relating to neoplasm risk-factors, assign <i>Z40.00 Prophylactic surgery for risk-factors related to malignant neoplasms</i> as the principal diagnosis. • the surgery being performed for prophylactic reasons (other than for neoplasm risk-factors) such as a product recall, assign <i>Z40.8 Other prophylactic surgery</i> as per the index. <p>In episodes for adjustment and/or fitting of breast prosthesis assign <i>Z44.3 Fitting and adjustment of external breast prosthesis</i> as per the index.</p> <p>The QCC has sent a response to NCCC for ratification.</p> <p>QCC has advised the NCCC of index modifier inconsistencies when coding <i>Z40.00 Prophylactic surgery for risk-factors related to malignant neoplasms</i> and <i>Z40.8 Other prophylactic surgery</i>.</p> <p>The QCC has recommended index updates to align with the advice provided in ACS 1204 <i>Plastic Surgery</i>.</p> <p>The QCC has recommend to the NCCC that the code title for <i>Z44.3 Fitting and adjustment of external breast prosthesis</i> be updated to remove the word "External" as this is not an essential modifier in the index pathways.</p>
1010-03	PD in Obstetrics	<p>What constitutes an ante partum condition as principal diagnosis in obstetric cases coded in 7th Edition as this affects ACS 1513 <i>Induction and augmentation</i> and ACS 1530 <i>Premature labour and Delivery</i>?</p>	<p>QCC Response: This has been addressed by the NCCC errata changes February 2011.</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1010-05	Respiratory Distress, newborn	<p>Could the QCC please clarify if (and when) it is acceptable to assign code P22.9 <i>Respiratory Distress of newborn, unspecified</i>?</p> <p>Should ACS 1614 <i>Respiratory Distress Syndrome/Hyaline Membrane Disease/Surfactant Deficiency</i> be interpreted as P22.9 should not be used at all or is the meaning of the standard to clarify that Respiratory Distress unspecified should not be coded to P22.0 <i>Respiratory Distress Syndrome</i>?</p> <p>Previously, coders have been advised to look for a more specific respiratory symptom (such as P28.83 <i>Grunting in newborn</i>) in preference to assigning P22.9. Is this correct?</p> <p>Available information regarding use of this code: ACS 1614 <i>Respiratory Distress Syndrome/Hyaline Membrane Disease/Surfactant Deficiency</i> states: <i>"The term 'respiratory distress unspecified' should not be coded as such, as it is considered a symptom not a diagnosis. Further information regarding a definitive diagnosis should be sought from the clinician."</i></p> <p>PICQ (Warning) indicator 101422 - Respiratory distress of newborn unspecified: <i>"... Respiratory distress unspecified code should not be used as this is a symptom, not a diagnosis. Coders should look for specific symptoms such as grunting and assign codes for these instead of respiratory distress unspecified"</i></p> <p>Response to VICC query 1948 (2003/2004): <i>"The phrase 'should not be coded as such' in this standard should be interpreted as 'should not be coded as respiratory distress syndrome'. The Committee recommends that coders look for a more specific respiratory symptom than 'respiratory distress', e.g. P28.83 Grunting in newborn, and only use 'P22.9 Respiratory distress of newborn, unspecified' when there is nothing else documented."</i></p> <p>Clinical advice regarding use of the term Respiratory Distress: <i>"This is the diagnosis used when the condition doesn't meet criteria of specific diagnoses such as Transitory tachypnoea of newborn (TTN), Hyaline membrane disease or Meconium aspiration syndrome. Sometimes these babies are tachypnoeic but it would be incorrect to classify these to P22.1 TTN as this is a specific condition."</i></p>	<p>QCC Response:</p> <p>In cases where "Respiratory Distress" is documented in the record, the QCC recommend seeking clinical clarification to determine if a definitive diagnosis or underlying condition is present. Where no other condition exists, assign P22.9 <i>Respiratory distress of newborn, unspecified</i> by following the index pathway: Distress - respiratory -- newborn P22.9</p> <p>ACS 1614 <i>Respiratory Distress Syndrome/Hyaline Membrane Disease/Surfactant Deficiency</i> refers to the assignment of Respiratory Distress Syndrome (Hyaline membrane disease). Where these conditions are documented, assign P22.0 <i>Respiratory distress syndrome of newborn</i>.</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p>
1010-06	Kidney Failure – wording of instructional note	<p>Could the QCC recommend the addition of the words 'if / when applicable' to be included at the instruction note under the ICD-10-AM Disease Tabular block N17-N19 "Use additional external cause code (Chapter 20) to identify external agent".</p>	<p>QCC Response:</p> <p>The QCC refer to ACS 0002 <i>Additional diagnoses</i> and ACS 0027 <i>Multiple Coding</i> which explain situations where multiple codes may need to be assigned to reflect the various components of a disease. Instructional terms such as "use additional code..." identify instances where multiple codes may be required.</p> <p>It should be noted however that ACS 0027 also states "indiscriminate multiple coding of irrelevant information should be avoided".</p> <p>The QCC considers the above standards adequate and note that kidney failure does not always result from an external cause. Where an external cause for the kidney failure is documented this should be coded as per the instructional note. It is unnecessary to assign external causes in all instances of Kidney Failure.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1010-07	E-Book issue - Anastomosis intestinal	<p>There is an error in eBook 7th edition. Please find as follows:</p> <p>Anastomosis - Intestinal Z89.0 <i>Acquired absence of finger(s) [including thumb], unilateral</i></p> <p>In the books the index reads</p> <p>Anastomosis - Intestinal Z98.0 <i>Intestinal bypass and anastomosis status</i></p>	<p>QCC Response: The QCC notes the eBook index incorrect code reference and advises the inclusion of this code revision in the eBook errata 2, September 2010 release.</p> <p>Further, the NCCC have advised the eBook is unable to be electronically updated and the errata provided will be in a .pdf format for addition into the eBook notes. To access a copy of the errata please refer to the NCCC website. http://nccc.uow.edu.au/productservices/icd10am/index.html#errata</p>
1010-08	Massive aspiration syndrome	<p>Could the QCC please confirm the following: ACS 1613 <i>Massive Inspiration Syndrome</i> implies that you cannot use P24x unless there is massive aspiration syndrome - is this correct?</p> <p>To then assign the correct code you first need to determine whether supplemental oxygen was used for a period greater than 24 hrs or not. If less than 24hrs, the correct code is P22.1 <i>Transient tachypnoea of newborn</i>, if greater than 24 hrs use code from block P24x</p> <p>ACS 1613 states that: <i>"Category P24 Neonatal aspiration syndromes should only be used in cases of 'massive aspiration syndrome' (P24.9 Neonatal aspiration syndrome, unspecified), 'meconium aspiration syndrome' (P24.0 Neonatal aspiration of meconium), etc and cases who have a significant respiratory illness indicated by the requirement for supplemental oxygen for a period of at least 24 hours."</i></p> <p>For conditions such as 'meconium aspiration syndrome' or 'massive aspiration syndrome' with supplemental oxygen required for less than 24 hours, code to P22.1.</p>	<p>QCC Response: The QCC confirm P24 <i>Neonatal aspiration syndromes</i> should only be assigned in cases where it is both documented and supplemented oxygen has been required for a period of at least 24 hours.</p> <p>For additional information relating to coding advice given referring to MAS, please review QCC Query 0211-11.</p>
1010-09	Shortcut abbreviation of CIDP in the 3M Codefinder	<p>In Codefinder the shortcut of CIDP assigns G618. Enter Key Word: -- CID - CID -- CIDP [chronic inflammatory demyelinating polyneuropathy]</p> <p>Query: Querying hospital is questioning code assignment and abbreviation. Clinician from their hospital suggests that the shortcut should be "Chronic inflammatory demyelinating polyradiculoneuropathy" 3M notes that there are 4 potential meanings to the abbreviation of CIDP. The software could potentially offer all 4 abbreviations.</p> <p>Is it possible for QCC to consider suggesting these 4 potential meanings to the NCCC and ask for specific indexing?</p> <p>CIDP 1. Chronic Idiopathic Demyelinating Polyradiculoneuropathy 2. Chronic Idiopathic Polyradiculopathy 3. Chronic Inflammatory Demyelinating Neuropathy 4. Chronic Inflammatory Demyelinating Polyneuropathy</p>	<p>QCC Response: The QCC has recommended the removal of the CIDP shortcut in the 3M Codefinder as the commonly used acronym has multiple interpretations that should be clarified prior to code assignment. The QCC note CIPD is also not indexed.</p> <p>The QCC has sent a request to the NCCC to recommend the removal of CIDP shortcut in 3M Codefinder.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1010-10	Coding osteomyelitis of toe, staph aureus in the 3M Codefinder	<p>When using the 3M Codefinder the following occurs when coding osteomyelitis of toe, staph aureus.</p> <p>Enter Key Word: -- OSTEOM - OSTEOM -- Osteomyelitis (infective) (septic)(suppurative) -- Osteomyelitis (infective) (septic) (suppurative) -- Other specified --- Bone site -- Ankle and foot ---- Ankle and foot specified as -- Toes ----- Use additional code - to identify infectious agent -- Bacteria ----- Bacterial agent as cause of disease classified elsewhere [+] -- Staphylococcus ----- Staphylococcus specified as -- Aureus ----- Healthcare associated staphylococcus aureus bacteraemia? -- No ----- Use additional code - to identify infectious bacterial organism specified as -- Not specified as drug resistant to antibiotic</p> <p>The pathway assigns: M86.87 <i>Other osteomyelitis ankle and foot</i> B95.6 <i>Staphylococcus aureus as the cause of diseases classified to other chapters</i></p> <p>The enquirer considers that the correct coding would be: M86.97 <i>Osteomyelitis, unspecified ankle and foot</i> B95.6 <i>Staphylococcus aureus as the cause of diseases classified to other chapters</i></p> <p>Is it correct to code to .8 Other?</p>	<p>QCC Response: The QCC advise that when using this pathway to assign a code for osteomyelitis of toe, staphylococcus aureus, and the user should follow the pathway below.</p> <p>Enter Key Word: -- OSTEOM - OSTEOM -- Osteomyelitis (infective) (septic) (suppurative) -- Osteomyelitis (infective) (septic) (suppurative) -- Unspecified --- Bone site -- Ankle and foot ---- Ankle and foot specified as -- Toes ----- Use additional code - to identify infectious agent -- Bacteria ----- Bacterial agent as cause of disease classified elsewhere [+] -- Staphylococcus ----- Staphylococcus specified as -- Aureus ----- Healthcare associated staphylococcus aureus bacteraemia? -- No ----- Use additional code - to identify infectious bacterial organism specified as -- Not specified as drug resistant to antibiotic</p> <p>M86.97 <i>Osteomyelitis, unspecified ankle and foot</i> B95.6 <i>Staphylococcus aureus as the cause of diseases classified to other chapters</i></p>
1110-04	Appropriate external cause code for infected vascular dialysis catheter	<p>Can we review a previous query 0802-10 in regards to the appropriate external cause code for a patient admitted with infected vascular dialysis catheter? The encoder pathway leads you to assign the following codes: T82.7 <i>Infection and inflammatory reaction due to other cardiac and vascular devices</i> Y84.1 <i>Kidney dialysis as the cause of the abnormal reaction of the patient or of later complication</i> Y82.22 <i>Health Service Area</i></p> <p>Would Y84.8 <i>Other medical procedures as the cause of abnormal reaction of the patient or of later complication</i> be more appropriate, to represent the infection being related to the vascular dialysis catheter insertion as opposed to the dialysis?</p>	<p>QCC Response: 10AM Commandment Vol 15 No. 4 states that the correct external cause code for complications related to dialysis is Y84.1 <i>Kidney dialysis as the cause of the abnormal reaction of the patient or of later complication</i> "irrespective of whether it is a complication of the fistula, catheter or infusion".</p>
1110-05	Use of M96.6	<p>Can M96.6 <i>Fracture of bone following insertion ortho implant, joint prosthesis or bone plate</i> be used only for a fracture at the site of the implant/prosthesis/plate?</p> <p>Previous QCC response: The QCC agreed more information is required. Was there any existing disease of ankle or post procedural complications or trauma?</p>	<p>QCC Response: The QCC considers that M96.6 <i>Fracture of bone following insertion of orthopaedic implant, joint prosthesis, or bone plate</i> should only be allocated when the fracture occurs as a direct outcome of the insertion of the implant, prosthesis or plate.</p> <p>It is possible that the fracture of the talar dome occurred due to the physical force of insertion of the implant (e.g. from a mallet strike). If this is the case M96.6 can be coded.</p> <p>If the fracture is unrelated to the actual insertion and has occurred due to some other intraoperative trauma, the QCC advises that another surgical complication code is allocated where appropriate.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-06	Passive Smoking	<p>When Z58.7 <i>Exposure to tobacco smoke</i> was introduced into the classification in 5th Edition, there was an instruction that it was not for use within the admitted patient data collection as there needed to be rules developed for its use.</p> <p>Can this code be used where passive smoking affects are documented?</p>	<p>QCC Response:</p> <p>The QCC does not recommend the use of this code as it has not been approved for use by the NCCH (As stated in Codefile issue #23 article Edit for Z58.7: <i>"In line with NCCH recommendations that Z58.7 not be used until the rules around allocation of this code are defined."</i>) nor approved by the NCCC.</p> <p>The QCC will discuss with the NCCC about future plans to allow for the allocation of this code in the Admitted Patient Collection.</p>
1110-07	Pain management	<p>This query was previously sent to the NCCH.</p> <p>We would like clarification on application of standard ACS 0020 <i>Multiple/Bilateral Procedures</i> with regards to pain management procedures in particular spinal injections for back pain. The standard states that pain management procedures performed without anaesthesia should only be coded once.</p> <p>Does the term anaesthesia include sedation and local anaesthetic, as it would help determine how many times the procedure should be coded i.e. as many times as performed or only the once for the operative episode?</p> <p>Also could you please provide an explanation as to why there is a drug type breakdown for epidural, spinal and caudal injections and infusions but not on other pain management procedures?</p> <p>Scenario 1 Sacral paravertebral nerve injection of Marcain (LA) and Kenacort (steroid) 18274-03 [63] <i>paravertebral nerve injection</i> How do we capture the steroid component as block 1920 excludes the pain management procedures?</p> <p>Scenario 2 Cervical facet joint pain and cervical muscle spasm with pain Procedure: Cervical plexus block with Botox & LA Codes 18252-00[63] <i>Administration of anaesthetic agent around cervical plexus</i> What code would be used for the Botox as block 1920 excludes Botox for pain management</p> <p>Scenario 3 Radiofrequency neurotomy of spinal facets The committee agreed that there are issues relating to the classification of pain management require clarification from the NCCH.</p>	<p>QCC Response:</p> <p>The QCC agrees that the procedure should be coded as many times as performed and to follow advice in ACS 0020 <i>Multiple/Bilateral procedures</i>.</p> <p>The QCC is unable to provide an explanation for the drug type breakdown for certain pain management procedures and not others and suggests this enquiry could be sent to the NCCC.</p> <p>The QCC offers the following coding advice for the scenarios provided with the assumption that in scenario one and two the agents were delivered in the same injection:</p> <p>Scenario 1 18274-03 Paravertebral nerve injection by following the look up: Administration - nerve --paravertebral ---sacral Note that anaesthetic agent is a non-essential modifier for this code so it is not exclusive to anaesthetic agent and therefore can be used for the injection of the two agents (marcain and kenacort) given in the one injection.</p> <p>Scenario 2 Administration of agent around cervical plexus by following the look up: Administration - nerve --cervical ---plexus Note that anaesthetic agent is a non-essential modifier for this code so it is not exclusive to anaesthetic agent and therefore can be used for the injection of the two agents (Botox and LA) given in the one injection</p> <p>Scenario 3 39118-00 Percutaneous neurotomy for facet joint denervation by radiofrequency by following the index: Neurotomy - peripheral --percutaneous ---radiofrequency ----for facet joint denervation</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-08	CMV Mismatch	<p>Can the previous query involving CMV mismatch be reviewed for currency?</p> <p>Advice is sought on how to code "CMV mismatch" for admissions solely for infusion of CMV hyperimmune globulin, with their only diagnosis being CMV mismatch. On some occasions there is mention of rejection, but in other cases there is no mention of rejection. Likewise, there is not usually documentation of "infection" either.</p> <p>When there is no documentation of CMV infection or graft rejection, but mention of CMV mismatch, is it acceptable to assign:</p> <p>D80.- <i>Hypogammaglobulinaemia</i></p> <p>as per ACS 0214 <i>Intragam (5th Edition)</i>, or is this standard not able to be applied?</p>	<p>QCC Response:</p> <p>The QCC recommends that the following codes are allocated for this scenario: Z29.1 - <i>Prophylactic immunotherapy</i> Z20.8 - <i>Contact with and exposure to other communicable diseases</i></p> <p>The QCC recommends that where CMV mismatch is documented, and it fulfils the criteria for coding under the Australian Coding Standards, that the coder allocates Z20.8 <i>Contact with and exposure to other communicable diseases</i>.</p>
1110-10	Error AR-DRG Review	<p>Error AR-DRG previously reviewed in 2005 is still an issue in V6.0 of the AR-DRGs Query:</p> <p>D38.5 <i>Neoplasm of uncertain or unknown behaviour of other respiratory organs</i> M86931 <i>Extra-Adrenal Paraganglioma NOS (CHEMODECTOMA)</i> 4162000 [312] <i>Removal of lesion of Glomus, Transtympanic approach</i> 4151200 [305] <i>Reconstruction of external auditory canal</i></p> <p>Block D38 is described as Neoplasm of uncertain or unknown behaviour of middle ear and respiratory and intrathoracic organs. Would you kindly have this pathway error adjusted to reflect the diagnosis?</p> <p>QCC Response (2005): From the information provided on the operation report and the pathology report the QCC agreed to use the following codes: D44.7 <i>Aortic body and other paraganglia</i> M86931 <i>Extra-Adrenal Paraganglioma NOS (CHEMODECTOMA)</i> 4162000 [312] <i>Removal of lesion of Glomus, Transtympanic approach</i> 4151200 [305] <i>Reconstruction of external auditory canal.</i></p> <p>The QCC also agreed to forward the grouping anomaly to Commonwealth to seek their opinion on the grouper logic.</p>	<p>QCC Response:</p> <p>The QCC recommends that these AR-DRGs issues are escalated and has submitted an AR-DRG query to the NCCC.</p> <p>The AR-DRG outcome of this advice has been forwarded to the Activity Based Funding Unit for their information.</p>
1110-12	Principal diagnosis in a palliative care episode	<p>From a previous query, can we review where a patient is admitted for palliative care with metastases to multiple sites from a breast carcinoma that had been previously removed?</p> <p>ACS 0224 <i>Palliative Care</i> directs that in palliative care episodes the principal condition is a diagnosis resulting in the relatively shortened prognosis. Palliative episodes receive a per diem payment regardless of AR-DRG but coding of different metastatic sites as the principal diagnosis does result in different AR-DRG assignment.</p> <p>Can guidance be given as to whether this has any importance for palliative patients and if so how the principal diagnosis (PD) should be selected for patients with metastatic carcinoma admitted where it is not clear which site is responsible for the shortened prognosis.</p>	<p>QCC Response:</p> <p>QCC recommends two options for the PD with a patient admitted for palliative care with metastases to multiple sites from a breast carcinoma that had been previously removed are:</p> <ol style="list-style-type: none"> 1. The PD needs to be clarified with the treating clinician. 2. Otherwise to default to the first condition documented on the list as per ACS 0001 <i>Principal Diagnosis</i>.

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-13	Haematopoietic malignancies with anaemia	<p>Please advise which, if any, haematopoietic malignancies should have an additional code for anaemia assigned when present?</p> <p>If these conditions should have anaemia coded additionally, where there is no anaemia documented, should the coder seek clinical clarification as a significant percentage of patient's with haematopoietic malignancies will be anaemic?</p>	<p>QCC Response: The QCC notes that anaemia in neoplastic disease is no longer a current code.</p> <p>Coding matters article Volume 16, No.3 – Myelodysplastic disease or syndrome states that anaemia does not need to be additionally coded.</p> <p>As no other haematopoietic malignancy has been mentioned as not requiring the additional code of anaemia (if present) it is assumed anaemia would be coded in addition if it meets ACS 0002 <i>Additional Diagnosis</i> and according to type.</p> <p>The QCC has sent this enquiry to the NCCC to determine if this is the correct assumption.</p> <p>The QCC has sent this query to the NCCC to determine the appropriate code if the documentation stated “not described as myelodysplastic anaemia”.</p>
1110-14	Alcohol withdrawal scale	<p>What action should be initiated (code, don't code, seek clarification) if there is no statement of alcohol withdrawal yet:</p> <p>1) 'Moderate ...' has been circled on an alcohol withdrawal chart, scores within this range are recorded and the corresponding area for medication indicates that medication was given. OR 2) Alcohol, Tobacco and Other Drugs Service (ATODS) review stages</p>	<p>QCC Response: QCC recommends that where the alcohol withdrawal scores had been recorded on the chart or there were ATODS review stages, that further clinical clarification from the clinician as to the diagnosis is required versus the documentation in the record.</p>
1110-16	Coding G82.- as an additional code with non-traumatic quadriplegia and paraplegia	<p>When coding conditions related to quadriplegia and paraplegia (non-traumatic) such as hereditary spastic paraplegia, should an additional code of G82.- <i>paraplegia and tetraplegia</i> always be added?</p>	<p>QCC Response: QCC recommends that when coding conditions related to quadriplegia (non traumatic) such as hereditary spastic paraplegia, apply ACS 0625 <i>Quadriplegia and paraplegia, non traumatic</i></p> <p>QCC note that G82.- should not routinely coded unless it meets the following standards ACS 0002 <i>Additional diagnoses</i> ACS 0027 <i>Multiple coding</i> ACS 0001 <i>Principal diagnosis</i></p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-17	Coding a medical condition treated by circumcision	<p>If a patient is admitted for a medical condition treated by circumcision (eg balanitis), should Z41.2 be used as the principal diagnosis (PD) and balanitis code additionally or PD = balanitis +/- Z41.2 additionally?</p> <p>Another example is a baby that had a Urinary Tract Infection (UTI) and there was documentation of evidence that circumcision decreases the incidence of UTI in the first year of life". The consultant recommended circumcision. The reason for admission in this episode was "medical circumcision". The patient does not actually have a UTI on admission and circumcision does not actually treat UTI. What code should be used as the PD- UTI or circumcision or Z40.8 other prophylactic surgery?</p> <p>If circumcision of the condition is not the PD, can UTI be coded additionally? (Bleeding gastric ulcer can be coded even though the patient does not have active bleeding on the day of endoscopy and patients having a tonsillectomy don't have tonsillitis at the time).</p> <p>In the index at circumcision, (in the absence of medical indication) is a nonessential modifier i.e. the code can be used regardless of there not being a medical indication. Does this then imply that it should be used even if there is a medical indication?</p>	<p>QCC Response:</p> <p>Scenario 1: QCC recommends that if a patient is admitted for a medical condition treated by circumcision (eg. Balanitis) the principal diagnosis is the condition (eg. Balanitis).</p> <p>Scenario 2: QCC recommends that if the circumcision was performed for a current UTI or there is supporting documentation linking the UTI to the procedure, then code the UTI.</p> <p>If there is no current condition but it is evident the procedure is being performed prophylactically then assign Z40.8/Z40.9 as appropriate as the PD.</p> <p>Z41.2 would not be coded as the PD or AD in either of the above as this is not a ritual circumcision.</p> <p>In relation to the non essential modifier at circumcision in the index the QCC agreed that circumcision is not the correct look up term for the scenarios cited ie the medical conditions or prophylaxis are the look up terms. The non-essential modifier allows the use of the code in the absence of any other documentation ie 'circumcision' is the only information documented.</p>
1110-18	Repeat Auditory brainstem response (ABR) testing	<p>A patient needs repeat Auditory brainstem response (ABR) under sedation after a recent grommet insertion to see whether there has been deterioration in hearing since the mild loss that was documented previously. What code should be used as the PD?</p> <p>Is this similar to follow up i.e. PD H90.8 <i>Mixed conductive and sensorineural hearing loss, unspecified</i> and Z96.2 <i>Presence of otological and audiological implants</i> additionally or should Z01.1 <i>Examination of ears and hearing</i> be used?</p> <p>Z01 codes are under the heading of examinations and investigations without complaint or reported diagnosis. Should these codes be included in the code range discussed in ACS 2111 <i>Screening for specific disorders</i>?</p>	<p>QCC Response:</p> <p>QCC recommends that the codes to assign for repeat ABR testing is:</p> <p>H90.8 <i>Mixed conductive and sensorineural hearing loss, unspecified</i></p> <p>With an additional diagnosis:</p> <p>Z96.2 <i>Presence of otological and audiological implants</i></p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-20	Appendicitis with peritoneal abscess	<p>What is the correct diagnosis code for appendicitis with appendiceal abscess – K35.3 <i>Acute appendicitis with localised peritonitis</i> or K35.2 <i>Acute appendicitis with generalised appendicitis</i>?</p> <p>These codes changed in 7th edition (WHO-URC Updates-Trieste 2007). 7th Edition education states: ACS 1101 <i>Appendicitis</i> is deleted. Coders should follow the ICD-10-AM Alphabetic index for code assignment. Inclusion terms and index entries have been added to ICD-10-AM to clarify the classification of appendicitis with or without histological confirmation.</p> <p>How do the “new” inclusion terms and index entries clarify the selection when both codes have acute appendicitis in the code titles? We believe that K35.3 (localised peritonitis) is the best fit, but are we to follow the entry of Appendicitis, - acute, -- with, ---peritoneal abscess (K35.2 with generalised peritonitis) because the histology (and clinical documentation) specifies acute.</p> <p>7th Ed index entries: Phlegmon — see Abscess</p> <p>Abscess (embolic) (infective) (metastatic) (multiple) (pyogenic) (septic) L02.9 - appendix K35.3</p> <p>Appendicitis K37 - with - - peritoneal abscess K35.3 - - peritonitis (localised) (perforation) (rupture) K35.3 - - - generalised K35.2 - acute (catarrhal) (fulminating) (gangrenous) (obstructive) (retrocaecal) (suppurative) K35.8 - - with - - - peritoneal abscess K35.2 - - - peritonitis (localised) (perforation) (rupture) K35.2 - - - generalised K35.2</p> <p>The same index entry structure is in 6th Edition, but the same code (K35.0) is given for peritoneal abscess, regardless of whether the look-up is Appendicitis, - with, -- peritoneal abscess OR Appendicitis, - acute, -- with, --- peritoneal abscess.</p> <p>6th Edition index entry Appendicitis K37 -with - - perforation or rupture K35.0 - - peritoneal abscess K35.1 - - peritonitis (localised) K35.9 - - - with mention of perforation or rupture K35.0 - - - generalised K35.0</p>	<p>QCC Response: QCC recommends that the correct diagnosis code for appendicitis with appendiceal abscess is:</p> <p><i>K35.3 Acute appendicitis with localised peritonitis</i></p> <p>QCC notes that there may be a discrepancy in the index pathway, should this be an errata change. QCC follow up with NCCC.</p> <p>Appendicitis K37 - with - - peritoneal abscess K35.3 - - peritonitis (localised) (perforation) (rupture) K35.3 - - - generalised K35.2 - acute (catarrhal) (fulminating) (gangrenous) (obstructive) (retrocaecal) (suppurative) K35.8 - - with - - - peritoneal abscess K35.2 - - - peritonitis (localised) (perforation) (rupture) K35.2 - - - generalised K35.2</p> <p>QCC noted that in the code title there is:</p> <p>K35.2 <i>Acute appendicitis with <u>generalised</u> peritonitis</i></p> <p>K35.3 <i>Acute appendicitis with <u>localised</u> peritonitis</i></p> <p>The QCC has sent a query to NCCC to clarify the difference of generalised and localised peritonitis.</p> <p>Query the index pathway from acute appendicitis with peritoneal abscess. Should this be an errata with the correct code K35.3 - Acute appendicitis with localised peritonitis. - acute (catarrhal) (fulminating) (gangrenous) (obstructive) (retrocaecal) (suppurative) K35.8 - - with - - - peritoneal abscess K35.2 - - - peritonitis (localised) (perforation) (rupture) K35.2 K35.3 - - - generalised K35.2</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1110-20 cont.		<ul style="list-style-type: none"> - acute (catarrhal) (fulminating) (gangrenous) (obstructive) (retrocaecal) (suppurative) K35.9 - - with - - - perforation or rupture K35.0 - - - peritoneal abscess K35.1 - - - peritonitis (localised) K35.9 - - - - with mention of perforation or rupture K35.0 - - - - generalised K35.0 	
1110-22	Follicular Non-Hodgkin's Lymphoma	Could the QCC please advise the correct code and morphology assignment for Follicular Non-Hodgkin's Lymphoma?	<p>QCC Interim Response: The QCC directs coders to ACS 0233 <i>Morphology</i>.</p> <p>The QCC recommends assign the higher morphology as the highest number is usually more specific. In the interim code Follicular Non-Hodgkin's Lymphoma to:</p> <p><i>C82.9 Follicular lymphoma, unspecified</i> <i>M9690/3 Follicular Lymphoma NOS</i></p> <p>QCC will submit a public submission to NCCC to have an index entry for Follicular Non Hodgkin's Lymphoma.</p>
1110-23	TOV - Australian Coding Standard clarification	<p>Can the QCC please advise whether post op or non-post op should be followed in the scenario given below:</p> <p>If a patient develops urine retention in the post op period but it is not documented as due to the surgery. Therefore R33 alone is assigned in accordance with ACS 1904 <i>Procedural Complications</i>. Patient is discharged with indwelling catheter in-situ to return for Trial of Void.</p> <p>Do we assign codes for non-post op? Is the intention of the standard to continue assigning the same codes?</p> <p>This was queried at a recent coding education day and all coders assigned the Trial of Void Post Op codes even though post op codes were not assigned in the original admission in which the retention arose. They did so as the Trial of Void followed a procedure.</p> <p>Please note the disease code selection for ACS 1436 <i>Admission For Trial Of Void</i></p>	<p>QCC Interim Response: The QCC notes the wording to standard ACS 1904 <i>Procedural complication</i> can be confusing, there are mixed concepts. Does ACS 1904 need to be made more explicit to this scenario?</p> <p>The QCC advises that in an admission for trial of void, post operative is a period of time not post procedural.</p> <p>The QCC decided better definitions are required with the ACS 1436 <i>Admission for trial of void</i>.</p> <p>Postoperative period vs postoperative complication. The QCC has sent a query to NCCC on inclusion note N99.8 <i>Other postprocedural disorders of genitourinary system</i>.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1210-01	Redundant Colon - Deleted ACS 1109	<p>ACS 1109 <i>Redundant Colon</i> was deleted for ICD-10-AM 7th Edition 'because the code for Redundant Colon should not be assigned unless it meets criteria in ACS 0001 <i>Principal Diagnosis</i> or ACS 0002 <i>Additional Diagnosis</i>.</p> <p>I have coded scenarios since July 2010 where Redundant Colon is documented as either the cause of a symptom or is an incidental finding in a same day colonoscopy episode.</p> <p>Does that mean that for cases as above we can now allocate code Q43.89 <i>Other specified congenital malformations of intestine</i>?</p>	<p>QCC Interim Response: The QCC recommends that redundant colon is assigned.</p> <p>Q43.89 <i>Other specified congenital malformations of intestine</i>.</p> <p>By following the index pathway: Redundant - colon Q43.89</p> <p>The QCC notes that redundant colon may be an acquired condition and will submit a query to the NCCC as to the correct coding for an acquired condition (non congenital).</p>
1210-03	Infected hydroureter	<p>When using the Codefinder and entering hydroureter with infection you get the following codes –</p> <p>N13.4 <i>Hydroureter</i> and N13.6 <i>Pyonephrosis</i></p> <p>The book index directs you to only N13.6 and there is no "code also" information instructing you to add N13.4. So if you were using the books your code would only be N13.6.</p> <p>Is this an error with the Codefinder or should the books have a notation to code also the N13.4?</p>	<p>QCC Interim Response: The QCC advises to follow the Index with the lead term hydroureter as provided by the documentation and assign N13.6 <i>Pyonephrosis</i>. Use an additional code to identify the infective agent (if known) as per the Use additional instruction Hydroureter - with infection</p> <p>The QCC has submitted a query to 3M to investigate the Codefinder pathway that provides two codes when entering hydroureter with an infection:</p> <p>N13.4 <i>Hydroureter</i> N13.6 <i>Pyonephrosis</i> + Infective agent.</p>

Queensland Coding Committee July to December 2010 Queries

QCC_ID	Query summary	Query De-identified	QCC response
1210-05	External Cause Codes in Codefile, Postprocedural Multiple External Cause Code Example	<p>We would like to query the selection of the codes used in the Multiple External Cause Codes scenario provided by a hospital enquiring about sequencing of external cause codes.</p> <p>Codefile Issue 38, Item 11 Multiple External Cause Codes states:</p> <p>Coding of acute cholecystitis defined as a post op complication from a previous procedure. T81.8 or K91.8?</p> <p>The diagnosis is given as acute cholecystitis that was subsequently defined as a post-op complication from a previous procedure. Codes provided are: T81.8 <i>Other complications of procedures not elsewhere classified</i> Y83.8 <i>Surgical Procedure</i> Y92.22 <i>Health Service Area</i> K81.0 <i>Acute cholecystitis</i> Y83.8 <i>Surgical Procedure</i> Y92.22 <i>Health Service Area</i></p> <p>According to our interpretation of ACS 1904 <i>Procedural Complications</i>, to get the correct procedural complication code, the steps would be as follows:</p> <p>Firstly check the Alphabetic Index under the main term which best describes the complication (Cholecystitis) for the subterm of 'procedural' or 'postprocedural'. No subterm for procedural, post procedural, or describing the procedure involved is listed under Cholecystitis. Therefore, follow the look-up for 'Complication(s)', followed by the relevant body system to which the complication pertains (digestive) and then 'postprocedural'. By following these instructions and Example 11 in ACS 1904, we believe that the correct postprocedural complication code for postprocedural cholecystitis is K91.8 <i>Other postprocedural disorders of digestive system NEC</i>.</p>	<p>QCC Response: QCC agrees that the code for acute cholecystitis defined as a post op complication from a previous procedure is:</p> <p><i>K91.8 Other post procedural disorders of digestive system, not elsewhere classified.</i></p>
1210-06	Penile Adhesions	<p>What are the correct codes for coding postprocedural penile adhesions?</p> <p>An error is raised when procedure code 90402-01 <i>Division of penile adhesions</i> is coded without one of the following diagnosis codes:</p> <p>Q55.8 <i>Other specified congenital malformations of male genital organs</i> N47 <i>Redundant prepuce, phimosis and paraphimosis</i> or N99.8 <i>Other postprocedural disorders of genitourinary system</i></p> <p>When N99.8 was used as the PD this returned an ungroupable AR-DRG.</p> <p>Could the QCC please advise.</p>	<p>QCC Interim Response: The correct codes are N99.8 as the PD with procedure code 90402-01. This will group to 901Z. Note to QCC members:</p> <p>The QCC has reported the ungroupable AR-DRG issue to NCCC and the Activity Based Funding Unit.</p>