

Queensland Coding Committee December 2009 Coding Queries

| QCC_ID | Query summary | Query | QCC Response |
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| 0709-01 | Crush & Compression fractures | <p>Please provide clarification for crush and compression fractures.</p> <p>Are they pathological for elderly people?</p> <p>If there is no documented injury, are non-injury codes acceptable to use?</p> | <p>QCC Response: The QCC advises “crush”, “compression”, or other fractures where there is no documentation of an external cause and the fracture is not stated to be ‘pathological’, should be coded to the appropriate ‘S’ or ‘T’ code by following the index default.</p> <p>A query will be sent to the NCCH to check whether the current default is the most appropriate, and whether any guidance can be provided for coding fractures where there is no mention of trauma or ‘pathological’ (particularly in elderly people with crush or compression fractures and osteoporosis).</p> <p>NCCH Response: Could the NCCH please provide guidance for coding Crush and Compression fractures where there is NO mention of trauma or ‘pathological’ (particularly in elderly people with osteoporosis)?</p> <p>Could advice also take into consideration how this should be coded where there is an apparently minor trauma? For instance when a patient has turned over in bed and is consequently admitted with back pain. An X-ray taken on admission shows an old fracture. There is no other diagnosis such as strain or sprain provided and the pain is likely attributable to the old fracture.</p> <p>The QCC advised “crush”, “compression”, or other fractures where there is no documentation of an external cause and the fracture is not stated to be ‘pathological’, should be coded to the appropriate ‘S’ or ‘T’ code by following the index default under 'Fracture' by site.</p> <p>Is this advice correct or are non-injury codes acceptable to use if there is no documented injury or an injury is described as "old"?</p> |
| 0709-02 | Difficult Intubation | This query is in relation to difficult intubation (Coding Commandments Volume 15 Number 3). | <p>QCC Response: The QCC were divided in their opinion, as to whether documentation of difficult intubation always meets</p> |

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| | | <p>It is still unclear what kind of criteria should be met to assign this code. If difficult intubation is documented in the record and different equipment (for example Cook introducer) was used, does it meet criteria of difficult intubation?</p> <p>Should difficult intubation only be coded if another form of anaesthesia is used (regional or neuraxial) instead of intubation?</p> | <p>ACS0002. Some members were of the opinion that difficult or failed intubation should not be coded where the intubation proceeds and there is no further care associated with the difficult intubation (e.g. aspiration pneumonia or radiological investigation to ensure there have been no complications).</p> <p>QCC agreed to ask the NCCH whether changing intubation instruments or discussion of reasons for the difficult intubation alone, meets ACS 0002 criteria.</p> <p>This query will be forwarded to the NCCH for advice and suggest that a new code is created for "difficult airway". In addition, the QCC wants to see the creation of a code for difficult intubation that is not a complication code in addition to the existing code.</p> <p>A suggestion was made that a Codefile article be written on this topic.</p> |
| 0709-03 | Use of Z35.5x as Pdx | <p>Could QCC please provide clarification on the use of Z35.x and if using it as a principal diagnosis is acceptable in the following situation.</p> <p>Consider a situation where admission is for induction of labour due to maternal age (multigravida), and a medical induction performed and there are no other conditions.</p> <p>Bearing in mind the ruling on obstetric principal diagnosis (that being the reason for admission).</p> <p>In this situation there are no other conditions and admission is for induction of labour due to being a multigravida with advanced maternal age.</p> <p>Would Z35.52 be acceptable code allocation as a principal diagnosis? The rationale for this is because in the index the word (supervision of) is a nonessential modifier.</p> <p>There seems to be a reluctance to use a "Z" code as an obstetric principal diagnosis. Common practice seems to be to code O80 as the principal diagnosis plus Z35.52 as an additional code. This then places the case into DRG O60C. Whereas If coded with Z35.52 as principal it goes to DRG O60B.</p> | <p>QCC Response: The QCC advises that for 6th Edition, Z35.52 <i>Supervision of multigravida with advanced maternal age</i> should be coded as the principal diagnosis in the situation given.</p> |

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| | | There is the ruling on social admissions where O80 can be used along with the induction code to show that there were no other reasons for induction but in this type of case the maternal age was the reason for admission. | |
| 0709-04 | Gestational Trophoblastic Disease | <p>Please provide advice on the coding of Gestational Trophoblastic Disease with Lung Metastases?</p> <p>The Index does the following; Disease, -trophoblastic (M9100/0) (see also Mole, hydatidiform) O01.9</p> <p>Mole -hydatid, hydatidiform (benign) (complicating pregnancy) (delivered) (undelivered) (M9100/0) O01.9 --classical (M9100/0) O01.0 --complete (M9100/0) O01.0 --incomplete (M9103/0) O01.1 --invasive (M9100/1) D39.2 --malignant (M9100/1) D39.2</p> <p>Should a code for malignant Hydatidiform Mole (D39.2 M9100/1) be assigned? If so, how are the metastases coded?</p> <p>NCCH ID 2195 from 2005 provides direction to code to Malignant neoplasm of placenta (choriocarcinoma – C58 M9100/3 and C78.0 M9100/6).</p> | <p>QCC Response: The QCC advises that the appropriate codes in the case cited are: C58 M9100/3 C78.0 M9100/6</p> <p>This advice has been confirmed with the Queensland Cancer Registry.</p> |
| 0709-05 | Newborns and meeting the criteria for coding under ACS 0002 | <p>I agree/ understand that conditions noted on examination of the newborn are not routinely coded (as per ACS 0002 Conditions noted on examination of the newborn) and that they need to meet 0002. However, this is where it gets a bit tricky.</p> <ol style="list-style-type: none"> 1. What constitutes "increased clinical care and/or monitoring". 2. Does review by another doctor suffice? 3. Does review need to be specifically for the abnormality/condition? 4. Is review alone sufficient? 5. Is referral for external opinion counted? <p>Vic used to have "active evaluation" as a Victorian</p> | <p>QCC Response: The QCC noted that ACS 0002 directs that assessments/ conditions documented during a clinical assessment should only be coded when they meet ACS 0002 criteria or where the condition changes the standard treatment protocol for a particular procedure/condition.</p> <p>The QCC advises that conditions assessed but deemed to not warrant further action would not generally be coded.</p> <p>The QCC will refer this query to NCCH.</p> <p>NCCH Query: The QCC has recently had a query relating to ACS 0002.</p> |

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| | | <p>addition to 0002.</p> <p>6. Does the QCC consider that "active evaluation" is incorporated in the current 0002 definition?</p> <p>7. Does an "active decision" (not necessarily with action) count? This would include a decision that something could be treated out of the hospital setting.</p> <p>8. Does this constitute an assessment?</p> <p>9. Is assessment increased clinical care?</p> <p>For example: A neonate has a forceps bruise and a clinical consult is arranged specifically to review the bruise.</p> <p>10. Is specific review (during admission) of the newborn condition/abnormality enough, even if the decision is for no further action?</p> <p>11. What if there is a decision that no further action is required? Does decision= assessment? Does assessment= clinical care?</p> | <p>Conditions noted on examination of the newborn are not routinely coded (as per ACS 0002 Conditions noted on examination of the newborn) and they need to meet 0002. However, further clarification is sought:</p> <ol style="list-style-type: none"> 1. What constitutes "increased clinical care and/or monitoring". <ol style="list-style-type: none"> a. Does review by another doctor suffice? b. Does review need to be specifically for the abnormality/condition? c. Is review alone sufficient? d. Is referral for external opinion counted? e. Is "active evaluation" sufficient? f. Does an "active decision" (not necessarily with action) count? This would include a decision that something could be treated out of the hospital setting. g. Does this constitute an assessment? h. Is assessment increased clinical care? <p>For example: A neonate has a forceps bruise and a clinical consult is arranged specifically to review the bruise.</p> <ol style="list-style-type: none"> i. Is specific review (during admission) of the newborn condition/abnormality enough, even if the decision is for no further action? j. What if there is a decision that no further action is required? Does decision = assessment? Does assessment = clinical care? <p>The QCC notes that ACS 0002 directs that assessments/ conditions documented during a clinical assessment should only be coded when they meet ACS 0002 criteria or where the condition changes the standard treatment protocol for a particular procedure/condition.</p> <p>The QCC advised that conditions assessed but deemed to not warrant further action would not generally be coded.</p> <p>Could the NCCH please advise upon the coding conditions of ACS 0002?</p> <p>Response from Coding Matters Vol 17 No 1</p> |
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| | | | <p>Newborn conditions In what circumstances should conditions noted on the examination of a newborn be coded?</p> <p>ACS 0002 <i>Additional diagnoses</i> states: “Abnormalities noted on examination of the newborn A code should be assigned for these conditions only when they meet the criteria outlined in this standard.” This statement is included to ensure that only significant neonatal conditions are coded.</p> <p>Coders should be guided by the documentation in the clinical record to determine if a neonatal condition meets the criteria for code assignment as per ACS 0002.</p> <p>If a condition is significant enough to warrant review/ evaluation by a clinician or referral for an external opinion then it has met the criteria for ‘increased clinical care and/ or monitoring’ and coders should assign a code for the condition.</p> <p>The guidelines in ACS 0002 regarding ‘abnormalities noted on the examination of newborns’ are to steer coders away from assigning codes for conditions which are mentioned on the newborn examination only, but do not require any further treatment, diagnostic procedure or increased clinical care/monitoring.</p> |
| 0709-06 | Obstetrics Chapter vs ACS 0002 | <p>Does chapter 15 override ACS 0002?</p> <p>VICC query 2450 states that chapter 15 is considered to override ACS 0002 for those conditions included in the specialty chapter but that other conditions should be subject to ACS 0002.</p> <p>What is the QCC stance?</p> | <p>QCC Response: The QCC advises that some speciality standards may give guidance to code certain conditions that would not normally meet ACS 0002.</p> <p>ACS 1524 <i>Advanced maternal age</i> states: “Z35.51 Supervision of primigravida with advanced maternal age should be assigned if a primigravida's age equals 35 years or more. Z35.52 Supervision of multigravida with advanced maternal age should be assigned if a multigravida's age equals 35 years or more.</p> <ul style="list-style-type: none"> • These conditions should be coded when documented by an obstetrician/clinician/midwife. |

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| | | | <p>• If the criteria for the specific obstetric diagnosis are met but the relevant diagnosis is not documented, consult the clinician before assigning a code.”</p> <p>The QCC advises where advanced maternal age has been documented by an obstetrician/clinician/midwife, it is not necessary for ACS 0002 criteria to be met before coding.</p> |
| 0709-07 | Zonular Dehiscence | <p>Consider the following situation where admission is for cataract repair.</p> <p>If clinicians document Zonular Dehiscence in the operation records and misadventure is not mentioned.</p> <p>Should a code for Zonular Dehiscence be assigned? If so, what is the best disease code?</p> | <p>QCC Response: The QCC advises that, based on old NCCH advice, ‘zonular dehiscence’ would be coded as H21.2 <i>Degeneration of iris and ciliary body</i>.</p> |
| 0709-08 | Errata 3, March 2009 – ICD-10-AM Index: Place Of Occurrence - Highway Y92.49 | <p>Please provide clarification of the correct code to use for Place of occurrence for accidents that occur on a street or highway?</p> <p>Considering the following:</p> <p>In the NCCH ICD-10-AM/ACS/ACHI Sixth Edition Coding Workshops 2009 (Coding Workbook, page 9, Case 9). Place of occurrence was coded out to Y92.40 Roadway.</p> <p>However Errata 3, March 2009 amended ICD-10-AM alphabetical index look up to read:</p> <p>Place of occurrence of external cause -highway (see also Place of occurrence of external cause, street) Y92.49 Unspecified public highway, street or road -street (highway) Y92.49 Unspecified public highway, street or road --roadway Y92.40 Roadway, Freeway, Motorway</p> <p>Page 470 of the Tabular List – DEFINITIONS RELATED TO TRANSPORT ACCIDENTS (c) A traffic accident is any vehicle accident occurring on the public highway..... A vehicle accident is assumed to have occurred on the public highway unless another place is specified, except in the case of accidents involving only off-road motor vehicles, which are classified as non-traffic accidents</p> | <p>QCC Response: The QCC advises that when an accident occurs on the actual road, the place of occurrence should be coded as Y92.40.</p> <p>Y92.49 would be assigned where the terms ‘street’ or ‘road’ have been used as broad/general terms and the accident may have occurred anywhere on the footpath or road itself.</p> <p>NCCH will be asked to provide formal advice regarding this.</p> <p>NCCH Query: The QCC has recently had a query related to Y92.49 Place of occurrence - highway.</p> <p>Differing advice is recommended in Errata 3, March 2009 that amended the ICD-10-AM alphabetical index look up and in the NCCH ICD-10-AM/ACS/ACHI Sixth Edition Coding Workshops 2009 (Coding Workbook, page 9, Case 9). Please see page 470 of the Tabular List – DEFINITIONS RELATED TO TRANSPORT ACCIDENTS for further information.</p> <p>The QCC advises that when an accident occurs on the actual road, the place of occurrence should be coded as Y92.40.</p> <p>Y92.49 would be assigned where the terms ‘street’ or ‘road’</p> |

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| | | <p>unless the contrary is stated.</p> <p>The NCCH coding workshop advice was to continue to code to Y92.40 Roadway as we were doing previous to the Errata change. This goes against the usual practise of following the alphabetical index to allocate the correct code.</p> <p>Of Note, 3M Codefinder pathway leads to Y92.40 Place of occurrence at or in street and highway, roadway.</p> | <p>have been used as broad/general terms and the accident may have occurred anywhere on the footpath or road itself.</p> <p>Please provide clarification of the correct code to use for Place of occurrence for accidents that occur on a street or highway.</p> <p>NCCH Coding Matters Vol. 17 No. 1 response: Question: Errata 3, March 2009 updated the ICD-10-AM Alphabetic Index for place of occurrence roadway/highway causing confusion as to the correct code assignment when an accident occurs on a roadway.</p> <p>Is it Y92.40 <i>Roadway</i> or Y92.49 <i>Unspecified public highway, street or road</i>?</p> <p>Answer: The correct place of occurrence code to assign for an accident occurring on the roadway of a street or highway is Y92.40 <i>Roadway</i> by following the index pathway: Place of occurrence of external cause - street (highway) - - roadway Y92.40</p> <p>The definition of a street or highway in ICD-10-AM includes the sidewalk, cycleway and roadway itself, all of which are open to the public. So, the roadway by this definition makes up part of the street or highway. Therefore, if you know an accident has occurred on the roadway of a street or highway then Y92.40 <i>Roadway</i> is the correct place of occurrence code to assign.</p> <p>However, if an accident has occurred and there is no documentation to indicate on which part of the street or highway, as per the above definition, then the correct place of occurrence code to assign is Y92.49 <i>Unspecified public highway, street or road</i>.</p> <p>This ambiguity has been corrected for ICD-10-AM Seventh Edition by deleting Y92.40 <i>Roadway</i> and adding <i>freeway, motorway</i> and <i>roadway</i> as inclusion terms at Y92.49 <i>Unspecified public highway, street or road</i>.</p> |
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| 0709-09 | T2DM with Renal Impairment/Failure NOS | <p>Is advice in NCCH query ID 2156 (see below) to code unspecified Renal failure to Chronic renal failure still relevant to 6th edition?</p> <p>The advice given in NCCH Query ID 2156 was: <i>'Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign: E1-.23 '*Diabetes mellitus with advanced renal disease 'N18.90 'Unspecified chronic renal failure'</i></p> <p>Considering the NCCH advice in this query would the eGFR result to assign a more specific code from N18.*?</p> <p>Impairment -kidney N19 --acute N17.- ---with diabetes E1-.29 --chronic N18.9 ---with diabetes E1-.22 ---end-stage N18.5 ----with diabetes E1-.22 ---stage 1 N18.1 ---stage 2 N18.2 ---stage 3 N18.3 ---stage 4 N18.4 ---stage 5 N18.5</p> <p>Diabetes , diabetic - with --impairment, kidney ---acute E1-.29 ---chronic — see Diabetes, with, chronic kidney disease</p> <p>Diabetes, diabetic -with --chronic kidney disease (CKD) E1-.22 ---end-stage (ESKD) E1-.22 ---stage 1 E1-.21 ---stage 2 E1-.21 ---stage 3 E1-.22 ---stage 4 E1-.22</p> | <p>QCC Response: The QCC advises where no further information is available and clinician clarification is not possible, diabetes with unspecified renal failure should be coded as E1-.22 and N18.9.</p> <p>This will be further checked with NCCH.</p> <p>NCCH Query: Is advice in NCCH query ID 2156 (see below) to code unspecified Renal failure to Chronic renal failure still relevant to 6th edition?</p> <p>The advice given in NCCH Query ID 2156 was: <i>'Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign: E1-.23 '*Diabetes mellitus with advanced renal disease 'N18.90 'Unspecified chronic renal failure'</i></p> <p>Considering the NCCH advice in this query would the eGFR result enable the coders to assign a more specific code from N18.*?</p> <p>Impairment -kidney N19 --acute N17.- ---with diabetes E1-.29 --chronic N18.9 ---with diabetes E1-.22 ---end-stage N18.5 ----with diabetes E1-.22 ---stage 1 N18.1 ---stage 2 N18.2 ---stage 3 N18.3 ---stage 4 N18.4 ---stage 5 N18.5</p> <p>Diabetes , diabetic - with --impairment, kidney ---acute E1-.29</p> |
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| | | <p>---stage 5 E1-.22</p> | <p>---chronic — see Diabetes, with, chronic kidney disease</p> <p>Diabetes, diabetic -with --chronic kidney disease (CKD) E1-.22 ---end-stage (ESKD) E1-.22 ---stage 1 E1-.21 ---stage 2 E1-.21 ---stage 3 E1-.22 ---stage 4 E1-.22 ---stage 5 E1-.22</p> <p>The QCC advises where no further information is available and clinician clarification is not possible, diabetes with unspecified renal failure should be coded as E1-.22 and N18.9.</p> <p>The QCC seek clarification from the NCCH of the correct code to use in this case.</p> <p>NCCH Response from Coding Matter Vol 17 No.1 Question: Previous advice issued by the NCCH indicated that diabetes with unspecified renal failure should be coded to diabetes with chronic renal failure: “Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign: E1-.23 <i>diabetes mellitus with advanced renal disease</i> and N18.90 <i>Unspecified chronic renal failure.</i>”</p> <p>Given that this advice suggests unspecified chronic renal failure can be assigned to chronic renal failure can coders further specify the stage of chronic renal failure by consulting the eGFR result?</p> <p>Answer: The advice quoted above is related to ICD-10-AM Fourth Edition and is no longer current given the changes made to ACS 1438 <i>Chronic kidney disease</i> in ICD-10-AM Sixth Edition.</p> |
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| | | | <p>This is a documentation issue rather than a coding issue.</p> <p>The coder should verify with the clinician whether the kidney failure is acute or chronic to be able to assign either E1-.29 ... <i>diabetes mellitus with other specified kidney complication</i>, E1-.22 ... <i>diabetes mellitus with established diabetic nephropathy</i> or E1-.21... <i>diabetes mellitus with incipient diabetic nephropathy</i>.</p> <p>Once this is determined then follow the 'use additional code' note to identify the presence of chronic kidney disease (N18.-) as applicable.</p> <p>The advice in ACS 1438 is related to the documentation of CKD (or chronic renal failure). The eGFR can then be used to determine the stage of the CKD for the assignment of the correct N18.- <i>Chronic kidney disease...</i> code.</p> <p>It should not be used to determine acute kidney failure versus chronic kidney failure but rather to establish the stage of CKD where CKD (or chronic renal failure) has already been documented.</p> |
| 0709-10 | Sedation with Ventilation | <p>Please provide advice on when to code sedation with mechanical ventilation</p> <p>QCC ID 1200-08 is the last advice I can find.</p> <p>Advice from a recent audit was that ventilation under sedation that continued for more than 24 hrs after a procedure with a GA didn't need a sedation code with it.</p> <p>There are some differing schools of thought on this, some state to always coded sedation, and some don't.</p> | <p>QCC Response: The QCC advises that sedation for intubation/ ventilation should be coded (for any period where the patient is not receiving general anaesthetic).</p> <p>NCCH response from Coding Matters Vol 16 no.2 FAQs Q20: Does sedation need to be coded with ventilation when it is administered?</p> <p>A: As per ACS 0031 <i>Anaesthesia</i>, a code is assigned for any form of anaesthetic except local anaesthesia and oral sedation, when administered for anaesthetic purposes to perform a procedure i.e. for intubation/ventilation.</p> |
| 0809-01 | Diagnosis on discharge - referral | <p>Discharge referral: Exacerbation of Asthma & Underlying LRTI (Bronchopneumonia). CXR – Areas of postero-basal opacification likely infection. SPUTUM MSC SENT. Treatment Roxithromycin & Cefuroxime. I have 2 questions:</p> | <p>QCC Response: <u>Q1:</u> Clarification was sought from the enquirer and query 0809-03 relates to query 0809-02.</p> <p>The emphasis of the question is that if the diagnosis at transfer out is provided as LRTI with wheeze and ?Swine</p> |

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| | | <p>Question 1: Are coders allowed to code Pneumonia due to an organism purely from the organism result on pathology report and no documentation of the Pneumonia being due to any organism in patient's notes. According to expert educators, the answer is "no".</p> <p>What is the QCC's direction re the above?</p> <p>Question 2: Considering the above referral information and ACS 0012, what is the PDx when the sputum culture (which showed streptococcus pneumoniae) was not available until after the patient left and the notes state: impression state viral exacerbation asthma? Suggestions include:</p> <p>J18.0 J45.9</p> <p>J12.9 J45.9</p> <p>J13 J45.9</p> | <p>Flu, and the results of investigation are not available at the time of transfer, should the whole specificity of the queried diagnosis be used, or only that part which is known at the time?</p> <p>ACS 0012 <i>Suspected Conditions</i> - Transferred to another hospital states that <i>If a patient is transferred for further investigation of a suspected condition, the transferring hospital should assign the suspected condition code (eg meningitis). Also assign Z75.3 Unavailability and inaccessibility of health-care facilities as a 'flag' to identify patients transferred because of a suspected condition (Note: this code is not to be used for ALL transfers as the discharge status provides that information).</i></p> <p>The standard states <i>Clinical coders at the transferring hospital should use only the available information at the time of transfer to code the case but this should be read in continuity with the next sentence Information which becomes available from the hospital to which the patient was transferred should not be used to inform the coding decision.</i></p> <p>I.e. The emphasis of the statement is that findings of investigations performed after discharge should not be used. This statement does not exclude the use of results of investigations performed during the episode even if the results are not available until after discharge.</p> <p>Note: For patients transferred with a suspected diagnosis, Z75.3 should be coded additionally.</p> <p><u>Q2:</u> The QCC considers that application of ACS 0001 <i>Principal Diagnosis -Problems and underlying conditions</i> is problematic in certain situations and will consult NCCH regarding this issue.</p> <p>The Committee considered that either Asthma or Pneumonia could potentially meet the definition for principal diagnosis and clinical consultation should be sought.</p> |
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| | | | <p>Although the patient was stated to have a query diagnosis of <i>viral</i> exacerbation of asthma they were treated with antibiotics.</p> <p>ACS 0001 states The principal diagnosis is defined as: <i>“The diagnosis established after study ...”</i>When considering ACS 0012 Suspected Conditions which states <i>“Clinical coders at the transferring hospital should use only the available information at the time of transfer to code the case and information which becomes available from the hospital to which the patient was transferred should not be used to inform the coding decision”</i>.</p> <p>Emphasis should be placed on the concept that findings of investigations performed after discharge should not be used. This does not exclude use of results of investigations performed during the episode even if the results are not available until after discharge.</p> <p>In this scenario, logic provided in Coding Matters Volume 15, Number 2 –FAQ part 1 should be applied.</p> <p>Principal/Additional diagnoses Q: Patient admitted for breast lumpectomy histopathology pending and patient was discharged. Findings showed cancer. What is coded as the principal diagnosis, the breast lump or the cancer?</p> <p>A: As per ACS 0010 General abstraction guidelines – Test results, the histopathology result is providing further specificity to an already documented condition. In this scenario the patient was admitted for the removal of a breast lump and the histopathology confirmed that the lump was cancerous; therefore, the cancer would be coded as the principal diagnosis.</p> |
| 0809-02 | Diagnosis on discharge - transfer | <p>Inter-Hospital transfer form: LRTI with wheeze. ? Swine Flu. Needs isolation until swab results. Results are still not available. Are coders allowed to code pneumonia due to an organism purely from the organism result on pathology report and no documentation of the Pneumonia being due</p> | <p>QCC Response: The QCC considers that since investigations were carried out, coding should not be finalised until results are available (Interim coding may be necessary in order to meet coding deadlines and in these circumstances Clinician Clarification may be necessary as per ACS 0012).</p> <p>If the test result is negative; the LRTI is the principal</p> |

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| | | <p>to any organism in patient's notes? According to expert educators, the answer is "no".</p> <p>Considering the above and ACS 0012, what is the QCC's suggestion for this patient? What are the correct codes for the above patient?</p> <p>J11.1 Z29.0 Z75.3</p> <p>or</p> <p>J09 Z29.0 Z75.3</p> | <p>diagnosis.</p> <p>If the test result is positive, Swine flu is the principal diagnosis.</p> <p>If test results are inconclusive, then the coder should refer to ACS 0012 Suspected Conditions.</p> |
| 0809-03 | Diagnosis on discharge - went home | <p>Are coders allowed to code pneumonia due to an organism purely from the organism result on pathology report and no documentation of the Pneumonia being due to any organism in patient's notes? According to expert educators, the answer is "no".</p> <p>Considering the above and ACS 0012 what is the QCC's suggestion for this patient?</p> <p>What are the correct codes for the above patient</p> <p>J45.9 J09 Z29.0</p> <p>OR</p> <p>J45.9 J11.1 Z29.0</p> | <p>QCC Response: Clarification was sought from the enquirer and query 0809-03 relates to query 0809-02.</p> <p>The emphasis of the question is that if the diagnosis at transfer out is provided as LRTI with wheeze and ?Swine Flu, and the results of investigation are not available at the time of transfer, should the whole specificity of the queried diagnosis be used, or only that part which is known at the time?</p> <p>ACS 0012 <i>Suspected Conditions</i> - Transferred to another hospital states that <i>If a patient is transferred for further investigation of a suspected condition, the transferring hospital should assign the suspected condition code (eg meningitis). Also assign Z75.3 Unavailability and inaccessibility of health-care facilities as a 'flag' to identify patients transferred because of a suspected condition (Note: this code is not to be used for ALL transfers as the discharge status provides that information).</i></p> <p>The standard states <i>Clinical coders at the transferring hospital should use only the available information at the time of transfer to code the case but this should be read in continuity with the next sentence Information which becomes available from the hospital to which the patient was transferred should not be used to inform the coding</i></p> |

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| | | | <p><i>decision.</i></p> <p>I.e. The emphasis of the statement is that findings of investigations performed after discharge should not be used.</p> <p>This statement does not exclude the use of results of investigations performed during the episode even if the results are not available until after discharge.</p> <p>Note: For patients transferred with a suspected diagnosis, Z75.3 should be coded additionally.</p> |
| 0809-04 | Redundant Colon | <p>Diagnosis: Altered Bowel Habit Procedure: Colonoscopy</p> <p>Procedure & Findings: Colonoscopy was performed to the caecum. The colon was redundant and negotiated with difficulty. The procedure was otherwise normal. Comment: I have reassured (patient name) today. I have asked her to keep in touch with you and her altered bowel habit is most likely related to her grossly redundant colon.</p> <p>No ACS ▼ 1109 symbol in Tabular at Q43.8</p> <p>ACS 1109 Redundant Colon states: This finding should not be coded. How do Coders get around ACS 1109 advice not to code redundant colon when documentation supports the condition has caused the symptom (altered bowel habit)?</p> <p>Do we just code the altered bowel habit?</p> <p>What is the relevance of code Q43.8 if coders are unable to use it?</p> | <p>QCC Response: The QCC considers that in this specific episode Q43.8 <i>Other specified congenital malformations of intestine</i> should be assigned.</p> <p>ACS 1109 <i>Redundant colon</i> refers to redundant colon as a finding not as a diagnosis. Consideration should be given on a case by case basis as to whether the standard should be applied to the episode being coded.</p> <p>If there is any doubt as to the relevance of redundant colon (i.e. diagnosis meeting ACS criteria for coding as opposed to <u>incidental</u> finding) clinician clarification should be sought.</p> <p>Convenor's Note: Please be aware that ACS 1109 Redundant colon has been removed from the 7th Edition Australian Coding Standards.</p> |
| 0809-05 | Orbital cellulitis | <p>It has been noted that there is no reference link to ACS 1210 in the Tabular against code H05.0.</p> <p>When clinical documentation is listed as "orbital cellulitis" the index leads to code H05.0 and there is currently no way of Coders being aware of ACS 1210 at that code level.</p> | <p>QCC Response: The QCC will send a tabular update recommendation to the NCCH for the addition of the reference link from H05.0 to ACS 1210 <i>Cellulitis</i>.</p> |
| 0809-06 | Coding of CREST syndrome | <p>Patient is admitted for amputation of fingers due to Raynaud's phenomenon. PD documented by the Clinician</p> | <p>QCC Response: QCC are divided in their opinion regarding this scenario. A</p> |

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| | | <p>is Raynaud's. It is also documented that the patient suffers from CREST syndrome. No other treatment for the syndrome is undertaken. Admission is specifically for the amputation due to Raynaud's.</p> <p>Following the alphabetical index and according to ACS 0005 <i>Syndromes</i> CREST syndrome would be coded as the PD as Raynaud's is listed as a component of the syndrome and a "single code is available to describe all elements of the syndrome."</p> <p>However, in this instance when the patient is admitted specifically for an amputation because of a problem of a known condition as per ACS 0001 (2.) and the known condition is not treated; is it correct to code the CREST as the PD which would in fact, change the DRG (?)</p> <p>It is also noted that in the Guide for Clinicians and Clinical Coders, Immunology, Rheumatology and Infectious Diseases (2003?) published by NCCH which states:</p> <p>"CREST is a multiple manifestation syndrome, therefore selecting a principal diagnosis may sometimes be difficult. Australian Coding Standard 0001 Principal Diagnosis should be followed, eg. if a patient is admitted with symptoms such as oesophageal reflux and telangiectasia, and CREST is identified, as the principal diagnosis assign M34.1 CREST syndrome.</p> <p>However if CREST has been previously diagnosed and the patient is admitted with a manifestation, assign as principal diagnosis the manifestation or the condition, for which the patient is receiving treatment."</p> <p>This would seem to support the second supposition.</p> <p>Could the Committee please advise –</p> <ol style="list-style-type: none"> 1. Is the PD I73.0 Raynaud's with M34.1CREST syndrome coded as an additional diagnosis <p>Or</p> <p>Is the PD just M34.1 CREST syndrome with no mention of Raynaud's?</p> <ol style="list-style-type: none"> 2. Does ACS 0005 only apply to syndromes which do not | <p>query will be sent to the NCCH.</p> <p>ACS 0005 <i>Syndromes</i> point 3 states: <i>If the principal diagnosis definition rule is difficult to apply due to the multiple manifestations of the syndrome, and no one diagnosis is receiving treatment, assign the most severe condition as the principal diagnosis code.</i></p> <p>Interpretation differed amongst Committee members with some considering that because Raynaud's was the condition being treated; it should be the principal diagnosis with an additional diagnosis of CREST syndrome.</p> <p>The point of issue requiring NCCH clarification is that the first statement made in ACS 0005 is <i>If no single code is available to describe all elements of a syndrome, it can be difficult to code all elements separately.</i></p> <p>A single code does exist for CREST syndrome (introduced in the Classification relatively recently) M34.1 <i>CR(E)ST syndrome</i> which has an inclusional term <i>Combination of calcinosis, Raynaud's phenomenon, (o)esophageal dysfunction, sclerodactyly, telangiectasia.</i> Some countries only assign one ICD code (hence would assign M34.1).</p> <p>If Raynaud' s was assigned as the principal diagnosis, it would be necessary when comparing international data, to consider any episodes where a component of CREST has been sequenced as the principal diagnosis with M34.1 <i>CREST</i> coded additionally.</p> <p>A query will be submitted to the NCCH to establish whether the <i>Guidelines for sequencing when coding syndromes</i> component of the standard applies <u>regardless of whether</u> vs. <u>only when</u> there is not an applicable single code indexed i.e. whether if coding any syndrome, the principal component representing the reason for admission in that episode should always be split out and coded as the principal diagnosis (A further query regarding coding of syndrome components will be submitted as a separate query to the QCC).</p> |
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| | | <p>have a single code to identify them or all syndromes? 3. Should ACS 0005 take precedence over ACS 0001 (2) 4. Is the historical guidance given in the abovementioned Guide for Clinicians and Clinical Coders still to be observed by coders?</p> <p>I have contacted various hospitals and there would appear to be divided opinion regarding the coding of this syndrome.</p> | |
| 0809-07 | Insertion of UVC, UAC, CVC, PIV, PIVC in neonates | <p>Insertion of UVC, UAC, CVC, PIV, PIVC in neonates.</p> <p>Should the following procedures be coded for Neonate admissions: - insertion of UVC (umbilical venous catheters)? 13300-02 [738] - insertion of UAC (umbilical arterial catheters)? 13303-00 [694] - insertion of CVC (central venous catheters)? 13319-00 [738] - insertion of PIV/PIVC (peripheral intravenous line/catheter)? 13300-00 [738]</p> <p>There is confusion as to whether these procedures should be coded or not.</p> <p>One opinion is that the above procedures should NOT be coded unless the Neonate is admitted specifically for the procedure to be attended or if the procedure is performed under an anaesthetic (except LA) during an admission. One of the standards referenced is ACS 0042.</p> <p>ACS 0042 Procedures not normally coded states: "These procedures are normally not coded because they are usually routine in nature, performed for most patients and/or can occur multiple times during an episode. Most importantly, the resources used to perform these procedures are often reflected in the diagnosis or in an associated procedure. That is, for a particular diagnosis or procedure there is a standard treatment which is unnecessary to code"</p> | <p>QCC Response: The coding service should make a decision to code or not to code these procedures for consistency and await further advice/guidelines regarding procedures not normally coded in 7th edition.</p> |
| 0809-08 | Excisional Biopsy | <p>Should 'Excisional Biopsy' be coded to excision of lesion or biopsy?</p> | <p>QCC Response: A query will be sent to the NCCH regarding the terminology "excisional biopsy" and whether 'excision' should be coded</p> |

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| | | <p>I have some old advice that states “a procedure documented as ‘excision biopsy’ should be assigned a code for ‘excision’, rather than ‘biopsy’, as the tumour has been excised with a view to histological diagnosis”.</p> <p>I note that excisional biopsy of the breast is indexed to 31500-00 [1744] Excision of lesion of breast.</p> | <p>in all instances or whether a case-by-case judgement should be made whether the intent is to remove the bulk of the lesion (and also obtain pathological diagnosis) vs. sample the lesion by an excisional technique in order to gain a pathological diagnosis with the option of removing the lesion completely at a later date.</p> <p>In the interim, clinical consultation should be sought to ascertain the intent of the procedure.</p> |
| 0809-09 | Barrett's oesophagus surveillance | <p>In admissions for Barrett's oesophagus surveillance, where the patient had gastroscopy with biopsy in past, do you assign a code Z09.0 Follow up after surgery or other Z code (pharmacotherapy or other)?</p> <p>Do you classify biopsy as a surgery for Barrett's oesophagus?</p> | <p>QCC Response: For this instance, the QCC recommends the use of Z09.9 - <i>Follow-up examination after unspecified treatment for other conditions</i>.</p> <p>If the patient treatment is known, code to the specific Z08-Z09 code.</p> <p>The QCC will send a query to the NCCH asking if the patient has had a biopsy and Barrett's is diagnosed and they come in 6 months later for another biopsy and no treatment has been given is it appropriate to utilise the codes from Z09.*? In other words, does a diagnostic biopsy constitute treatment?</p> <p>The QCC will also clarify with the NCCH if biopsy is considered to be surgery and if Z09.0 includes biopsy and if a patient has more than one treatment do we code to the higher 4th digit or do we code both?</p> |
| 0809-10 | Procedure code for insertion of gastric bubble (Balloon) | <p>Query regarding: Morbid Obesity. Insertion of a para-gastric implant (balloon) via laparoscopy. General Anaesthetic.</p> <p>Query A new procedure has been introduced where a balloon is inserted para-gastrically via laparoscope, is filled with saline and then applies pressure on the stomach to reduce oral intake. This procedure is not as invasive as gastric banding. We have coded 90500-00 insertion of gastric bubble (balloon) and laparoscopy which gives a DRG of 902Z (Non extensive or procedure not related to PD) in v4.2</p> <p>If we leave the laparoscopy code off it groups to K62C</p> | <p>QCC Response: QCC Members agreed with the codes suggested by the enquirer.</p> <p>The QCC will review the DRG logic. If there has been no other mention of this particular DRG issue; the SSU will raise a query with DoHA.</p> <p>QCC to forward a public submission to the NCCH for creation of a new code for laparoscopic balloon insertion.</p> |

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| | | (Miscellaneous metabolic disorders.) Whilst not being sure that 90500-00 is the correct code, we could find no other that matched the description of the procedure. | |
| 0809-11 | Wound of lip requiring suture | <p>Wound of lip requiring suture. Wound sutured. Following the pathway, the procedure code we have been using is 30052-02 [406].</p> <p>Using the pathway:</p> <p>Suture - lip 30052-02 [406]</p> <p>or</p> <p>Suture - skin - - lip (full thickness) 30052-02 [406]</p> <p>When you look up this code, in the exclusion notes it excludes superficial (30032-00 [1635]). However there is no pathway in the index to get to 30032-00. Is this an error in the index? Should we use 30052-02 [406] for all sutures of lip and ignore exclusion note?</p> | <p>QCC Response: The QCC recommends the following code allocation: Lip alone - 30052-00 regardless of whether soft tissue or superficial Lip with mouth - 30032-00 if superficial Lip with mouth - 30035-00 if involving soft tissue</p> <p><u>Index</u> Suture - lip 30052-02 [406] ... - mouth, superficial wound 30032-00 [1635] - - soft tissue 30035-00 [1635] ... - skin, subcutaneous tissue - - lip (full thickness) 30052-02 [406]</p> <p>Repair - lip - - wound (full thickness) (laceration) 30052-02 [406] ... - skin (subcutaneous tissue) NEC 90675-00 [1655] - - wound - - - lip (full thickness) 30052-02 [406] - - - mouth, superficial wound 30032-00 [1635] - - - - soft tissue 30035-00 [1635] ... - soft tissue — <i>see also Repair, wound, by site</i> ... - wound — <i>see also Repair, laceration</i> ... - - lip (full thickness) 30052-02 [406] - - mouth, superficial wound 30032-00 [1635] - - - soft tissue 30035-00 [1635]</p> <p>(Note repair laceration lip gives same codes).</p> <p>Tabular</p> |

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| | | | <p>30052-02 Repair of wound of lip Excludes: that with mouth: • involving soft tissue (30035-00 [1635]) • superficial (30032-00 [1635]) i.e • involving soft tissue (30035-00 [1635]) • superficial (30032-00 [1635]) are only if <u>with mouth</u>.</p> <p>Note that 30035-00 <i>Repair of wound of skin and subcutaneous tissue of face or neck, involving soft tissue</i> excludes • lip (30052-02 [406])</p> |
| 0909-01 | Induction of labour for IUFD at term | <p>Induction of labour for IUFD @ term</p> <p>ACS 1518 DURATION OF PREGNANCY advises:</p> <p>A code from O09 should be assigned as an additional diagnosis in all cases of:</p> <p>Abortion (O00-O07 Pregnancy with abortive outcome) Threatened abortion (O20.0) Fetal death in utero (O36.4) Premature rupture of membranes (O42) (before 37 completed weeks of gestation) Threatened premature labour (O47.0 False labour before 37 completed weeks of gestation) Early onset of labour (O60 Preterm labour)</p> <p>Can a (before 37 completed weeks of gestation) be added at Fetal death in utero (O36.4)?</p> | <p>QCC Response: QCC members noted that there is currently a fatal validation edit raised when a code for O36.4 is coded without O09.-.</p> <p>The intent of this validation edit is to provide a safety net to correct episodes with fetal death in utero (particularly before 37 completed weeks of gestation) that have been coded without O09.- codes.</p> <p>The edit is currently applied to all episodes with O36.4 regardless of gestation as ACS 1518 currently has no qualifying duration, but rather states an O09.- code is required with O36.4</p> <p>Available O09.- codes are: O09.0 < 5 completed weeks O09.1 5–13 completed weeks O09.2 14–19 completed weeks O09.3 20–25 completed weeks O09.4 26–33 completed weeks O09.5 34–36 completed weeks O09.9 Unspecified duration of pregnancy</p> <p>There is no code provision for duration of pregnancy greater than 36 completed weeks and ACS 1518 <i>Duration of pregnancy</i> specifically states O09.9 <i>Unspecified duration of pregnancy</i> should be used only when the case meets the criteria set out and the duration of pregnancy has not been recorded.</p> |

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| | | | <p>ACS 1518 states that <i>The duration of pregnancy</i> codes were developed by the Obstetrics and Gynaecology CCGG specifically to identify the duration of pregnancy for a specific group of high-risk pregnancies (identified above) and only these conditions should be assigned code O09.-.</p> <p>The QCC will seek NCCH clarification as to whether they consider there is value in capturing the duration of pregnancy when fetal death in utero occurs after 36 completed weeks.</p> <p>The QCC will also raise a query regarding the discrepancy between the ACS 1518 requirement to code O09.- for Premature rupture of membranes (O42) (before <u>37 completed weeks</u> of gestation), Threatened premature labour (O47.0 False labour before <u>37 completed weeks of gestation</u>), Early onset of labour (O60 <u>Preterm labour</u>) and ACS 1518 which only provides codes to <u>36 completed weeks</u>.</p> <p>ACS 1530 <i>Premature Delivery</i> requires O60.- to be assigned when coding 'premature delivery' or delivery (spontaneous, induced or caesarean) with onset before <u>37 completed weeks</u> gestation.</p> <p>This would appear to be a significant discrepancy.</p> <p>There appears to be no directive as to how to code conditions requiring assignment O09.- (in accordance with ACS 1518) when the duration is greater than 36 completed weeks.</p> <p>It has also been observed that there is no reference link from O36.4 to ACS 1518 in the tabular. The QCC will recommend that this be amended.</p> <p>A public submission will be made to NCCH to address these issues. Edits will be reviewed once this process has been finalised.</p> |
| 0909-02 | Injury to Chest. | Injury to Chest. Chest Injury. Soft tissue injury of chest. | <p>QCC Response: The QCC will recommend that an index suggestion be made to the NCCH for: Injury</p> |

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| | | <p>ACS 1331 Soft Tissue Injuries advises that where the nature of the soft tissue injury cannot be obtained, code to 'Injury, site' and not open wound.</p> <p>Current index look up for chest injury by site leads to: Injury -chest, flail S22.5 Therefore coders are going to: Injury -thorax and on occasions to: Injury -trunk</p> <p>Is it possible to have an index entry added for injury by site for chest?</p> | <p>-chest (see thorax) --flail S22.5</p> |
| 0909-03 | Water Transport Accidents | <p>Diagnosis: Dislocation of Shoulder following fall from boat while white water rafting down river Procedure: Reduction of Shoulder Dislocation under sedation</p> <p>CM Vol 16 No 1 advises to code fall from water ski to a fall from pedestrian conveyance although water skis are also listed in the Tabular List as water crafts in Water Transport Accidents (V90-V94). This advice was based on the fact that the injury was considered to be 'other than drowning/submerging injury'.</p> <p>How then should coders code a fall overboard from watercraft, without accident to water craft, with injury, other than drowning/submerging injury?</p> <p>Index: Fall, falling (accidental) – from, off --boat, ship, watercraft (with drowning or submersion) NEC V92.- nonessential modifier or Accident (to) -watercraft NEC V94.- Other and unspecified water transport accidents</p> <p>V92 Water-transport-related drowning and submersion</p> | <p>QCC Response: The QCC recommends utilising V92.9 - <i>Water-transport-related drowning and submersion without accident to watercraft, unspecified watercraft</i> as this code is more specific than the V94 code suggested by the enquirer.</p> <p>The QCC noted that "with drowning or submersion" is a non-essential modifier in the index.</p> |

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| | | <p>without accident to watercraft Includes: drowning and submersion as a result of an accident, such as:</p> <ul style="list-style-type: none"> • fall: • overboard <p>Should coders code external cause code for the above scenario to V94.6 Other and unspecified water transport accidents - .6 inflatable craft and if so; can a further includes note be added at code V94 to include: injuries other than drowning and submersion as a result of an accident, such as:</p> <ul style="list-style-type: none"> • fall: • overboard <p>and can the (with drowning or submersion) nonessential modifier be removed from the index at Fall, falling (accidental) –from, off - - boat, ship, watercraft (with drowning or submersion) NEC V92.-</p> | |
| 0909-04 | Admission for insertion of IP Port | <p>Admission for insertion of IP Port</p> <p>What is the correct diagnosis code for a same day admission for insertion of IP Port?</p> <p>Coding Matters Vol 15 No 2 provides guidance on using the procedure code of 90331-00 [1004] Other procedures on abdomen, peritoneum or omentum.</p> <p>Would Z45.1 Adjustment and management of drug delivery or implanted device be correct?</p> | <p>QCC Response: The QCC agree that Z45.1- <i>Adjustment and management of drug delivery or implanted device</i> is the most appropriate code for Admission for insertion of IP Port.</p> <p>This code is located by following the index entry: Admission for -fitting of --drug delivery device</p> |
| 0909-05 | Impulsive, disinhibited and inappropriate behaviour due to ABI | <p>Impulsive, disinhibited and inappropriate behaviour due to ABI</p> <p>What would be the correct codes for patient with an Acquired Brain Injury as a result of a MVA that occurred 10yrs ago?</p> <p>Patient presents with impulsive, disinhibited and inappropriate behaviour due to history of ABI.</p> | <p>QCC Response: AIHW documentation (Disability in Australia: acquired brain injury; Bulletin 55, December 2007) indicates that the coding for ABI uses only "acute" brain injury codes (see p24 of the document).</p> <p>The QCC will send a query to the NCCH regarding the correct coding for ABI.</p> <p>An option that will be suggested / discussed is that with ABI, regardless of the "primary" code, that T90.5 - Sequelae of intracranial injury or T90.2 Sequelae of fracture of skull and facial bones is added in all cases to identify the ABI.</p> <p>The QCC will also recommend the potential to use F06.9 Unspecified mental disorder due to brain damage and</p> |

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| 0909-06 | Elective classical C/S | <p>There seems to be an anomaly with the ICD-10-AM index and the 3M Codefinder choices. 3M Codefinder does not exactly replicate the index.</p> <p>We recently discovered we had been performing an unusual amount of elective classical C/S. On chart review we found it to be a coding anomaly.</p> <p>Coders were selecting Elective for elective LSCS without realising they were going down the path of classical.</p> <p>If you look in the eBook index grey section to the left it does not offer Elective (classical) as an option which makes sense.</p> <p>ICD-10-AM Books – Index Caesarean section</p> <ul style="list-style-type: none"> - classical (elective) 16520-00 [1340] - - emergency 16520-01 [1340] - elective (classical) 16520-00 [1340] - - lower segment 16520-02 [1340] - emergency - - classical 16520-01 [1340] - - lower segment 16520-03 [1340] - lower segment - - elective 16520-02 [1340] - - emergency 16520-03 [1340] <p>3M Codefinder</p> <ol style="list-style-type: none"> 1. Classical (elective) 2. Classical emergency 3. Elective (classical) 4. Lower Segment elective 5. Lower Segment emergency <p>Query: Can we either modify the 3M listing or request that NCCH re-order the book index to look something like:</p> <p>Classical</p> | <p>dysfunction and to physical disease.</p> <p>QCC Response: In response to this query, the SSU carried out frequency analysis and identified that there has been an increase in the coding of elective classic caesarean section. The level of increase is not supported by informal literature searches.</p> <p>The QCC feels that the Codefinder pathway is aligned with the index.</p> <p>It is important that coders ensure when coding LSCS that a Lower Segment option is chosen regardless of the pathway followed.</p> |
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| | | <ul style="list-style-type: none"> - elective - emergency <p>Lower Segment</p> <ul style="list-style-type: none"> - elective - emergency <p>or perhaps this; Elective</p> <ul style="list-style-type: none"> - classical - lower segment <p>Emergency</p> <ul style="list-style-type: none"> - classical - lower segment | |
| 0909-07 | Procedures repeated multiple times in an admission, but performed without anaesthetic | <p>Diagnosis/Procedure: Multiple coding of ascites drainage, intercostal catheters, pleural taps, insertion of peripheral lines in neonates, PICC, central venous and arterial lines.</p> <p>Can the QCC please advise on the coding of procedures repeated multiple times in an admission, but performed without anaesthetic?</p> <p>Procedures such as abdominal taps, pleural taps, insertion of intercostal catheters (not performed in association with respiratory or thoracic procedures, usually to treat traumatic haemopneumothorax or spontaneous pneumothorax), peripheral line insertions for neonates (not routine line changes).</p> <p>In Edition 5 there was an instruction in 0020 Multiple/bilateral procedures: (c Procedures performed without anaesthesia should be coded once only (unless listed in ACS 0042 Procedures normally not coded as a procedure not to code, or unless directed otherwise in another specialty standard).</p> <p>As abdominal taps & ICC insertions were not listed in ACS 0042 Procedures normally not coded, we assigned 1 code per admission if there was no anaesthesia administered other than local anaesthesia. In 6th edition this instruction has disappeared.</p> <p>Should these procedures be coded as many times as they</p> | <p>QCC Response: The QCC acknowledge that the standard has changed and no longer includes the directive about coding procedures without anaesthetic.</p> <p>In Sept. 10-AM Commandments the following advice was given: Where the NCCH has not published advice to exempt the coding of specific procedures/interventions multiple times, or they are not listed in ACS 0042 or ACS 0020, they should be coded as many times as they are performed.</p> <p>For example, thoracentesis, paracentesis or lumbar punctures should be coded each time they are performed during an episode of care.</p> <p>The QCC considers that (following this logic) the insertion of suprapubic catheters should be coded as many times as performed.</p> <p><i>This advice does not apply to arterial, PICC, CVCs, MRIs or nuclear medicine scans. Please apply the below advice from Coding Matters, Volume 16, number 2.</i></p> <p>Where arterial, PICC or CVC lines, MRIs or nuclear medicine scans are inserted/performed as stand alone procedures under an anaesthetic (except local), assign a code as many times as performed, as per the principles in ACS 0042 <i>Procedures normally not coded.</i></p> |

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| | | <p>are performed? If so, what is the distinction between NCCH advising not to code PICC, CVL & arterial lines at all unless with anaesthetic AND coding abdominal taps, pleural taps ICCs as many times as they are performed even without anaesthesia as could be interpreted by reading 6th Ed ACS 0020?</p> <p>Should we be referring to ACS 0042 Procedures not normally coded? If so, is there a reason why suprapubic catheters are specifically mentioned in this list to always be coded regardless of whether anaesthesia is administered? What is the significance of a suprapubic catheter? If it is no more "special" than the other procedures in this query, can we suggest to NCCH that it needs to be reviewed?</p> <p>Perhaps if we understood the NCCH logic behind that instruction we could apply it to coding pleural, abdominal taps and ICCs.</p> | <p>Where multiple arterial, PICC or CVC lines, MRIs and nuclear medicine scans are performed as stand alone procedures, but not performed under anaesthetic, or are performed under a local anaesthetic only, assign a code for the procedure once only.</p> <p>Convenor's Note: Please be aware that there have been changes to ACS0042 <i>Procedures not normally coded</i> for 7th Edition and the above advice would not apply for separations from 1 July 2010.</p> |
| 1009-01 | Type 2 DM due to Haemochromatosis | <p>Look up under Diabetes, haemochromatosis takes to E83.1 Disorder of iron metabolism. Is this correct? Seems to be inconsistent to</p> <p>ACS 0401 Diabetes Mellitus and Impaired Glucose Regulation</p> <p>Other specific forms of diabetes (including diabetes secondary to other disorders) These include:</p> <ul style="list-style-type: none"> • genetic defects of beta-cell function • genetic defects of insulin action • pancreatic exocrine diseases • infections • endocrinopathies • drug-induced or chemical-induced diabetes • immune-mediated diseases • other genetic syndromes sometimes associated with diabetes. <p>CLASSIFICATION When another specific form of diabetes is documented, code to E13. Other specified diabetes mellitus followed by the appropriate code for the underlying disorder or associated genetic syndrome.</p> | <p>QCC Response: The QCC agree that E83.1 should be allocated and diabetes should be coded additionally if it meets ACS0002.</p> <p>If there are no diabetic complications and the diabetes is caused by the haemochromatosis, E13.9 should be allocated.</p> <p>If there are diabetic complications then E13.X should be allocated according to the diabetic complications present.</p> <p>In rare circumstances it may be known that the diabetes pre-dates haemochromatosis in which case the Type I/II diabetes (E10/E11) should be coded rather than Other Specified E13.</p> |

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| 1009-02 | MRSA colonisation/carrier | <p>At a recent conference there was a presentation given on Infections and Resistant Microorganisms indicating coding of MRSA colonisation/carrier to Z22.3 + B95.6 +Z06.32.</p> <p>Does the NCCH support this and if so, can it be published in Coding Matters for future reference and consistency?</p> <p>The only standard I can find on coding carrier status is the standard on coding strep B carrier in Pregnancy and the B code was only assigned if the patient had an infection.</p> <p>ACS 1549 Streptococcal Group B Infection/Carrier in Pregnancy</p> <p>Classification The following coding rules apply for obstetric patients with Strep B:</p> <p>If no prophylactic treatment is given, assign: Z22.3 Carrier of other specified bacterial diseases</p> <p>If prophylactic treatment (eg penicillin) is given, assign: Z22.3 Carrier of other specified bacterial diseases and Z29.2 Other prophylactic pharmacotherapy</p> <p>If there is documentation of a genitourinary tract infection due to Strep B, assign: O23.9 Other and unspecified genitourinary tract infection in pregnancy and B95.1 Streptococcus, group B, as the cause of diseases classified to other chapters.</p> | <p>QCC Response: Where colonisation/carrier status is deemed to meet ACS0002, it is appropriate to assign Z22.3 Carrier of other specified bacterial diseases.</p> <p>Z29.0 Isolation can be added as an additional diagnosis when the patient is isolated due to their carrier status. It should be noted that isolation is a different concept to sterile precautions.</p> <p>B95.6 is not assigned as the patient does not have current infection.</p> <p>The QCC will further investigate the use of B95.6 for colonisation with the NCCH.</p> |
| 1009-03 | Multiple skin punch biopsies | <p>Please confirm whether multiple skin biopsies performed during the same visit to theatre should be assigned code 30071-00 Biopsy of skin and subcutaneous tissue once or multiple times as performed. Please note that these skin lesion sites do not include eyelid or external ear where there are specific codes. Please advise for both:</p> <ul style="list-style-type: none"> multiple punch biopsies performed on separate skin lesions (eg. Punch biopsy of skin lesion of face and punch biopsy of skin lesion of back) AND | <p>QCC Response: The QCC will submit this as a query to the NCCH.</p> <p>The QCC will ask the NCCH whether the same multiple procedure rule applies for excision of skin lesion as for skin biopsy according to ACS 0020 Bilateral/Multiple Procedures?</p> <p>QCC Interim Response :</p> |

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| | | <ul style="list-style-type: none"> multiple punch biopsies of the same lesion at one site (eg. Multiple punch biopsies of single nose lesion) <p>We note the following extract from ACS 0020 Bilateral/Multiple Procedures ACHI generally refers to organs, diseases and sites using the singular tense. This is done for consistency and ease of updating. For example, the code title intranasal removal of polyp from maxillary antrum includes where one, or more than one, polyp is removed. Thus polyp can be interpreted as polyp or polyps. Other examples include wart(s), skin tag(s), biopsy/biopsies, lesion(s).</p> | The QCC Interim coding advice is to continue current practice until NCCH advice has been received. |
| 1009-04 | S/C Ceph + Dex | Is the S/C Ceph + Dex a component of a Vitrectomy or does it require coding out separately, ie: 42824-01 Subconjunctival administration of agent? | <p>QCC Response: The QCC agree that the S/C Ceph & Dex is an inherent part of the procedure and as such, should not be coded out separately.</p> <p>This is in accordance with ACS 0016 General procedure guidelines (procedure components).</p> |
| 1009-05 | Hypotensive episode whilst on antihypertensive medication | <p>Diagnosis/Procedure as stated in medical record: An admitted patient is on antihypertensive medication for hypertension. During the episode of care has a major Hypotensive episode and the Antihypertensive drugs are altered/ceased; increased monitoring and IV fluids.</p> <p>Query: We should obviously code the Hypotension - as this is treated. We also code the Hypertension as the medication has been ceased - but it always looks funny on the screen.</p> <p>Is it correct that we code Hypertension, please?</p> | <p>QCC Response: The QCC recommends assigning codes for both hypertension and hypotension.</p> <p>Hypertension should be coded because it fulfils ACS0002 (Adjustment of therapeutic treatment).</p> <p>If the hypotension was documented as due to a drug then drug induced hypotension would be coded.</p> |
| 1009-06 | Swine flu affecting pregnancy | <p>Diagnosis/procedure as stated in medical record: Pregnant female admitted with Swine Flu. Treated with Tamiflu and admitted to ICU. Transferred to a Tertiary Hospital.</p> <p>Query: Using the index, I looked up influenza, maternal affecting foetus or newborn. It took me to P00.2 which says "Fetus & Newborn affected by maternal infectious and parasitic diseases" which corresponded to the description of O98.8. But when I look at O99.5, J09 is contained under that, so I</p> | <p>QCC Response: The QCC refers the enquirer to ACS 1521 <i>Conditions complicating pregnancy</i>.</p> <p>Firstly, it is important to ascertain whether the condition (swine flu) is complicating or complicated by the pregnancy. If it is complicating the pregnancy please refer to Example 4 in the standard ACS 1521 which states to locate the code for the disease/condition from the other chapters (J09) and then consult the index under Pregnancy, complicated by, conditions in J00-J99.</p> |

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| | | would think that O99.5 is probably more correct. Should it be an infectious or respiratory code? O99 excludes infectious diseases. | Therefore, the QCC recommends that the correct code in this situation is O99.5. <i>Diseases of the respiratory system complicating pregnancy, childbirth and the puerperium</i> The J code assigned as an additional code will depend on whether the H1N1 (Swine flu) has been confirmed by laboratory testing. |
| 1009-07 | GH stimulation test | Diagnosis/ Procedure as stated in medical record: Patient being investigated for short stature – admitted for GH stimulation test – test involves Administration of Glucagon, IM and L-Arginine, IV and multiple blood tests. Query: I have coded the GH stimulation test to 9220400 [1866] Noninvasive diagnostic tests, measures or investigations, not elsewhere classified – is this the correct code for this procedure? | QCC Response: The QCC recommends that if the episode meets the admission criteria as per the current admission policy then the code 13839-00 <i>Collection of blood for diagnostic purposes</i> should be used to reflect the GH stimulation test. |
| 1109-01 | Anti D given to Rh -ve Obstetric/Gynae patients | Diagnosis/ Procedure: Obstetric/Gynae patients who are Rh -ve and given Anti D during the admission Query: Is it still appropriate to code the administration of Anti D to Z29.1 and 92173-00 for Obstetric/Gynae patients who are Rh -ve and given Anti D during the admission? Anti D Background information NCCH Query No 845 Obstetric patients who are Rh -ve. When is it appropriate to code Rh -ve in obstetric patients: ie. When Anti-D is given during the admission; and/or when an obstetric patient is admitted? Decision: If an obstetric patient requires injection of Anti - D during her admission for Rh -ve, assign the following codes 'Z29.1 Prophylactic immunotherapy' and '92173-00 [1884] Passive immunisation with Rh (D) immunoglobulin'. 22/02/1999 1st Edition. Anti D is a blood product and would now be included in ACS 0302 Blood transfusions. The administration of blood and blood products should be coded whenever performed. | QCC Response: In Queensland we have discovered that there is differing practice pertaining to the coding of Anti D. This query will be sent to the NCCH for clarification. QCC Interim Response: If your Hospital/Health Service District are currently coding administration of Anti-D, you should be coding it as follows as it is specifically indexed: Z29.1 <i>Prophylactic immunotherapy</i> and 92173-00 <i>Passive immunisation with Rh(D) immunoglobulin</i> . The QCC will confirm with the NCCH if Anti D should be coded. |

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| 1109-02 | Rigors without fever | <p>Diagnosis/ Procedure: Rigors – No fever/ no cause found Rx IV antibiotics: Pathology tests: Scans.</p> <p>Query: Following the index Rigors without fever takes us to R68.8. Validation error report # H613 states: ICD code ODR68.8 is not an acceptable diagnosis code. Please specify actual morbidity OD.</p> <p>Which ICD Disease Code should we use for “Rigors, no fever” that is treated and monitored and there is no cause found to clarify further?</p> | <p>QCC Response: It is essential that the documentation is checked and clinical clarification is sought prior to allocation of this symptom code.</p> <p>If this has been done and this is all the information available, then the QCC recommend coding R68.8 for this particular scenario.</p> <p>This code is not to be used as a ‘dummy code’ (or R69 <i>Unknown and unspecified causes of morbidity</i>) where a chart cannot be found or where no information is available at the first point of coding.</p> <p>This edit was created to encourage accurate coding through follow up prior to coding where possible.</p> <p>While a patient may be admitted with certain symptoms and signs, we should generally be coding the diagnosis made after study.</p> <p>A suggestion has been made that there be a section in QHAPDC explaining that for fatal edits, codes are to be carefully checked and any Clinical clarification undertaken that is required; however, if the coding is confirmed to be correct, the codes should <i>not</i> be changed.</p> |
| 1109-03 | Mesothelioma cases | <p>We have quite a number of mesothelioma cases come through.</p> <p>I’m getting rather frustrated at the number of times I have error ICD-H562 come back on my HDP error report. This error states: “ICD code ___/6 must be preceded by a code in the range C77-C7999, C80”. I am aware that the smaller C codes refer to primary tumours, however this is not specified either in the code itself or in the pathway to the code. For example, if you follow the pathway for a patient presenting with a metastatic epithelioid mesothelioma of the pleura, secondary to a primary meso. of the lung that was previously removed (screen-dump):</p> <p>Enter Key Word: -- MESOT - MESOT -- Mesothelioma (malignant) - - Mesothelioma (malignant) -- Epithelioid</p> | <p>QCC Response: QCC believe that the Codefinder is reflective of the ICD-10-AM 6th ed Alphabetical Index wherein there is no index entry under Mesothelioma for secondary sites.</p> <p>By following the pathway on 3M Codefinder selecting the primary site first and then the secondary site, the correct secondary site code is assigned: C45.7 Mesothelioma of other sites M8052/3 Epithelioid mesothelioma, malignant C78.2 Secondary malignant neoplasm of pleura M8052/6 Epithelioid mesothelioma, malignant, metastatic. Alternatively, coders should refer to the Neoplasm Table in the Alphabetical Index to assign a code for the secondary site.</p> <p>Codefinder are working on resolving the issue regarding</p> |

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| | | <p>- - - Epithelioid mesothelioma (malignant) -- Other/unspecified - - - - Behaviour of malignancy -- Secondary - - - - - Mesothelioma (malignant) site -- Pleura - - - - - - Mesothelioma (malignant) of pleura -- Other/unspecified - - - - - - - Wish to code additional secondary site? -- No - - - - - - - - Wish to code primary site? -- Yes - - - - - - - - - Primary malignancy -- Lung - - - - - - - - - - Site of neoplasm - lung or bronchus -- Other/unspecified</p> <p>You have returned the following codes: C450 – mesothelioma of pleura, M90526 – epithelioid mesothelioma, malignant, metastatic; and C349 + M90523 for the primary of the lung.</p> <p>Now the Coding Matters link at the returned codes only takes you to the sequencing of neoplasms standard, while the tabular reference for this section states: “Neoplasms (C00-D48); Malignant neoplasms (C00-C75) Malignant neoplasms, stated or presumed to be primary, of specified sites..... (C00-C75) Malignant neoplasms of mesothelial and soft tissue (C45-C49)”.</p> <p>Depending on how this is read, you could assume higher or lower specificity for each of those lines – confusing, particularly when (a) the pathway takes you to this code, (b) there is no error message in either Codefinder or IBA (and I would assume similar systems); and (c) the coding matters link does not lead to anything specifying this.</p> <p>As you can understand, I would like to not only reduce the workload for those producing and re-entering the reports, and for me also not having to fix these errors every time; but I would also think that there could be a more specific (and therefore clinically relevant, esp. in those states not collecting morphology) code for secondary neoplasms of a type that matches the available primary codes. In this case, a secondary code such as “C7821 – secondary</p> | <p>assignment of a non metastatic diagnosis code on the secondary behaviour of malignancy pathway in the query.</p> <p>The logic of the validation is correct.</p> |
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| | | <p>malignant mesothelioma of pleura”.</p> <p>Please let me know your thoughts on this, and if you have any advice as to where would be the best place to submit this issue</p> | |
| 1109-04 | Bronchopneumonia suspected swine flu | <p>Diagnosis/ Procedure as stated in medical record: Dx – Bronchopneumonia</p> <p>Details in record – Presented with fevers and non productive cough, chill, nausea, myalgia. Impression was H1N1 flu – managed with antibiotics to cover overlying pneumonia and Tamiflu. On day 3 Tamiflu ceased as all negative for H1N1.</p> <p>Discharged with the above diagnosis of Bronchopneumonia but also stated in summary treated with Tamiflu in case of a false negative result. Clear statement from Clinician that this pt did not have influenza.</p> <p>Query: Have we coded this case correctly as: J18.0 Bronchopneumonia J11.1 Suspected Swine Flu Z29.0 [DRG E62B}</p> <p>Our reasoning being that diagnosis after study was Bronchopneumonia, also treated for suspected swine flu so we followed the NCCH advice that was sent out.</p> <p>We are concerned that coders can link the pneumonia with the influenza because it was associated and come up with DRG [E62C] using J11.0 in which case we would be over-coding.</p> | <p>QCC Response: In this scenario, it is the QCC’s opinion that the principal diagnosis after study is J18.0 Bronchopneumonia.</p> <p>In this particular case, as the pathology for the patient was negative to H1N1; H1N1 should not be coded.</p> <p>For this particular case Z29.0 <i>Isolation</i> should not be coded as the patient was not isolated.</p> |
| 1109-05 | Further clarification of 0709-03 | <p>Query 0709-03: Patient was admitted for induction of labour due to maternal age (multigravida). Medical induction performed.</p> <p>No other conditions.</p> <p>Original query 15/6/9 Bearing in mind the ruling on obstetric PDx (that being the reason for admission) – in this case there is no other condition and the patient was specifically admitted for</p> | <p>QCC Response: In Query 0709-03 the QCC recommended that an appropriate Z code can be a PD where it fulfils the requirements for coding under ACS 0001 Principal Diagnosis.</p> <p>This response does not mean that every O80 should be replaced with a Z code.</p> <p>Convenor’s Note:</p> |

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| | | <p>induction of labour due to being a multigravida with advanced maternal age.</p> <p>I see no problem with having Z35.52 as a principal diagnosis as in the index the word (supervision of) is a nonessential modifier. There seems to be reluctance for coders to use a “Z” code as an obstetric PDx and I am finding that it is often coded as O80 plus Z35.52 – as an additional code, this then places the case into DRG O60C. If coded with Z35.52 as principal it goes to DRG O60B.</p> <p>There is the ruling on social admissions where O80 can be used along with the induction code to show that there were no other reasons for induction but in this type of case the maternal age was the reason for admission.</p> <p>Could QCC please provide clarification on the use of Z35.x and if using it as a PDx is acceptable? I have not been able to find any information but would be grateful for your advice.</p> <p>The QCC decision for original query 0709-03 is as follows: QCC Response: The QCC advises that Z35.52 Supervision of multigravida with advanced maternal age should be coded as the principal diagnosis in the situation given.</p> <p>New Query: Now querying re. 0709-03 - the answer was yes to the case in question. However, the Z35 codes are often used to accompany a PDx of O80. Can we take it from this advice that whenever there is a Z35 code it can replace the O80?</p> <p>See example in the string below as there is a significant change up from a C to a B.DRG</p> <p>O80, Z37.0, Z35.52 groups to O60C Z35.52, Z37.0 groups to O60B</p> | <p>For 7th Edition there have been significant changes to the way that the Principal diagnosis is allocated in a delivery episode.</p> |
| 1109-06 | Prophylactic BSO | <p>Diagnosis/ Procedure as stated in medical record: Prophylactic BSO</p> <p>Related to queries:</p> | <p>QCC Response: The QCC recommend using the same logic as in ACS 1204 <i>Plastic surgery</i> Prophylactic mastectomy to code the following:</p> |

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| | | <p>0609-01/0708-03, 0209-04</p> <p>Query (in detail) Scenario 1. Pt seen in high risk Gynae-Onc clinic for Ovarian cancer surveillance after being found to have the BRCA2 gene fault on predictive gene testing and is subsequently admitted for prophylactic Laparoscopic BSO.</p> <p>Principal Diagnosis on Discharge Summary is "BRCA2". Patient has past history of bilateral Breast Carcinoma, L mastectomy 28 years ago.</p> <p>We note the QCC response to query 0609-01 (which advises to code the neoplasm as the PD in a patient with Breast Ca undergoing prophylactic bilateral oophorectomy, citing ACS 1204) and thereby assign;</p> <p>C50.9 M8000/3 Z40.01 35638-12 [1252] This groups to J11Z Other Skin, Subcutaneous tissue and Breast procedures</p> <p>Alternatively, sequenced as ; Z40.01 C50.9 M8000/3 35638-12 [1252] This groups to N05B Oophorectomies & Complex Fallopian Tube Procs</p> <p>Scenario 2. Patient has strong family history Ovarian Carcinoma and therefore presents for prophylactic surgery</p> <p>If we apply the logic in the response to QCC query 0609-01 and ACS 1204 Plastic Surgery – Prophylactic Mastectomy - and assign the family history as Principal Diagnosis and code;</p> <p>Z80.3</p> | <p>Scenario 1 C50.9 M8000/3 Z40.01 35638-12 [1252]</p> <p>Scenario 2 Z80.4 Z40.01 35638-12 [1252]</p> <p>The QCC will confirm this advice with the NCCH and ask if the logic in ACS 1204 Plastic surgery can be applied to this scenario.</p> |
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| | | <p>Z80.4 Z40.01 35638-12 [1252] This groups to Z01B O.R Procedures w Diagnoses Other Contacts W Health Services</p> <p>Alternatively, sequenced as Z40.01 Z80.3 Z80.4 35638-12 [1252] This groups to N05B Oophorectomies & Complex Fallopian Tube Procs</p> <p>1. Could the QCC please confirm the correct Principal Diagnosis in these scenarios?</p> <p>2. We would like to know if the logic in ACS 1204 Plastic Surgery – Prophylactic mastectomy – is applicable outside of this scenario.</p> <p>[Info: A breast cancer (BRCA) gene test is a blood test to check for specific changes (mutations) in genes that help control normal cell growth. Finding changes in these genes, called BRCA1 and BRCA2, can assist in determining a patients’ chance of developing breast cancer and ovarian cancer. This test is only done for people with a strong family history of breast cancer or ovarian cancer, and sometimes for those who already have one of these diseases. A woman’s risk of breast or ovarian cancer is higher if she has BRCA1 or BRCA2 gene changes]</p> | |
| 1109-08 | Amputee with new prosthesis | <p>Diagnosis/ Procedure as stated in medical record: Left Lower Limb Amputee with new knee prosthesis.</p> <p>Query (in detail): Patient was admitted to Rehab after AKA for gait, strength and balance training for new knee prosthesis.</p> <p>Patient has already had Rehab for the initial AKA due to thromboembolism.</p> <p>Which codes would be correct for this admission?</p> | <p>QCC Response: The QCC recommend using the following codes: Z50.* - dependent upon the appropriate rehab code Z97.1 Presence of artificial limb (complete)(partial) Z89.6 <i>Acquired absence of leg above knee</i> 96142-00 [1878] <i>Skills training in use of assistive or adaptive device, aid or equipment</i></p> <p>It is not necessary to code I74.3 <i>Embolism and thrombosis of arteries of lower extremities</i> as the condition is no longer receiving treatment.</p> |

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| | | Z50.9 AZ97.1 AZ89.6 OR Z50.9 I74.3 Z97.1 Z89.6. | |
| 1109-09 | Blue Rubber Bleb Naevus Syndrome | <p>Diagnosis/ Procedure as stated in medical record: Patient admitted to Day Surgery for Colonoscopy and Panendoscopy. Patient has Blue Rubber Bleb Naevus Syndrome and has had vascular lesions on his skin removed previously. Syndrome present for years.</p> <p>Results found: Vascular lesion of tongue, vascular lesion of stomach but otherwise normal upper GI Endoscopy.</p> <p>Query (in detail): Would like to confirm code for Blue Rubber Bleb Naevus Syndrome/vascular lesion as PD. Have assigned K55.8 Other Vascular Disorder of Intestine.</p> <p>Other codes assigned: L98.8, I99, R10.4, K62.1 + Procedure codes.</p> | <p>QCC Response: The QCC advise that the coder cannot confirm that this is the PD in this situation as there is no definitive linkage described in the record.</p> <p>Therefore, Clinical consultation is required to ascertain whether there is a linkage between the hypogastric pain and the BRBNS and to define the Principal Diagnosis</p> <p>If the clinician confirms that the BRBNS is the Principal Diagnosis then QCC recommends that the enquirer take note of the following: Blue rubber bleb naevus syndrome is an uncommon condition manifested by gastrointestinal and skin haemangioma's that lead to gastrointestinal bleeding and anaemia.</p> <p>Therefore the QCC recommends that the enquirer use the following look up: haemangioma - venous</p> <p>This query will be sent to the NCCH for ratification of advice.</p> |
| 1209-01 | Cardiac arrest with resuscitation | <p>Question: If patient has had cardiac arrest and resuscitation was performed do we code resuscitation as a procedure (intubation, cardiac massage)? We assign the code for cardiac arrest only when resuscitation is undertaken, maybe the diagnosis code already includes resuscitation procedures (like external cardiac massage).</p> <p>Could you clarify for us please?</p> | <p>QCC Response: The QCC will send a query to the NCCH in relation to this query about coding an intervention when a cardiac arrest occurs.</p> <p>The QCC note that ACS 0904 <i>Cardiac arrest</i> provides instruction regarding the use of diagnosis codes with no mention of an intervention code.</p> <p>The QCC were concerned with the following issues:</p> |

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| | | | <p>1. Should we be using an intervention code when it meets the criteria in this standard?</p> <p>2. Is there any reason why an intervention code cannot be used at the local level? Practice in the past for most coders is not to code the intervention but the QCC could not find a reference to confirm this.</p> <p>The QCC assumes that intubation occurring during the intervention is not to be coded unless ventilation is applied.</p> <p>QCC Interim Response: Continue with current practice until clarification has been given by the NCCH in relation to this query.</p> |
| 1209-02 | Findings of anaemia with cancer treatment | <p>Question: Patient admitted for one day chemotherapy for cancer treatment. Anaemia was found and chemotherapy was cancelled and patient given blood transfusion. What code should we use as a PD: cancer with anaemia in neoplastic disease and cancelled procedure or Z511 (chemotherapy)?</p> | <p>QCC Response: The QCC note that example 5 in ACS 0011 <i>Admission for surgery not performed</i> is applicable to this scenario, i.e. the patient requires admission to hospital for treatment of a condition present on admission (anaemia in neoplastic disease †*) for which the procedure was cancelled.</p> <p>Therefore, in line with this advice, the QCC would recommend coding the following:</p> <p>PDx: Neoplasm† ODx: D63.0 - <i>Anaemia in neoplastic disease*</i> ODx: Z53.0 - <i>Procedure not carried out because of contraindication</i></p> |
| 1209-03 | Investigation of anaemia with cancer findings | <p>Question: Patient admitted for investigation of anaemia. Colonoscopy was performed, found tubular adenoma of colon. After that, patient developed urinary retention and prostate cancer with metastasis was found and investigated during this admission.</p> <p>Anaemia and cancer was not linked by clinician.</p> <p>According to the last Coding Matters we should not link anaemia with cancer, however D630 Anaemia in neoplastic disease should be assigned when anaemia occurs in, due or with a neoplastic condition.</p> <p>Tubular adenoma of colon is a neoplastic condition as well, could we use anaemia in neoplastic disease with tubular adenoma or prostate cancer?</p> | <p>QCC Response: The QCC recommends that Clinical clarification should be sought to confirm if there is a linkage between the prostate cancer and the anaemia.</p> <p>In regards to coding D63.0 <i>Anaemia in neoplastic disease</i> in unlinked conditions, Coding Matters Volume 16 Number 2 September 2009 states: "It was not intended for this code to be assigned where the anaemia has been documented as due to an unknown cause or a non-neoplastic condition."</p> <p>The advice does not say that there is required to be a link between the neoplasm and cancer; rather it says that where the anaemia is definitely not caused by the neoplasm, then D63.0 <i>Anaemia in neoplastic disease</i> is not coded.</p> |

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| | | | <p>Considering this advice, the QCC recommends coding PDX=Prostate cancer ODx=Anaemia</p> <p>If the episode was a same day endoscopy, QCC recommends that the tubular adenoma (and any other condition found on endoscopy) would also be coded, following advice from ACS 0046 <i>Diagnosis selection for same day endoscopy</i></p> <p>If the episode is not same day endoscopy, the tubular adenoma would not be coded unless it fulfilled the criteria for coding under ACS 0002 <i>Additional diagnosis</i>.</p> |
| 1209-04 | Koilocytotic atypia and HPV effect pathology | <p>Diagnosis/ Procedure as stated in medical record: Koilocytotic atypia and HPV effect pathology</p> <p>Query (in detail): Further on from discussion relating to QCC Query ID: 0907-05 which asked: ‘What codes should be assigned for cervical dysplasia and koilocytotic atypia? Should the code for papillomavirus be used additionally to the code for cervical dysplasia?’</p> <p>QCC Response was: The relationship between CIN, dysplasia & HPV needs to be further clarified to alleviate ambiguity. The QCC recommends that NCCH undertake a review of the CIN standard.</p> <p>To date the QCC has not received a response from the NCCH.</p> <p>Please review the attached (3) pathologies. Does the QCC agree that based on these pathologies, can it be assumed that Koilocytotic Atypia = HPV effect and can the code for HPV (B97.7) be assigned?</p> <p>Please note: the additional information provided in this query (pathology reports) will not be published with the query due to patient confidentiality requirements. If you require further information please contact the Data Quality Team: QCC@health.qld.gov.au</p> | <p>QCC Response: Cervical dysplasia is indicative but not diagnostic of HPV.</p> <p>Atypia = HPV effect is incorrect (Please refer to the International Journal of Gynecological Cancer. 2004 Jan-Feb; 14(1):126-32). Correlation between histological criteria and human papillomavirus presence based on PCR assay in cervical biopsies.)</p> <p>In the additional information provided with this query (the pathologies) HPV should not be coded from the first as:</p> <ul style="list-style-type: none"> • ‘indicative of HPV’ is used instead of <i>diagnostic</i> • HPV is not mentioned in the summary • There are insufficient clinical details: “The specimen is labelled with the patient’s details only” <p>It would not be unreasonable to code HPV from the 2nd and 3rd results.</p> <p>Please note: the additional information provided in this query (pathology reports) will not be published with the query due to patient confidentiality requirements. If you require further information please contact the Data Quality Team: QCC@health.qld.gov.au</p> |

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| 1209-05 | Age Edit on code Q86.0 Fetal alcohol syndrome | <p>If a child is born and diagnosed with fetal alcohol syndrome would that condition not continue into adolescence/adulthood i.e. not curable?</p> <p>The current age edit ('0' – '1' years) on code Q86.0 indicates that only a child under one year would be coded as having this syndrome.</p> <p>My research on FAS showed that a baby born with FAS has it for life even though some of the symptoms of FAS may resolve.</p> <p>Can code Q86.0 Fetal alcohol syndrome be coded as a current condition in an adolescent patient and is the age edit valid for this code?</p> | <p>QCC Response: QCC believe that ACS 1605 <i>Conditions originating in the perinatal period</i> is applicable to this scenario.</p> <p>ACS 1605 states: “Most conditions originating in the perinatal period disappear after a short time. Some, however, can persist throughout life and should be classified to the codes in this chapter regardless of the patient's age.”</p> <p>QCC recommend that in this scenario Q86.0 should be allocated.</p> <p>Please note: The allocation of Q86.0 <i>Fetal alcohol syndrome (dysmorphic)</i> will result in a warning edit in this scenario.</p> <p>However, Q86.0 <i>Fetal alcohol syndrome (dysmorphic)</i> can be coded in an adolescent patient (Refer to ACS 1605 <i>Conditions originating in the perinatal period</i>).</p> <p>The QCC recommends that Q86.0 should only be coded on a case by case basis.</p> |
| 1209-06 | Metastatic Neoplasms | <p>Query (in detail): When coding patients with neoplasms, ACS 0236 <i>Neoplasm coding and sequencing</i> instructs that “where there are multiple metastatic sites, assign a code for each site in order to reflect the severity of the condition.”</p> <p>There are two components to this query: 1. Does this (or any other specialty standard) over-ride instructions in ACS 0002 – Additional Diagnoses? Does the advice in ACS 0236 mean that mets are coded regardless of whether they meet the requirements for coding under ACS 0002? 2. If ACS 0236 has primacy over ACS 0002: should metastatic disease that has been resected still be coded at all times?</p> | <p>QCC Response: The QCC supports the primacy of ACS 0001 <i>Principal diagnosis</i> and ACS 0002 <i>Additional diagnoses</i>.</p> <p>In Coding Matters, Volume 16, number 3, December 2009 10-AM Commandments, there is advice about whether specialty standards over-ride ACS 0002 <i>Additional diagnoses</i>.</p> <p>Utilising the flowchart published within this document the following decision pathway should be followed:</p> <p>Does the condition/status meet ACS 0002 Additional diagnoses? For previously excised/no longer treated metastatic disease, the answer would be “no”.</p> <p>Is there a specialty ACS which advises the condition/status should be coded only following specific criteria? Yes, ACS 0236 <i>Neoplasm coding and sequencing</i> states that, “where there are multiple metastatic sites, assign a</p> |

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| | | | code for each site in order to reflect the severity of the condition.” Is the criteria met? Yes, it is a metastatic site Assign code. |
| 1209-07 | Power saw injury | <p>Trying to code an external cause code with only documentation given: power saw injury.</p> <p>In the ICD-10-AM Alphabetical Index there is no default for contact with powered saw. You have to default to hand saw unless you know whether powered saw is chain, circular, etc etc.</p> <p>Contact -with --saw W27 Contact with non powered hand tool.</p> <p>There is however a code in the Tabular W29.1 Contact with powered saw.</p> <p>It would be useful to have an index entry that leads to a default code when the only documentation is ‘powered saw’.</p> <p>Contact -with -- powered ---saw W29.1 Contact with powered saw</p> | <p>QCC Response: QCC recommend following the ICD-10-AM index to allocate W29.9 in this scenario: Contact (accidental) - with -- hand --- tool (not powered) NEC W27 ---- powered W29.9</p> |
| 1209-08 | Anaemia due to hypertensive renal failure | <p>Diagnosis/ Procedure as stated in medical record: Patient has other co-morbidities, but the coder needs to code:</p> <p>Anaemia due to hypertensive renal failure.</p> <p>Query (in detail): Choices: (1) I12.0 D63.8 (Asterisk code needs to be with an N18.- code)</p> <p>(2) I12.0 N18.4</p> | <p>QCC Response: The QCC refer the enquirer to Errata 2, published Sept 2008, where there has been an amendment to the inclusion notes for anaemia in kidney disease: “Assign N18.3 – N18.5 <i>Chronic kidney disease stage 3 – stage 5</i> or N18.9 <i>Chronic kidney disease, unspecified</i> with D63.8* <i>Anaemia in other chronic diseases classified elsewhere.</i>”</p> <p>Therefore, the QCC recommend coding: PDX: I12.9 - <i>Hypertensive kidney disease without kidney failure</i> ODX: N18.4 - <i>Chronic kidney disease, stage 4</i></p> |

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| | | <p>D63.8 (PICQ edit – N18.4 should not be coded with I12.0)</p> <p>(3) I12.0</p> <p>D64.9 (This doesn't attribute the anaemia to chronic renal failure).</p> <p>Which of these is appropriate?</p> | <p>ODx: D63.8* - <i>Anaemia in other chronic diseases classified elsewhere</i></p> |
| 1209-09 | Incontinent in an overnight admission for UTI | <p>Diagnosis/ Procedure as stated in medical record: Incontinent of urine and faeces in an overnight admission (LOS= 1 day) for UTI</p> <p>Query (in detail): Discharge Summary – 90 year old patient admitted overnight (LOS = 1 day) for treatment of a UTI due to increasing confusion (dementia) and increased urinary frequency. Treated with IV antibiotics.</p> <p>Nursing notes on admission – pt incontinent urine & faeces, pt cleaned, pad insitu.</p> <p>Nursing Plan of Care form, under heading Specific Needs: Patient problems: potential worsening infection secondary UTI; incontinent urine & faeces. Clinical Actions: TPR – watch for □, Keep clean & dry, IV abs as charted. Review Time: 2/24 hour pad checks</p> <p>Nursing notes on discharge – pt incontinent urine & faeces. No other information regarding continence in the record.</p> <p>Question: Does incontinence documented as above meet ACS 0002 and therefore should be coded? We are aware of the Coding Matters question in Vol 16, Number 1, June 2009, but find this unhelpful. R32 & R15 both have the potential to change DRG if assigned as additional diagnoses.</p> | <p>QCC Response: Incontinence should be coded where it fulfils the criteria for coding either under ACS 0001 <i>Principal diagnosis</i> or ACS 0002 <i>Additional diagnoses</i> or as in ACS 1808 – <i>Incontinence</i>.</p> <p>ACS1808 states that “<i>Urinary and faecal incontinence codes (R32 Unspecified urinary incontinence, R15 Faecal incontinence) should be assigned only when the incontinence is persistent prior to admission, is present at discharge or persists for at least seven days</i>”</p> <p>In addition, Coding Matters Vol 16, No.1 (June 09) advises to code incontinence if it is documented as a “persistent problem”.</p> <p>QCC recommend coding the urine and faecal incontinence because they were present at discharge (as per ACS 1808), if the documentation noted is within the last nursing entry at discharge.</p> |
| 1209-10 | Donor of Haematopoietic Progenitor Cells | <p>Diagnosis/ Procedure as stated in medical record: Same day Patient who is a Voluntary Unrelated donor of Haematopoietic Progenitor Cells.</p> <p>Admitted for 1st dose of G-CSF s/c {Granulocyte Colony Stimulating Factor}.</p> | <p>QCC Interim Response: Since a better defined code is not currently available, QCC recommend allocating: Z52.3 <i>Bone Marrow Donor</i> and 96200-09 <i>Subcutaneous administration of pharmacological agent, other and unspecified pharmacological agent</i>.</p> |

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| | | <p>Query (in detail): Codes used: Z52.3 Bone Marrow Donor & 96200-09</p> <p>Do the above codes correctly reflect this episode of care?</p> | <p>QCC Response: The QCC believe that the Z52.3 is not truly representative of this scenario where the patient is receiving preparatory care to be a donor.</p> <p>The QCC feel that a Public Submission to the NCCH should be sent proposing two options for resolution of this issue:</p> <ol style="list-style-type: none"> 1. Create a code to better represent the scenario where a patient is admitted for examination and preparation of potential donor. <p>Or</p> <ol style="list-style-type: none"> 2. Add an inclusion note at either Z52.3 <i>Bone Marrow Donor</i> or Z00.5 <i>Examination of potential donor of organ and tissue</i> stating that this includes preparatory care for bone marrow donation. |
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