Queensland Coding Committee February 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0208-01	Maintenance of Vascular Access Device Codes	Consider the scenario where a patient has a malignant neoplasm and is admitted with either a complication of this or another condition. The hospital has a proforma for capture of conditions and interventions common in sameday cancer related admissions. On the proforma, there is a tick box field "maintenance of port (inc blood tests)". If this is ticked (in either a same day or multi day episode), should Z45.1 be coded additionally to the procedure code or is Z45.1 only used when the patient is admitted specifically for this? Also does the direction in ACS 0045 *"These codes should not be assigned when these procedures are done in conjunction with more major procedures such as insertion, loading, removal or replacement of drug delivery devices"* refer to the same time versus during the same admission? Also can the standard be worded to clarify if a patient who has a malignant neoplasm is admitted same day for taking bloods (maintenance) then should the PD = Z45 and the neoplasm coded additionally or PD = malignant neoplasm with Z45 coded additionally?	**QCC Response:** The QCC considers that there are three components to this query. 1. The QCC considers that the taking of blood from a port does not necessarily constitute "maintenance of port". 2. 13839-00 - *Collection of blood for diagnostic purposes* is included in the MBS Type C exclusion list and therefore carries admission procedure implications. 3. The QCC considers that in the instance described that there is no requirement to code Z45.1 as an additional diagnosis.
0208-02	Abnormal Liver Function Tests	A proforma is currently used to capture of conditions and interventions common in day cancer related admissions. On this there is a check box field "abnormal LFTs" and the code given is R74.0 Elevation of levels of transaminase and lactic acid dehydrogenase [LDH] There is another code indexed for abnormal function studies -liver R94.5 Abnormal results of liver function studies. Should coders default to R94.5 unless there is documentation in notes or pathology that the patient has high transaminase or LDH? What code should be assigned if notes state "abnormal LFT"?	**QCC Response:** The QCC considers that where the check box described as abnormal LFTs is checked and the condition meets the requirements of ACS 0002 that R94.5 *Abnormal results of Liver function tests* should be coded. If more specificity is required, the QCC suggests that the check box names be adjusted to reflect the code required. Where there is documentation in the notes of elevated transaminase and LDH, and the conditions meet the requirements of ACS 0002, R74.0 *Elevation of levels of transaminase and lactic acid dehydrogenase [LDH]*, should

Queensland Coding Committee February 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		Should Coders then check the AST and LDH values?	be coded. The QCC considers that where abnormal LFTs are documented and the condition fulfils the requirements of ACS 0002, R94.5 *Abnormal results of Liver function tests* should be coded.
0208-03	Neoplasm Complications found after bloods taken in same day episodes	If a patient with all or other neoplasm is admitted as a day patient to have routine bloods taken (and subsequent maintenance of vascular access device), and these show an abnormal result such as anaemia or neutropenia or thrombocytopenia or abnormal liver function studies, should the PD be maintenance of port (bloods taken) with the neoplasm and complications coded additionally or is the complication or neoplasm and anaemia coded as the PD (+/- Z45.1 coded additionally).	**QCC Response:** The QCC considers that there are three components to this query. 1. 13839-00 - *Collection of blood for diagnostic purposes* is included in the MBS Type C exclusion list and therefore carries admission procedure implications. 2. The QCC considers that the taking of blood from a port does not necessarily constitute “maintenance of port” 3. If a patient is admitted for maintenance of vascular access device, and there are particular findings of blood tests such as anaemia or neutropaenia, then these findings should be assigned as additional diagnoses. 4. In this instance however, the QCC believes that the patient would not usually be admitted for blood collection (unless it was under Type C exclusion list requirements). If the patient was consequently admitted for the findings the PD would be the condition found.
0208-04	Coding of test values and trends	Please see NCCH query 1918 and ACS 0010 abnormal findings. Can NCCH verify the following concepts and if so re-word ACS 0010 to make them clearer. Coders should not independently turn to pathology, notice an abnormal result and code this without an indication of significance in the notes/summary. Similarly doctors may transcribe/report pathology results into progress notes as an	**QCC Response:** The QCC will ask the NCCH in regards to values and trends where there is related treatment given. **NCCH Query:** When can a coder use the Hb or Hb 98 and code this as anaemia especially if a transfusion is given or K or K2.9 if a patient is started on potassium supplements such as span K, when a particular alternate drug or treatment is chosen

Queensland Coding Committee February 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
		indication/communication that results have been viewed, and hence findings (normal, slightly abnormal, or significantly abnormal) taken into account. This should not be coded unless significance is clearly indicated or clarification of this sought. In light of the NCCH response to query 1918, the SSU auditors have promoted that values and trends should be supported by a 'documented diagnosis' rather than a value or trend alone. However we have advised coders that they must seek clinical clarification if there is not a documented diagnosis, but clear evidence of reactive intervention or other significance relative to the abnormal result. However we are concerned by exactly what ACS 0010 "Do not code laboratory, x-ray, pathological and other diagnostic results which require the interpretation of the treating clinician to decide their clinical significance and/or relationship to a specific condition." means. E.g. can "↓Hb" or "Hb 98" be coded if a transfusion is given or "↓K" or K 2.9 if the patient is started on potassium supplements such as span K or in view of xxx, a particular alternate drug or treatment chosen for another condition can xxx be coded?	for another condition can the condition be coded? **NCCH Response:** Clinicians sometimes use abbreviations and symbols to document conditions in the clinical record. Each case should be assessed on its own merits to determine if the documentation sufficiently describes a condition that meets the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, in order to be coded. When "↓ Hb" or "↓ K" is documented as the indication for an intervention such as a blood transfusion or commencement of medication, a code for the condition can be assigned if the test result or clinician confirms that the patient's haemoglobin or potassium is below the normal range, as the criteria for code assignment in ACS 0001 or ACS 0002 has been met. See ACS 0010 General abstraction guidelines. So, where "↓ Hb" is documented as the indication for a transfusion and the test results and/or clinician verifies the patient's haemoglobin is below the normal range - follow the index pathway, Low, haemoglobin and assign D64.9 Anaemia, unspecified. Where "↓K" is documented as the indication for commencement of medication and the test results and/or clinician verifies the patient's potassium is below the normal range, follow the index pathway, Deficiency, potassium (k), Depletion, potassium, Hypokalaemia, or Hypopotassaemia and assign E87.6 Hypokalaemia. However, if ICD-10-AM does not provide an index look up or there is uncertainty or ambiguity in relation to such abbreviated forms of documentation they should be confirmed with the clinician prior to code assignment.

Queensland Coding Committee February 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
			Coders should not assign codes on the basis of test results alone.

Queensland Coding Committee March 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0308-01	Low Rectal Carcinoma ULAR with Loop Ileostomy	Is it correct to assign code T81.2 Accidental puncture & laceration during procedure NEC for documentation on Operation Report of "serosal tear in splenic flexure oversewn"? Clinical advice received is that because this is a serosal tear, and not an actual breach of an organ, that it would be inaccurate to classify this as a misadventure/complication.	**QCC Response:** The QCC considers that the correct code allocation for this scenario is: T81.2 - Accidental puncture and laceration during a procedure, NEC. Y60.0 - Unintentional cut, puncture, perforation or haemorrhage during surgical operation. Y92.22 – POO Health Services. At the request of the committee, this query response will be forwarded to the NCCH for ratification. **NCCH Query:** Thank you for considering our request. The Queensland Coding Committee (QCC) has received a query in regards to the code for Low Rectal Carcinoma ULAR with Loop Ileostomy. Is it correct to assign code T81.2 Accidental puncture & laceration during procedure NEC for documentation on Operation Report of "serosal tear in splenic flexure over sewn". When a serosal tear occurs interoperatively does this constitute a misadventure? **Additional Information:** Misadventure, according to ACS 1904 is classified as "a complication occurring during medical or surgical care". A condition should only be coded as a complication if it "directly related to a surgical/procedural intervention".

Queensland Coding Committee March 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
			If it cannot be determined whether a condition meets the definition of a post procedural complication, it should not be coded as such.
0308-02	PD - Carpal Tunnel PP – Release Carpal Tunnel (performed under LA)	Carpal tunnel diagnosed before pregnancy. If release of carpal tunnel was performed during pregnancy, then which code assignment would be correct: Opinion 1: PD= G560 plus additional diagnosis =Z33. Opinion 2: PD= O26.82.	**QCC Response:** The QCC considers that clinical clarification should be sought as to whether the carpal tunnel complicated the pregnancy. The QCC will also query the NCCH as to whether it is correct to over-ride the index where documentation indicates "in pregnancy". Is this similar to "diabetes with"? **NCCH Query:** The QCC would like to know if it is correct to over-ride the index where documentation indicates "in pregnancy". Is this similar to "diabetes with"?
0308-03	Admission for cystoscopy with no documentation of a symptom or indication for the procedure. Attempts at consulting clinician have been unsuccessful.	Query is in relation to when to code Z01.8. The initial query was for Colonoscopies / Endoscopies for unspecified disorders (ie no documentation of reason for scope). The clinician needs to be consulted to source an 'indication' for the scope; however this is may not always achievable. It was decided that Z01.8 is the best diagnosis code for the PDx followed by all incidental findings. The question is: "should this be applied also to Cystoscopy coding where clarification from the clinicians for a diagnosis has proved to be unsuccessful?" Old school cystoscopy coding used N32.9 Bladder disorder, unspecified as the PDx, if no abnormalities were detected, and no diagnosis documentation given. If there was a finding (.e.g. trabeculation) then this would be coded instead.	**QCC Response:** The QCC recommends that when there is no documentation or indication for this particular procedure that you would use R39.8 – Other and unspecified symptoms and signs involving the urinary system. This advice is only to be applied in the very rare occurrence when clinical consultation is impossible.

Queensland Coding Committee March 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
		However for cystoscopies with no abnormalities detected and no documentation of symptom or indication for the procedure, should Z01.8 Other specified special examinations and investigations be used as the PDx (Remembering that this is only for when all attempts at consulting with clinicians have failed) and code all incidental findings as additional diagnosis?	
0308-05	Major Depressive Episode	For cases where the admission is for treatment of a major depressive episode and this admission follows previous treatment for low mood and prescription for medication to treat this. Can this current major depressive episode be coded as recurrent based on the above documentation or does the clinician have to document the depressive episode as recurrent? ACS 0506 has the following listed under major depression. For major depression characterised by more than one major depressive episode, assign F33. Recurrent depressive disorder. Does this apply to depressive episodes as well?	**QCC Response:** Clinical advice indicates that “recurrent” is not reflected by recurrent admissions – recurrent depression is used when a patient is treatment resistant and requires treatment review. Therefore, prior to coding of recurrent major depression, clinical consultation should be sought where “recurrent major depression” is not documented.
0308-06	Adhesions noted in operation notes not divided	If adhesions have been noted but not divided. Can the adhesions be coded if they are not divided? ACS 0047 states to code adhesions if divided it doesn't mention to code them if not divided. NCCH database Q 1522 states when abdominal surgery is	**QCC Response:** The QCC considers that adhesions should be coded, where they are not divided, where they meet the requirements of ACS 0002. e.g. Where adhesions are so severe that the procedure is not done or is complicated by the presence of the adhesions.

<table>
<tr><th colspan="4">Queensland Coding Committee March 2008 Coding Queries</th></tr>
<tr><th>QCC_ID</th><th>Query Summary</th><th>Query</th><th>Meeting Response</th></tr>
<tr><td></td><td></td><td>performed and adhesions are documented but not divided surgically, should adhesions be coded as an additional diagnosis when appropriate, or should they only be coded if the adhesions are divided?</td><td>The QCC will send a suggestion to the NCCH that there be mention made of the requirements of ACS 0002 – Additional Diagnosis in ACS 0047-Adhesions

NCCH Query:
If adhesions have been noted but not divided, can the adhesions be coded if they are not divided?

ACS 0047 states to code adhesions if divided it doesn't mention to code them if not divided.

NCCH database Q 1522 states when abdominal surgery is performed and adhesions are documented but not divided surgically, should adhesions be coded as an additional diagnosis when appropriate, or should they only be coded if the adhesions are divided?

NCCH Response:
Adhesions should be coded when they are divided, as per the guidelines in ACS 0047 Adhesions. If the adhesions are not divided they should not be coded.</td></tr>
<tr><td>0308-07</td><td>Routine hysteroscopy, dilation & gentle sharp curette to remove polyps</td><td>If routine hysteroscopy is performed with dilation & gentle sharp curette to remove polyps

The code for the D&C of the uterus would be 35640-00 [1265] However this doesn’t reflect that polyps were excised. Is another code needed to show that polyps were excised?</td><td>QCC Response:
The QCC considers that prior to coding 35633-01 Polypectomy of uterus by hysteroscopy the removal of the polyps needs to be documented by the clinician rather than an incidental finding on histopathology (eg found on histopathology and no surgical intent for removal).

The QCC advises that the look-up is for removal/excision of polyp.

Removal, polyp – see Excision.
Excision, polyp, uterus (closed) 35633-01.

This code includes the hysteroscopy.
The D&C should be coded in addition.</td></tr>
</table>

Queensland Coding Committee March 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0308-09	Exacerbation of COPD	If COPD with pneumonia and COPD with acute lower respiratory infection and acute exacerbation of COPD/Asthma where the pneumonia was treated and resolved Can both codes J44.0 and J44.1 be used during the same admission?	**QCC Response:** The QCC considers that in this example a code should be allocated for both conditions.
0308-10	Thrombophlebitis and Left cephalic vein thrombosis (non occlusive) related to PICC insertion for IV antibiotics	What complication code should be used to code thrombophlebitis and Left cephalic vein thrombosis (non occlusive) related to PICC insertion for IV antibiotics?	**QCC Response:** The QCC considers that the correct code allocation is T82.8. Other complication of cardiac and vascular prosthetic devices, implants and grafts. The look up is as follows: Complication -vascular I99 --device, implant or graft T82.9 ---infection or inflammation T82.7 ---mechanical NEC T82.5 ---specified NEC T82.8 T82.8 Other complications of cardiac and vascular prosthetic devices, implants and grafts Complication } Embolism } Fibrosis } Haemorrhage } due to cardiac and vascular prosthetic devices, implants and grafts

Queensland Coding Committee April 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0408-01	Death certificate states Extreme prematurity As a consequence of termination Trisomy 21	In cases where termination of fetus due to congenital abnormalities causes the premature birth of live baby and as a consequence of extreme prematurity the baby dies. On the baby record codes used would be for premature birth and congenital abnormalities codes. However, should a complication of a procedure code be allocated (even though the procedure was done on the mother) as in this situation the Coroner has stated there is a direct link between the death, birth and procedure. If yes then which of these codes should be the PD: T81.8, Y83.8, and Y92.22?	**QCC Response:** The QCC will forward a query to the NCCH. **NCCH Query:** Questions: 1. Should we code a complication of a procedure code (even though the procedure was done on the mother) as in this situation the Coroner has stated there is a direct link between the death, birth and procedure, and thus reportable to him. 2. If yes, which codes (T81.8 + Y83.8 + Y92.22) 3. Which one should be the PD? **NCCH Response:** The NCCH advises that the correct code assignment for the scenario cited is a code from category P07.2 Extreme immaturity and P07.0 Extremely low birth weight as appropriate, with an additional code P96.4 Termination of pregnancy, affecting fetus and newborn. It is inappropriate to assign a procedural complication code on the baby's record.
0408-03	Dressing of POC	In cases where POC insertion has been performed and there is itching around the port site, no fever or slough from port site and no mucositis or diarrhoea. The dressing is removed, wound cleaned and cutifilm reapplied and new dressing applied. Which code should be used? Suggestions: Z45.1 Adjustment and management of implantable infusion device or pump or Z48.0 Attention to surgical dressings and sutures.	**QCC Response:** QCC members consider that the correct principal diagnosis code for this episode of care is: Z45.1 Adjustment and management of implantable infusion device or pump.
0408-04	Caustic soda ingestion	In cases where caustic soda is accidentally put into the mouth resulting in ulcer and swelling/damage limited to lips, tongue and an ulcer on pharynx. It is not clear whether this is a burn	**QCC Response:** The QCC recommends that clinical advice should be sought to ascertain whether this was ingestion or corrosion

Queensland Coding Committee April 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		or if any caustic soda was ingested.	and for the condition to then be coded accordingly.
0408-05	Alcohol poisoning and HI coding	Scenario: Person drinking at a party had a fall with a small graze on the forehead. On the way home, person's condition begins to deteriorate. ED notes gave the diagnosis as ?alcohol intoxication ?HI. (HI=Head Injury) Under what circumstances should a coder select as principal diagnosis, the code for acute alcohol intoxication versus poisoning by alcohol. The NCCH reply was "The NCCH acknowledges how difficult it is for clinical coders to differentiate between 'alcohol intoxication' and 'alcohol poisoning' and is currently seeking clinical advice from the mental CCCG. We will reply to your query as soon as a response is received and your patience is appreciated." The question is, does this constitute alcohol poisoning or alcohol intoxication? Additionally, would committee members code HI as an additional diagnosis?	**QCC Response:** QCC members consider that in this instance you would allocate a code for alcohol intoxication unless further supporting documentation for the allocation of poisoning is provided on clinical consultation. The QCC recommends that a query regarding the difference between intoxication and poisoning be re-addressed with the NCCH. **NCCH Query**: Under what circumstances should a coder select as principal diagnosis, the code for acute alcohol intoxication vs. poisoning by alcohol? **NCCH Response:** Clinical advice indicates that alcohol poisoning is a particularly severe form of alcohol intoxication. Typically alcohol poisoning is characterised by major disturbance of conscious level, inability to rouse the patient and resultant threat to life requiring supportive treatment. Coders should be guided by the documentation in the clinical record. Where acute alcohol intoxication is documented, assign F10.0 mental and behavioural disorders due to the use of alcohol, acute intoxication following the index pathway: Intoxication - alcoholic (acute) (with) F10.0 Where alcohol poisoning is documented, assign T51.0 Toxic effect of alcohol, ethanol following the index pathway:

Queensland Coding Committee April 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
			Poisoning (acute) (see also Table of drugs and chemicals) Table of Drugs and Chemicals Alcohol - beverage T51.0 and appropriate external cause of injury codes.
0408-06	Coding Of Syndromes	If a patient is admitted and it is identified that their deafness fulfils the criteria for ACS 0002 and then other syndromes related to deafness, but not related the current episode of care, such as Allagille syndrome are documented in the past, should this be coded in the current episode of care? <u>Additional Information:</u> ACS 0005 point 5 states "If the syndrome is a congenital one, assign Q87.- Other specified congenital malformation syndromes affecting multiple systems as an additional diagnosis code to the specified manifestations already coded. The addition of this code acts as an indication that this is a syndrome which does not have a specific code allocation in ICD-10-AM. These cases should be notified to your state coding advisory body."	**QCC Response:** The QCC considers that a code for Allagille Syndrome should not be coded unless further clinical clarification is sought regarding its direct relationship or impact upon this episode of care.

Queensland Coding Committee May 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0508-01	Early Labour	Consider a scenario where a patient is admitted to the birth suite, and the progress notes document backache and increasing back pain. CTG is commenced and VE performed to ascertain if patient is in labour. No contractions. There is documentation of verbal requests for pethidine IM and droperidol. Would a diagnosis of Z34.9 Supervision of normal pregnancy unspecified be appropriate for the principal diagnosis?	**QCC Response:** QCC members consider that in this instance you would allocate a code O99.8 and a code for back pain.
0508-02	Principal Diagnosis: LRTI. Other Conditions: mild CCF	In cases where diagnoses of LRTI (documented as Principal diagnosis) and CCF are reported and there is a past medical history of IHD – stable angina, MI in past, CABGx3, cor angioplasty & stent. My question is whether the advice in NCCH query 2154 old myocardial Infarct means that the coder should be assigning a code of I25.2 for the old AMI because the patient has CCF in this admission, or does this advice only apply when the patient is admitted primarily for their cardiac condition i.e. what is meant by “admitted for a cardiac condition”? NCCH 2154: “When a patient is admitted for a cardiac condition, it is appropriate to assign a code for ‘old MI’ or ‘history of CABGS’ if this is documented in the patient’s history”. If the decision is made to code the I25.2, is the IHD, history of CABG and coronary angioplasty able to be coded / relevant?	**QCC Response:** QCC members consider that in this instance you code IHD, old MI, history of CABG and history of stent, according to the direction provided by NCCH 2154.

Queensland Coding Committee June 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0608-01	When is the appropriate time to use the code Y96 – Work Related Condition.?	In this case the admission is for an inguinal hernia repair and there is no specific documentation to link the reason for admission to a work injury. However, in this instance a work cover form is completed by a doctor, and the documentation on the form confirms reason for admission as a work cover claim but the cause of this injury/reason for admission is not stated. Would the code allocation of Y96 be justified when the only documentation we have is the work cover claim form? If the cause of injury is clearly documented, then instead of the Y96 as shown in Codefile, can the following external cause codes be used – i.e. K40.9-, X50, Y92.-, U73.- ?	**QCC Response:** QCC consider that insufficient documentation is recorded in the chart to accurately allocate Y96. Sufficient documentation on the other hand should show a causal relationship between the actual work and the condition. Work Cover forms may be completed when the patient has sustained an injury going to work or at work that is not actually work related. Unless there is sufficient information on the work cover form stating that the condition is work related, Y96 would not be coded on the basis only of the work cover form being completed. Y96 can be used additionally to external cause codes where applicable.
0308-08	Leaking gastrostomy tube	Which code should be used for leaking gastrostomy tube? Depending on what lead term is used the index gives two options: Leak, leakage -device, implant or graft (see also complications, by site and type) --gastrointestinal (bile duct) (oesophagus) T85.5 (T85.5 Mechanical complication of other specified gastrointestinal prosthetic devices implants and grafts) and Complication -gastrostomy (stoma) K91.8 (K91.8 Other postprocedural disorders of digestive system, not elsewhere classified). This is simular to an old QCC query 0202-07 Dysfunctioning button for a PEG. Does the decision for this query apply here?	**QCC Response:** The QCC will request more information from the enquirer to determine if the tube increased in size and whether the issue with the tube or the stoma? This query will also be sent to the NCCH for clarification. **NCCH Query:** The Queensland Coding Committee (QCC) has received a query in regards to the code for leaking gastrostomy tube. Depending on the what lead term is used, the index gives two options: 1) Leak, leakage -device, implant or graft (see also complications, by site and type) --gastrointestinal (bile duct) (oesophagus) T85.5 Mechanical complication of other specified gastrointestinal prosthetic devices implants and grafts 2) Complication -gastrostomy (stoma) K91.8 Other postprocedural disorders of digestive system, not elsewhere

Queensland Coding Committee June 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
			classified. Can you please clarify correct indexing notation? **NCCH Response:** To assign a code for leaking gastrostomy tube follow the guidelines in ACS 1904 Procedural complications: "Firstly, check the Alphabetic Index under the main term which best describes the complication, for the sub term of 'procedural' or 'postprocedural'… In some cases, rather than the generic term 'postprocedural', the sub term may directly describe the procedure involved." Therefore, the correct code to assign is T85.5 Mechanical complication of gastrointestinal prosthetic devices, implants and grafts by following the index pathway: Leak, leakage - device, implant or graft - - gastrointestinal (bile duct) (oesophagus) T85.5 with Y83.3 Surgical operation with formation of external stoma and Y92.22 Health service area.

Queensland Coding Committee July 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0708-01	Orthopaedic – Buford Complex	May I have your assistance with regard to the appropriate diagnosis code for Buford Complex? I have 'googled' this and it states that Buford complex is not a tear or detachment, however is often mistaken for a tear or detachment. I have searched the NCCH Database but without success.	**QCC Response:** The QCC recommend: M25.81Other Specified Joint Disorders, shoulder region and a bursitis code should be allocated. It is to be noted that Buford Complex is a normal variant but because it is causing ongoing pain and has affected care it should be coded to M25.81.
0708-02	Port-a-Cath exploration and suture	Presents with metastatic neoplasm. Admission is for endoscopic pleurodesis. At completion of the procedure, the surgeon also accessed and flushed the port-a-cath. The coder assigned 92058-00 Irrigation of vascular catheter. However, sutures are not captured in this code description. Please advise if there is a more accurate code.	**QCC Response:** The QCC recommend the use of 34530-02 [766] Revision of implantable vascular infusion device or pump be used.
0708-03	Prophylactic Surgery	What would be the appropriate PD in cases where breast cancer has been diagnosed but prophylactic bilateral oophorectomy is performed?	**QCC Response:** The QCC recommend that the principal diagnosis is the breast cancer. Committee members were uncertain whether the appropriate code to reflect prophylactic ovary removal in management of breast carcinoma was Z74.00 *Breast* or Z74.01 *Ovary* and asked that this be submitted to NCCH for clarification Further review has shown index entries **Prophylactic** - organ removal (for neoplasia management) - - breast Z40.00 - - ovary Z40.01 - surgery Z40.9 - - for risk factors related to malignant neoplasm

Queensland Coding Committee July 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
			- - - breast Z40.00 - - - ovary Z40.01 After reviewing the index, it appears that the code relates to the organ removed, rather than the site of the malignant neoplasm. The Committee is asked to consider whether this explanation resolves the above question prior to the submission to NCCH. **This query was re-addressed as QCC query 0609-01.** The QCC decision at the June 2009 meeting for query 0609-01 answered QCC query 0708-03 and was as follows: The QCC advise that ACS 1204 is followed in this instance. ACS 1204 directs the coder to code the neoplasm as the PD and Z40.01 as an additional diagnosis identifies the organ being removed.
0708-04	ACS 0033 COPD & Bronchiectasis	If diagnosis given on admission is exacerbation of COPD and diagnosis on discharge is Exacerbation of COPD secondary to CCF. And history on admission notes *COPD/Bronchiectasis on home oxygen. Codes allocated in this case would be PD J44.0 COPD with acute lower respiratory infection and additional diagnoses of I50.0 CCF, should J47 Bronchiectasis be allocated as well.	**QCC Response:** The QCC recommends that J44.0 be coded as the principal diagnosis. J47 Bronchiectasis could be added as additional diagnosis when it meets the prerequisites of ACS 0002. QCC is seeking further information about the documentation of Bronchiectasis in this particular separation.
0708-05	ACS 0401 DM - CRF - Nephropathy	In cases where diagnosis is Type 2 diabetes mellitus (uncontrolled) with Diabetic Nephropathy and Chronic Renal Failure. In 5th Edition this would be coded to E11.65 Type 2 diabetes with poor control and additional diagnoses of E11.23 Type 2	**QCC Response:** The QCC recommends that the assignment of E11.22. Type 2 diabetes mellitus with established diabetic nephropathy is appropriate. N28.9 is not needed as an additional code as the

Queensland Coding Committee July 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		diabetes with advanced renal disease and N18.90 Unspecified Chronic Renal Failure and N28.9 Disorder of kidney and ureter, unspecified for the nephropathy 6th Edition coded to E11.65 Type 2 diabetes with poor control and additional diagnoses of E11.22 Type 2 diabetes with established diabetic nephropathy and N18.3 Chronic kidney disease, stage 3 and N28.9 Disorder of kidney and ureter, unspecified for the nephropathy ACS0401 DIABETES MELLITUS AND IMPAIRED GLUCOSE REGULATION Page 97 in 5th Edition. Example 2 and CLASSIFICATION indicate that when diabetic nephropathy changes classifiable to more than one code (E1-.21, E1-.22, E1-.23) are documented, only the advanced stage should be coded. Page 104 in 6th Edition In addition, example 3 and CLASSIFICATION indicates when nephropathy changes classifiable to more than one code from E1-.21 and E1-.22 are documented in a patient with diabetes, only the more advanced stage (E11.22) should be coded. The Query is whether the Nephropathy N28.9 should be coded as an additional diagnosis as per Example 2 in 5th Edition and Example 3 in 6th Edition. If additional code is required for the Nephropathy perhaps further clarification of this could be added to the classification wording in this standard.	description of this code is included within the title of E11.22. Please refer to 10-AM Commandments Volume 14 Number 1 – Diabetic Foot Ulcer.

Queensland Coding Committee August 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0808-01	Coding Diabetes	Patient is diabetic type 2 diet controlled. On admission, doctor wants Ob's QID and BSL's QID. BSL's normal. It is at the doctors request how often BSL's are taken. So how do you know whether it is increased nursing care or monitoring when it is not stated as such? Every time a diabetic patient is admitted here and the doctor says take BSL's so many times a day and they are within normal limits are we to assume that this is normal for this patient? Or is this increased monitoring compared to a patient that doesn't have diabetes? Or how many times more than once do you just regard this as increased monitoring?	**QCC Response:** QCC advises that for a condition to be coded additionally it should fulfill ACS 0002 criteria i.e. affect patient management in terms of requiring: • commencement, alteration or adjustment of therapeutic treatment • diagnostic procedures • increased clinical care and/or monitoring or as directed/permitted by another standard. Previously NCCH had advised that monitoring of blood sugar levels was one factor which may indicate that ACS 0002 criteria have been met. NCCH have revised some wording in ACS 0002 to make it clear that the National morbidity collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care. Monitoring of blood sugar levels may constitute normal care for a diabetic patient and the diabetes may not always be considered by the Clinician to be significant in terms of treatment required, investigations needed and resources used in that particular episode. ACS 0010 states the listing of diagnoses on the front sheet of the clinical record is the responsibility of the clinician. Before coding any diagnosis/procedure recorded, the clinical coder must **verify** information recorded on the front sheet by reviewing pertinent documents in the body of the clinical record. Diagnostic results which require the interpretation of the treating clinician to decide their clinical significance should

Queensland Coding Committee August 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
			not be coded without clarification. Committee members advise that there must be clear supporting documentation that diabetes and BSLs taken fulfill ACS requirements.
0808-02	6th edition change – ACS 0401 Dyslipidaemia	Referring to ACS 0401 under Dyslipidaemia can you clarify that if increased cholesterol along with diabetes is documented then coders can refer to path results to confirm increased fasting tri's and decreased HDL, and if found can assign insulin resistance. That is increased fasting tri's and decreased HDL does not have to be documented by the clinician. This query is referring to the first dot point under CLASSIFICATION.	**QCC Response:** QCC are waiting for the FAQs Part 1 to be finalised in order to follow the advice of NCCH. Excerpt from FAQs Part 1, Coding Matters Volume 15 Number 2 September 2008: **Diabetes** 1. Q: *If you have hypercholesterolaemia documented in the clinical record and the test results indicate increased triglycerides and decreased HDL, can this be used to assign a code for dyslipidaemia?* A: Yes, test results can be used to confirm an already documented condition as per ACS 0010 *General abstraction guidelines – Test results – Findings that provide more specificity about a diagnosis* and ACS 0401 *Diabetes mellitus and impaired glucose regulation – Dyslipidaemia* which indicates that: *The characteristic pretreatment dyslipidaemia attributed to insulin resistance features elevated fasting triglycerides and depressed HDL-cholesterol fraction.* Hypercholesterolaemia is a type of dyslipidaemia and therefore more information can be obtained from the test results to be able to code the characteristic dyslipidaemia which meets the criteria for insulin resistance.

Queensland Coding Committee August 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0808-03	Bladder Stone and Obstructive Prostate for Litholapaxy and TURP.	Litholapaxy for Bladder Stone and TURP for BPH were conducted and hard stone and several areas of mucosal trauma were identified and stone fragments retrieved. In addition, a TURP was carried out to capsule and several small capsular perforations and noted, haemostasis with rollerball. Would the committee consider it appropriate to assign any codes for the capsular perforation? Is it a question of whether anything was done to manage the capsular perforation (ie. was the rollerball haemostasis performed because of the perforation or is this a routine component of TURP?)? A literature review by the enquirer has revealed there is some suggestion that Capsular perforation may be linked to impotence after TURP.	**QCC Response:** In this instance, QCC would consult with the clinician to discover if capsular perforation could be related to TURP or the disease process. The response from the clinician will decide the manner in which this is coded.

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
0908-01	DRG issue when Z51.88 is coded as the PD	DRG issue when Z51.88 is not coded as the PDx episodes for infants >28 days and >/= 2500g on admission. In 6th Edition, the component pertaining to prematurity was deleted from ACS 1618 (Prematurity and Low Birth Weight) and some of the information in this standard incorporated into ACS 1605 (Conditions originating in the perinatal period). However, the 6th edition standard has no mention of the coding of Z51.88 as the PDx when an infant >28 days and >/= 2500g is admitted for care relating to their prematurity (e.g."feeding and fattening"). If you code these infants as directed by the standard, it results in a 963Z DRG (Neonatal Diagnosis not Consistent with Age/ Weight). If Z51.88 is utilised as the PDx the resultant DRG is Z63A or Z63B (Other Aftercare w or w/o CC). Would it be possible to ask the NCCH if coders should continue the practice of coding Z51.88 as the PDx for these infants?	**QCC Response:** The QCC agreed that this query is to go to the NCCH. **QCC Interim Response:** Continue as per your current practice. **NCCH Response:** The NCCH advises that Z51.88 Other specified medical care should no longer be assigned as the principal diagnosis for infants > 28 days old and ≥ 2500g who are readmitted for care relating to their prematurity. Codes from ICD-10-AM Chapter 16 Certain conditions originating in the perinatal period now applies for- infants > 28 days who are still in the birth episode and infants > 28 days who are discharged and subsequently readmitted with a condition documented as originating in the perinatal period. Please refer to the 10-AM Commandment entitled 'ACS 1618 'Low Birth Weight and Gestational Age' The Use of Z51.88 'Other specified medical care' in Coding Matters Vol 15 No 1 September 2008.
0908-02	Temporal Arteritis	Normally it is necessary to have all the 'essential modifiers' of a condition stated in order to choose that sub term from the index. In this case in order to code M31.6, you would expect to have to have the specific term 'giant cell' as well as having 'temporal' 'arteritis'. INDEX Arteritis I77.6 .... - giant cell NEC M31.6 - - with polymyalgia rheumatica M31.5	**QCC Response:** The QCC agreed that this query is to go to the NCCH for clarification. **Interim Response:** Continue as per your current practice. **NCCH Query:** Normally it is necessary to have all the 'essential modifiers' of a condition stated in order to choose that sub term from the index. In this case in order to code M31.6, you would expect to have to have the specific term 'giant cell' as well

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		- temporal, giant cell M31.6. http://en.wikipedia.org/wiki/Giant_cell_arteritis states that temporal arteritis is also called giant cell arteritis. Should the term 'giant cell' be made a non essential modifier ie arteritis -temporal (giant cell) M31.6.	as having 'temporal' 'arteritis'. INDEX Arteritis I77.6 .... - giant cell NEC M31.6 - - with polymyalgia rheumatica M31.5 .... - temporal, giant cell M31.6 http://en.wikipedia.org/wiki/Giant_cell_arteritis states that temporal arteritis is also called giant cell arteritis. Should the term 'giant cell' be made a non essential modifier ie arteritis -temporal (giant cell) M31.6? **NCCH Public Submission Response:** Re: Public Submission for the Modification of ICD-10-AM/ACHI/ACS Reference No: 38/09 Thank you for highlighting that giant cell arteritis is the same as temporal arteritis. The term giant cell has been removed from the Alphabetic Index pathway: Arteritis, temporal. I am pleased to advise that the NCCH has accepted this submission for inclusion into ICD-10-AM/ACS Sixth Edition, Errata 4, which will become effective from June 2009. Once again, thank you for initiating this proposal and for your interest in the continued development of ICD-10-AM/ACHI/ACS.
0908-03	Sequencing of alcohol dependence and intoxications	In cases where Principal diagnosis is Alcohol addiction for detoxification and intoxication was noted on admission and admission is directly to ADS unit, should the alcohol intoxication be sequenced before the alcohol dependence code?	**QCC Response:** The QCC agreed that in this scenario, the Principal diagnosis would be alcohol dependence code.

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		The passage under ACS heading Acute intoxication states that F10.0 may be assigned in addition to codes from F10 but does not mention sequencing. Example 1 states Assign first the code for acute intoxication. Should we interpret Example 1 as meaning that intoxication should always be sequenced as the PDx if it occurs in a patient admitted for dependence, or in withdrawal? Should Example 1 be only followed if the documentation specifically states that the patient was "treated" for the acute intoxication? Acute intoxication 'Acute intoxication' (0) may be assigned in addition to another four character code from F10–F19. For example, persons who have more persistent alcohol- or drug-related problems such as harmful use (F1-.1), dependence syndrome (F1-.2) or psychotic disorder, (F1-.5) may also have episodes of acute intoxication. EXAMPLE 1: A patient is treated for acute intoxication superimposed on alcohol dependence syndrome. Assign first the code for acute intoxication (F10.0 Mental and behavioural disorders due to use of alcohol, acute intoxication) with an additional diagnosis code of F10.2 Mental and behavioural disorders due to use of alcohol, dependence syndrome.	
0908-04	Hypertension/ dyslipidaemia/ acanthosis nigricans with diabetes	Could the QCC consider whether the lack of an index entry for the following diabetes related conditions is intentional: Hypertension -with diabetes dyslipidaemia (characteristic) -with diabetes and	**QCC Response:** The QCC agreed that this query is to go to the NCCH. **Interim Response:** Continue as per your current practice. **NCCH Query:** This query is in relation to the index entry for diabetes related conditions. Specifically:

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
		acanthosis nigricans -with diabetes Is intentional in the index? It seems illogical as there are index entries for Obesity -with diabetes E1-.72 and Fatty -liver --with diabetes E1-.72	Conditions such as Obesity and Fatty Liver have the option with diabetes within a level indentation. Other conditions such as hypertension, dyslipidaemia (characteristic) and acanthosis nigricans do not have the 'with diabetes' option. If appropriate, QCC request index entries with diabetes at hypertension, dyslipidaemia and acanthosis nigricans.
0908-05	GOR for Fundoplication – post op residual urine, discharged with IDC	In cases where admission is for Fundoplication surgery for GOR and on the first day the patient fails to pass urine, then a Bladder scan shows residual urine in the bladder, and an IDC inserted. Whilst some urine is passed there is some residual urine and a Urological review arranged but the TOV is failed and the patient is discharged with IDC insitu. If there is documentation to say that there has been a history of interrupted flow and difficulty initiating. Using the Index, Residual Urine is assigned to R39.1 Other difficulties with micturition. The coder is questioning whether they can use their clinical knowledge (or whether there is sufficient information) to assign a code for Urine Retention R33, but would like the advice of the committee please.	**QCC Response:** QCC advice is to consult with an appropriate clinician. In the absence of consultation and lack of the word “retention”, R39.1 would be the appropriate code. Clinical advice will be sought to help differentiate between retention and residual. Clinical Advice sought 09/04/09
0908-06	GDM with Placenta Praevia at 36wks gestation.	In scenarios where patients are admitted with GDM (diet controlled) with Placenta Praevia and Betamethasone is administered. If it is noted in the progress notes that the effects of betamethasone may increase BSL’s has been explained, and that a Dietician has provided education.	**QCC Response:** In this scenario, the QCC believe that it would be correct to assign O24.44.

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
		Would the committee consider it correct to assign an additional diagnosis of GDM O24.44 in this instance?	
0908-07	Gest DM – Augmented Vaginal Delivery	In cases where patients are admitted at term in labour, augmented with ARM and proceeds to vaginal delivery of singleton and there is a patient history of Hep B Positive and GDM. If it is noted in the progress notes that Diabetes Education has been given by CNC Diabetes, does the committee consider that the patient's GDM meets ACS 0002 in this scenario? If the GDM is not coded, the Principal Diagnosis will be O80.	**QCC Response:** The QCC recommend that GDM would be coded in this scenario.
0908-08	Gest DM – admitted for elective caesarean for maternal choice	A patient is admitted for elective Caesarean and the labour and delivery summary documentation indicates that this is planned for maternal choice, however operation report documents indicate have GDM documented and there is no further detail of GDM. Does the committee consider that the GDM meets ACS 0001, ACS 0002 or neither?	**QCC Response:** In this situation, the QCC does not recommend coding GDM. However to ensure coded data quality clinical clarification should be sought due to the operation diagnosis recorded on the operation report.
0908-09	90467-00 – Spontaneous vertex delivery	90467-00 – Spontaneous vertex delivery When would the above code be allocated? It would appear unnecessary with O80 – but what about with other codes?	**QCC Response:** The QCC agreed that this query is to go to the NCCH to clarify if Coding Matter advice given in 1998 is still current. **QCC Interim Response:** Continue as per Coding Matters advice in Vol 5 No 3 pg 20. **NCCH Query:** The QCC would like to know, when it would be appropriate to use 90467-00 – Spontaneous vertex delivery.
0908-10	Issue with ACS 1518 Duration of Pregnancy	Issue with ACS 1518 Duration of Pregnancy Please review the suggested change (text in red writing) to ACS 1518, to send to NCCH once ratified. 1518 DURATION OF PREGNANCY Category O09 Duration of pregnancy is intended for the	**QCC Response:** The QCC agreed that this suggestion should go to the NCCH. **NCCH Query:** <u>0908-10a:</u> Please review the suggested change to ACS 1518:

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		coding of the duration of pregnancy at admission on the mother's record. 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 A code from O09 should be assigned as an additional diagnosis in all cases of: Abortion (O00–O07 Pregnancy with abortive outcome) Threatened abortion (O20.0) Foetal death in utero (O36.4) **(before 37 completed weeks of gestation).** 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). The duration of pregnancy should be abstracted from the duration of pregnancy documented in the clinical record. O09.9 Unspecified duration of pregnancy should be used only when the case meets the criteria set out above, and the duration of pregnancy has not been recorded. The Duration of Pregnancy codes were developed by the Obstetrics and Gynaecology CCCG 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.-.	1518 DURATION OF PREGNANCY Category O09 Duration of pregnancy is intended for the coding of the duration of pregnancy at admission on the mother's record. 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 QCC would like to recommend: O09.6 > 37 completed weeks ~~~~~ O09.9 Unspecified duration of pregnancy A code from O09 should be assigned as an additional diagnosis in all cases of: Abortion (O00–O07 Pregnancy with abortive outcome) Threatened abortion (O20.0). Fetal death in utero (O36.4) QCC recommend (before 37 completed weeks of gestation). 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) The duration of pregnancy should be abstracted from the duration of pregnancy documented in the clinical record. O09.9 Unspecified duration of pregnancy should be used only when the case meets the criteria set out above, and the duration of pregnancy has not been recorded.

Queensland Coding Committee September 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
			The duration of pregnancy codes were developed by the Obstetrics and Gynaecology CCCG 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.-. 0908-10b: The QCC recommend in future editions there should be consideration for the creation of a new code to categorise greater than 37 completed weeks.

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
1008-01	Multiple gestation with malpresentation & ACS 1520 example	Multiple gestation with malpresentation & ACS 1520 Example Could the QCC please confirm: a) Whether the following scenarios that involve multiple gestations with malpresentation are coded correctly; and b) Whether the example provided in ACS 1520 may be erroneous, and be forwarded to the NCCH for review. Scenario 1 Twin gestation, where one (or both) fetus is malpresenting (e.g. breech) is delivered prior to labour by caesarean section. O32.5 Maternal care for multiple gestation with malpresentation O30.0 Twin pregnancy Scenario 2 Twin gestation, where only one fetus is malpresenting (breech) is delivered after labour commences (i.e. intervention occurs following onset of labour): O64.1 Labour and delivery affected by breech presentation O30.0 Twin pregnancy Scenario 3 Twin gestation, where both fetuses are malpresenting (e.g. one breech, one transverse) is delivered after labour commences (i.e. intervention occurs following onset of labour): O64.1 Labour and delivery affected by breech presentation O64.8 Labour and delivery affected by other malposition and malpresentation O30.0 Twin pregnancy ACS 1506 Malpresentation, Disproportion and Abnormality of Maternal Pelvic Organs gives direction on when to apply O32.x and O64.x. Index Entry: Malpresentation, fetus - in multiple gestation (one or more) O32.5 - - affecting - - - labour or delivery O64.- ACS 1520 Multiple births states that "in a multiple delivery, if the babies are delivered differently, both types of delivery	**QCC Response:** The QCC responses to each scenario is as follow: Scenario 1: If elective caesarian agree with the codes suggested – O32.5 Maternal care for multiple gestation with malpresentation of one fetus or more and O30.0 twin pregnancy. Scenario 2: Agree with the codes suggested – O64.1 Labour and delivery affected by breech presentation and O30.0 Twin pregnancy Scenario 3: Agree with the codes suggested – O64.1 labour and delivery affected by breech presentation, O64.8 labour and delivery affected by other malposition and malpresentation and O30.0 twin pregnancy.

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
		should be coded", and then provides an example. It appears that the intent of this standard is to clarify how to code the procedures when the method of deliveries is different, but the inclusion of both O64.8 and O32.5 in the example seems to contradict one another. Considering that the intervention for the malpresentation in the example at ACS 1520 occurred during labour, this would suggest coding O64.8 (for transverse twin) and O64.1 (for breech twin) as per the index and ACS 1506. The indexing indicates that O32.5 would not be used in this case, as it involves labour and so O64.- codes would be used instead. Does QCC agree that O32.5 Maternal Care for multiple gestation with malpresentation should not be used in a delivery admission where there is no intervention occurring before labour?	
1008-02	Procedural complications	Post EMD arrest. During an operation a patient had a cardiac arrest and was resuscitated. They were transferred to an ICU facility fully ventilated, due to a bed shortage in our hospital. The patient stayed at hospital B facility for 2 days and was transferred back to our hospital when a bed became available. Which code should we use for the intraoperative cardiac arrest…I97.8 (cardiac arrest postprocedural) or T81.8 (cardiac arrest complicating surgery)?	**QCC Response:** The QCC will send a query to the NCCH in relation to the index and ACS 1904. **NCCH Query:** During an operation a patient had a cardiac arrest and was resuscitated. They were transferred to an ICU facility fully ventilated, due to a bed shortage in our hospital. The patient stayed at hospital B facility for 2 days and was transferred back to our hospital when a bed became available. Which code should we use for the intraoperative cardiac arrest…I97.8 (cardiac arrest postprocedural) or T81.8 (cardiac arrest complicating surgery)? Following ACS 1904, section Classification of procedural complications (diagnosis codes), QCC believe the index needs to include additional information for situations such as the above. **NCCH Response:** For a procedural complication occurring during surgical care (as per the scenario cited) refer to ACS 1904 Procedural

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
			complications which states: "There are a number of terms used in ICD-10-AM to describe procedural complications and these generally relate to the timing of the complication. **Misadventure** A misadventure is defined as a complication occurring during medical or surgical care. It may be noted at the time of the procedure or after completion of the procedure." Then follow the guidelines for classification of procedural complications which states: "**Firstly**, check the Alphabetic Index under the main term which best describes the complication, for the subterm of 'procedural' or 'postprocedural'." Therefore, for the scenario cited, follow the index pathway: Arrest, arrested - cardiac - - postprocedural I97.8 and assign I97.8 Other postprocedural disorders of circulatory system, not elsewhere classified, I46.0 Cardiac arrest with successful resuscitation to provide further specification of the condition (as National Centre for Classification in Health per ACS 1904) and the appropriate external cause of injury codes. **Do not** follow the index pathway Arrest, cardiac, complicating, surgery and assign T81.8 as this is contrary to the guidelines in ACS 1904.

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
			Improvements to the Alphabetic Index in relation to procedural complications will be considered for a future edition of ICD-10-AM.
1008-03	Vacuum dressing	Past advice within the NCCH database has indicated that when coding vacuum dressings that the coder is to utilise 90686-01 - non-excisional debridement of skin and subcutaneous tissue. Would it be possible to ask the NCCH to insert an index entry as follows: Dressing (to) -vacuum – see debridement, non-excisional?	**QCC Response:** The QCC will send a query to the NCCH in relation to the index, ACS 0042 and the 6ed workshop exercise hints. **NCCH Query:** Past advice within the NCCH database has indicated that when coding vacuum dressings that the coder is to utilise 90686-01 (non-excisional debridement of skin and subcutaneous tissue). In the NCCH 6th edition workshop Exercises: Procedural complications (1), Answers (page 45) it is stated "Hints: A code for vacuum dressing is not assigned as per ACS 0042 Procedures normally not coded. However, if this procedure was performed under anaesthetic assign 90686-01 {1628} Non excisional debridement of skin and subcutaneous tissue". According to the standard ACS 0042 dressing would not normally be coded. With reference to the above Hint, it appears that dressing would be coded to debridement? Or is this because this particular procedure was done under anaesthetic. Regardless, would it be possible to insert an index entry as follows?: Dressing (to) -vacuum – see debridement, non-excisional.
1008-05	COAD and Smoking	Consider the scenario where a patient admitted and treated for a heart condition. No problem with the PDx. Further information documented in chart regarding a background of COAD due to many years of smoking and still smoking. COAD did not meet criteria for additional diagnosis and was	**QCC Response:** The QCC considers that F17.1 would be coded in this scenario.

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
		not coded. QUERY Coders are required to capture 'smoking' in the above case. Would you assign F17.1 even though it doesn't meet criteria for additional dx, as Z72.0 can not be used when harmful use is present?	
1008-06	Pregnancy with Diarrhoea & dehydration	Diarrhoea and dehydration. Patient pregnant. Admitted to Obstetric/Maternity ward. QUERY Diarrhoea unspecified in 6th edition is coded to A09.9. This patient was admitted to Maternity ward and her pregnancy was monitored. Coded to A09.9 and E86, but couldn't find an appropriate O98._ code to accompany the A09.9. Used O99.6 but wonder if this will be picked up as an error in PICQ if not elsewhere.	**QCC Response:** The QCC decided that where the diarrhoea is considered to complicate pregnancy or diarrhoea is complicated by pregnancy, O98.8 and A09.9 codes would be used. A query will be sent to the NCCH to confirm this and asking about indexing. **NCCH Query:** Diarrhoea unspecified in 6th edition is coded to A09.9. A patient was admitted to Maternity ward with diarrhoea and her pregnancy was monitored. This episode was coded to A09.9 and E86 but the Coder couldn't find an appropriate O98._ code to accompany the A09.9. QCC consensus is that the O98.8 and A09.9 codes would the most appropriate in this example. In addition, QCC suggested that AO9.9 be included in the range, Pregnancy - Complicated by -conditions in. For example: Pregnancy -complicated by — see also Pregnancy, management, affected by --conditions in ---A09, A40–A41 O98.8 The QCC also suggest the inclusion of index entry under Pregnancy to include diarrhoea.

Queensland Coding Committee October 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Member's Response**
			NCCH Response: The NCCH received a similar query which resulted in the following advice being published in the 10-AM Commandments of Coding Matters Vol 15 No 4, March 2009: "The correct code assignment for unspecified gastroenteritis complicating pregnancy is O98.8 Other maternal infectious and parasitic diseases complicating pregnancy and A09.9 Gastroenteritis and colitis of unspecified origin. Updates to the 'Pregnancy, complicated by' section of the WHO ICD-10 Alphabetical Index were made, however, some of these indexing changes have yet to be incorporated into ICD-10-AM." Indexing amendments to this area of the classification have since been made for ICD-10-AM, Seventh Edition.

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
1108-01	Codefinder "Code also when performed" frame in the pathway for LLETZ	LLETZ Operation report: Colposcopy Acetowhite area on the anterior and posterior cervix. LLETZ biopsy Diathermy of base of the cervix. **QUERY:** Can the QCC please advise if the Codefinder "Code also when performed" frame in the pathway for LLETZ should include an option for "diathermy, cervix" and whether this should be submitted to 3M. Block 1275 Destruction procedures of cervix does have a Code also when performed note for colposcopy, but there is no reference to also coding diathermy of cervix. Previously we have obtained clinical advice which stated not to code diathermy of the cervix as an additional procedure when coding a LLETZ as it is part of the procedure. The current Codefinder pathway would suggest to the coder that they need to assign a diathermy code in order to comply with coding convention, but this isn't in the tabular. Does the QCC agree that diathermy should not be coded when documented as the last step in a LLETZ procedure?	**QCC Response:** The QCC agree that the 3M Codefinder pathway needs review in this instance. Diathermy to the base of the CX is an inherent component in a LLETZ procedure. In this circumstance the diathermy should not be coded separately. The QCC will report this to the Codefinder Support Officer to send this as a fault the 3M Codefinder representative. **Codefinder Update:** This screen fault has now been amended.
1108-03	Coronary CTA and CT calcium score	We queried these procedures with our Imaging department and received education regarding the below procedures: CT scan heart (Calcium score), CT coronary angiography, CT venogram. These procedures are performed here with new equipment recently installed. The CT calcium score is done first, before dye is injected. This is a scan of the heart, not the chest.	**QCC Interim Response:** The QCC agreed that the enquirer should use spiral angiography of the chest in the interim for coronary CTA. The QCC did not determine a code set for 'CTA and CT calcium score' and agree that this query should go to the NCCH. Clarification will also be sought from NCCH whether CTA should be coded as spiral angiography (if so a recommendation will be made for improved indexing/or a

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		For the CT coronary angiography, a die is injected in the elbow and after a certain time, a CT is done of the coronary arteries. By this time the dye would have entered the arteries. Then after a certain time, when the dye has reached the veins, a CT of the veins is performed. We cannot find appropriate codes for these procedures. We thought that 38215-00 (668) may be appropriate for the CT coronary angiography, but are at a loss for the other two.	standard providing advice) or whether it needs to be established at each hospital that CTA =spiral angiography. **NCCH Query:** The Queensland Coding Committee (QCC) has received a query in regards to correct procedure code assignment for CT scan heart (Calcium score), CT Coronary Angiography and CT Venogram. The enquiry hospital queried these procedures with their imaging department and were informed of the following: The 'CT Calcium score' is done first, before dye is injected. This is a scan of the heart, not the chest. For the CT 'Coronary Angiography', a dye is injected in the elbow and after a certain time, a CT is done of the coronary arteries. By this time the dye would have entered the arteries. Then after a certain time, when the dye has reached the veins, a CT of the veins is performed. The QCC agreed that the enquirer should use spiral angiography of the chest in the interim for 'CT Coronary Angiography'. QCC was unable to determine appropriate codes for 'CT Calcium score' and 'CT Venogram'. Can the NCCH please provide advice on whether 'CT Coronary Angiogram' should be coded as spiral angiography (if so, the QCC recommends for improved indexing/ or a standard providing advice) and what codes to assign for 'CT Calcium score' and 'CT Venogram'?
1108-04	Bipolar Affective Disorder 'Current or Most Recent Episode'	Could the QCC please provide clarification of the coding of bipolar affective disorder and the use of the terminology 'most recent episode'?	**QCC Response:** The QCC agree to query the NCCH to clarify "most recent episode" in this case. Would it be the current episode of care or could you refer to a previous episode of care?

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		This terminology would seem to indicate that if no mention as to the type of bipolar disorder is documented in the current episode of care, then one may use documentation of a previous affective state - that is one in another episode of care. See below the classification logic for F31.x: • ICD-10-AM Index: **Disorder –** -bipolar F31.9 --affective F31.9 ---current episode ----hypomanic F31.0 **---most recent episode** ----hypomanic F31.0 • 3M Codefinder pathway for Bipolar Affective disorder – hypomanic F31.0: 1st Pathway Enter Key Word Prompt (KWP)…BIP…Bipolar disorder…Affective…Current episode…Hypomanic 2nd Pathway Enter KWP: BIP…Bipolar disorder...one…most recent episode...hypomanic **Literature Review** *Question: What are the differences between Bipolar Affective Disorder and Bipolar I and Bipolar II? Why is the term 'most recent' used to describe Bipolar I within the classification?* Evidence indicates that Bipolar Affective Disorder is subdivided into bipolar I, bipolar II, cyclothymia and other types, based on the nature and severity of mood episodes experienced; the range is often described as the bipolar	In addition, the QCC recommend asking the NCCH whether the most recent episode can include non admitted psychiatric consults and whether the documentation needs to reflect this exactly before coding. **NCCH Query:** The Queensland Coding Committee (QCC) has received a query in regards to the correct code assignment for Bipolar Affective Disorder (BPAD) 'Current or Most Recent Episode'. The QCC would like the NCCH to please provide some clarification in terms of the coding of BPAD with the use of the terminology 'most recent' episode. Could this be interpreted as: BPAD currently stable but with a history of a 'most recent episode' of hypomania/depression etc and assign these codes OR the 'most recent' state is to mean that it is a 'recurrent' state and hence to assign the code for current affective state only? Can the NCCH also please clarify the terminology 'most recent episode'? Can this include non admitted psychiatric consults and does the documentation need to reflect this exactly before this can be coded?

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		spectrum. There is also evidence in the DSM-IV-TR Guidebook that DSM-IV-TR does not use the term 'recurrent', but instead uses the term 'most recent'. **- Criteria and subtypes (Wikipedia)** There is no clear consensus as to how many types of bipolar disorder exist. In DSM-IV-TR and ICD-10, bipolar disorder is conceptualized as a spectrum of disorders occurring on a continuum. The DSM-IV-TR lists four types of mood disorders which fit into the bipolar categories: Bipolar I, Bipolar II, Cyclothymia, and Bipolar Disorder NOS (Not Otherwise Specified). Bipolar I In Bipolar I disorder, an individual has experienced one or more manic episodes with or without major depressive episodes. For a diagnosis of Bipolar I disorder according to the DSM-IV-TR, there requires one or more manic or mixed episodes. A depressive episode is not required for the diagnosis of Bipolar I disorder but it frequently occurs. Bipolar II Bipolar II disorder is characterized by more hypomanic episodes rather than actual manic episodes, as well as at least one major depressive episode. Hypomanic episodes usually do not go to the full extremes of mania (i.e. do not usually cause severe social or occupational impairment, and without psychosis), and this can make Bipolar II more difficult to diagnose, since the hypomanic episodes may simply appear as a period of successful high productivity and is reported less frequently than a distressing depression. For both disorders, there are a number of specifiers that indicate	

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	**Query Summary**	**Query**	**Meeting Response**
		the presentation and course of the disorder, including "chronic", "rapid cycling", "catatonic" and "melancholic". **Consideration** Could the QCC please provide some clarification in terms of the coding of Bipolar and the use of the 'most recent' episode? Could this be intepreted as: BPAD currently stable but with a history of "most recent episode"of hypomania/depression etc that we can assign these codes OR the 'most recent" state to mean that it is a "recurrent" state, and hence we are to assign the code for **current** affective state only?	
1108-07	Z76.2 Health supervision and care of other healthy infant and child	Previous queries - 1006-03; 1203-02; 1004-03; Coding Matters: Volume 7, Number 3; "Well Newborn or Healthy neonate". Can an addition be made to the Australian Coding Standards explaining the coding of subsequent admissions (not in the birth episode) of neonates <9 days of age, when the neonate is well and requires no care or treatment? When mothers of these newborns are admitted as patients and the focus of care is on the mother, the newborn is not able to be admitted as a Boarder because they are less than 9 days old. The newborn is admitted as Unqualified as per the QHAPDC manual. Coders often find it difficult not knowing how to code the newborn and there is currently no **Classification** in the ACS advising to code to Z76.2 *Health supervision and care of other healthy infant and child.*	**QCC Response:** The Committee's advice is to refer to ACS 1609, the QHAPDC manual (4.5 Newborns) and Codefile No. 20 Care Type Supplement July 2005: page 9, example 5. As stated by the enquirer, as per QHAPDC, all babies nine days old or less should be admitted as a newborn episode of care. ACS 1609 states "*if the maternal cause has necessitated provision of more health services than usual for a newborn, it may be appropriate to assign Z76.2* Health supervision and care of other healthy infant and child". The example provided in the Codefile care type supplement is: *<u>Example 5</u>* *A baby (seven days old) accompanies its mother into hospital but does not require treatment. The baby's mother was discharged two days post-delivery. On the fifth day post-delivery, she developed a post partum infection and is admitted to hospital. As the baby is under 9 days of age it is admitted into a Newborn care type.* *Care type – **05** Newborn*

Queensland Coding Committee November 2008 Coding Queries			
QCC_ID	Query Summary	Query	Meeting Response
			*Qualification Status – **U** Unqualified* *PD Z76.2 Health supervision and care of other healthy infant and child* The Committee will discuss the section of ACS 1609 referring to coding of Z76.2 and Z03.7 as 'Other Business' at a future QCC meeting. A suggestion will be put forward that it be made clearer that Z76.2 should be assigned when the baby is well and admitted only because the mother is admitted.
1108-08	Urinary Retention	Post op patient returned from theatre. Documented in Record: "Bladder Scan 600 – 800mls." Nothing else was documented. In a pathway there was mention of IDC removed a day later but no documentation of when it was inserted. Should we code urinary retention? Can Bladder Scans be interpreted as retention if an IDC is inserted but there is no documentation other than the bladder scan/IDC? Some coders are coding retention others are not. Some believe documentation of a bladder scan, with IDC insertion is enough to code retention, and others believe more documentation is required. Discussion amongst coders is that some clinicians order bladder scans on all patients post op, some patients (female) refuse to use a bed pan therefore IDC is placed.	**QCC Response:** The QCC agreed that coders should not code retention without appropriate documentation. However coders should clarify reason for any procedure performed where documentation seems to imply rather than actually state this.

Queensland Coding Committee December 2008 Coding Queries			
QCC ID	**Query Summary**	**Query**	**Meeting Response**
1208-01	Atrial Fibrillation	**Consider scenario A:** A patient with AF, treated with Warfarin. Booked to have surgery. The patient's Warfarin was being monitored as an outpatient prior to surgery. Surgery was postponed due to the patient's Warfarin levels. The patient continued to be monitored as an outpatient and eventually admitted for surgery. Surgery went well, patient discharged. **Consider scenario B:** Patient with AF, treated with Warfarin. Booked for surgery. Admitted one day prior to surgery for monitoring of anticoagulant. Surgery performed, patient stayed in an extra day to re adjust Warfarin. **QUERY** In the above scenarios what should we code?: (a) Z92.1 only (b) Z92.1 only We all agree that Z92.1 should be coded, however should the AF be coded, as it is the reason the Warfarin is being taken? Examples in the ACS (0303) show Z92.1 only. Could the AF be coded under ACS 0002 in scenario B, as the drug (Warfarin) was adjusted whilst patient was an inpatient? It was also documented that AF was the reason Warfarin was being taken. Would you code the AF in scenario A? This issue is being debated amongst coders at present, so clarification is sought.	**QCC Interim Advice:** QCC advice is not to code the AF unless the AF was the reason for admission or the AF itself required a change in treatment or met specific criteria in ACS 0002. In scenario (A) it was not clear whether Warfarin levels were monitored and this may require clarification. In scenario (B) the patient was admitted one day prior to surgery for monitoring and one day post surgery for adjustment of the anticoagulant; Z92.1 would be coded. The Committee queried whether there is a typographical error in the enquiry which should read (a) I48 rather than (a) Z92.1 (b) Z92.1. QCC agree that ACS 0303 indicates support for coding Warfarin use when levels or the dose is adjusted or monitored during an episode. Members debated whether AF should be coded if the administration of Warfarin is related to the AF and the Warfarin dose is adjusted and did not reach consensus as to whether atrial fibrillation should be coded additionally. **This issue will be raised with the NCCH:** When a medication is administered because of the existence of a condition (not as treatment for the condition per se); when the medication is adjusted – does this still fulfil the requirements of ACS 0002? QCC to forward public submission to the NCCH to amend example 2 in ACS 0303 and to ask the question above.

Queensland Coding Committee December 2008 Coding Queries			
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1208-03	Admission for Insulin Pump and Diabetic Education	What would be the Principal Diagnosis for the following scenario: Admission of a patient with IDDM, for insertion of an Insulin pump and diabetic education on its use? I have consulted a Clinician who stated the pumps are inserted to better control their Diabetes, thus possibly preventing later Diabetic complications. Whilst most admissions have unstable Diabetes, the Clinician stated the admissions were solely to treat their Diabetes. If E10.9 or E10.65 is used as the Principal Diagnosis then the DRG reflects an admission to treat a Diabetic conditions i.e. K60B- Diabetes without catastrophic or server CC. If Z51.4 Preparatory care for subsequent treatment is used the DRG is Z63B - Other aftercare without catastrophic or severe CC. Some have used the comparison between using Z51.4 and Z49.0 Preparatory care for dialysis, as an argument to use the Z51.4 code. I don't think the DRG reflects the admission. Using Z49.0 gives a Renal DRG - L67C which reflects the admission.	**QCC Response:** The QCC recommend in this instance that the appropriate Diabetes code E1-.-- should be assigned.
1208-05	RSV bronchiolitis with NG feeding	Consider the following scenario: 28 day old admitted with RSV+ve Bronchiolitis. Notes on admission are of decreasing oral intake and worsening breathing. Patient receives treatment in PICU with subnasal Oxygen NG feeding. Queried clinician as to whether the NG feeding was for "feeding difficulty" to which the reply was: "NG feeding required due to decreased oral intake due to being unwell with possible contribution from feeding difficulty due to illness".	**QCC Interim response:** Code bronchiolitis as the Principal Diagnosis as this was the reason for admission. Please refer to advice in ACS 1605 (example 5) where feeding difficulties is not coded where bronchiolitis and feeding difficulties exist together. Additionally, the QCC noted a conflict in ACS 1607 which states *a neonate is a liveborn who is* less *than 28 days* yet the Australian Institute of Health and Welfare (AIHW) definition cited states *exactly 28* completed *days.*

Queensland Coding Committee December 2008 Coding Queries			
QCC ID	**Query Summary**	**Query**	**Meeting Response**
		Would the committee consider it correct to assign R63.3 Feeding difficulties and mismanagement (Feeding Problem NOS)?	The QCC will notify the NCCH of this.