

Queensland Coding Committee September 2007 Coding Queries

QCC_ID	Query Summary	Query	QCC Response
0907-03	Closed reduction of fracture of acetabulum	<p>The only code for closed reduction of fracture of acetabulum leads to an Open reduction with internal fixation - Block 1486.</p> <p>Are there any other acceptable codes for this procedure? For example, in instances where the reduction was definitely closed.</p>	<p><u>QCC Response:</u> QCC decision was to consult the NCCH regarding the index suggestion.</p> <p><u>Interim Response:</u> 90552-00 [1491] "other repair of hip: was considered the most appropriate code to utilise in the interim, however a query will be sent to NCCH.</p> <p><u>NCCH Query Sent:</u> The only code for reduction of fracture of acetabulum leads to an open reduction with internal fixation. Block 1486. Are there any other acceptable codes for this procedure? This reduction was definitely closed.</p> <p>The QCC provided an interim response advising Clinical Coders to assign 90552-00 [1491] "other repair of hip". This was considered the most appropriate code to utilise in the interim.</p> <p>The QCC seeks NCCH advice on how to code a closed reduction of acetabulum with internal fixation. There is an instructional note at 47498-00 [1479] - "excludes: that with reduction of fracture".</p> <p>There appears to be a typographical error also at this code, 47489.</p>
0907-05		<p>What codes should be assigned for cervical dysplasia and koilocytotic atypia? Should the code for papilloma virus be used additionally to the code for cervical dysplasia?</p>	<p><u>QCC Response:</u> The relationship between CIN, dysplasia & HPV needs to be further clarified to alleviate ambiguity.</p> <p>The QCC recommends that NCCH undertake a review of the CIN standard.</p> <p><u>NCCH Query:</u> A query was received asking the QCC what codes should be assigned for cervical dysplasia and koilocytotic atypia? Should the code for papilloma virus be used additionally to the code for cervical dysplasia?</p>

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QCC_ID	Query Summary	Query	QCC Response
			<p>The QCC provided an interim response recommending that the relationship between CIN, dysplasia & HPV needs to be further clarified in the standard to alleviate ambiguity.</p> <p>The QCC recommends to NCCH that a review of the CIN standard be undertaken.</p>
0907-06		<p>Please advise whether it is necessary to assign a code P07.1 for all preterm babies if the birth weight is less than 2500g.</p>	<p>QCC Response: Birthweight <2500 g should be coded in short gestation. QCC members will consult further re: code allocation for neonates who are admitted to hospital after the birth episode for feeding and fattening.</p> <p>NCCH Query: Please advise whether it is necessary to assign a code P07.1_ for all preterm babies if the birth weight is less than 2500g regardless of whether this is the birth episode or a subsequent episode.</p> <p>The QCC provided an interim response to Clinical Coders advising that birth weight <2500g should be coded in short gestation. QCC members will consult further regarding code allocation for neonates who are admitted to hospital after the birth episode for "feeding and fattening".</p> <p>The QCC seeks further advice from the NCCH to clarify whether the intent behind ACS 1618 requires that low birth weight should always be coded when present, in conjunction with prematurity in the birth and subsequent episodes of care.</p>
0907-07		<p>Please see NCCH Query 2004.</p> <p>NCCH has advised that the appropriate code to use for the scenario is Z47.9 'Orthopaedic follow-up care, followed by the condition requiring surgery codes. Could this advice be confirmed and written into ACS 2103? ACS discusses only the use of Z48.8 and it is not clear from the current standards and tabular list that Z47.9 is intended for follow up care following an orthopaedic procedure that involves simple postoperative convalescence (as one would have after any major operation).</p>	<p>QCC Response: QCC will clarify with the NCCH whether Z47.9 is follow-up after orthopaedic or follow-up care that involves orthopaedic surgery or care. Additionally, should Z48.8 be assigned in all cases where patients are being admitted to a hospital for postoperative care which excludes specific follow-up care for dressings etc.</p> <p>NCCH Query: Regarding scenario 1, the NCCH has advised that the appropriate code to use for the scenario is Z47.9 'Orthopaedic</p>

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		<p>Without knowledge of the database question it might be construed that it is meant for cases when the follow up care itself is of an orthopaedic nature.</p> <p>Both Z47.1 and Z47.8 seem to relate to orthopaedic devices, external fixation etc. It does not seem totally appropriate to use orthopaedic follow up care unspecified when it is known that the care given is rest , normal mobilisation and review for fitness to return home (any required carers and mobility aids in place etc).</p> <p>A similar situation could be when a patient has breast reduction surgery at one hospital and is transferred to another for convalescence before going home. Should Z48.8 be assigned (providing there is not attention to dressings/ sutures etc)? Z42 does not seem appropriate because the aftercare does not involve plastic surgery.</p> <p>If Z47.9 is confirmed as the correct code for care following an orthopaedic procedure, is Z47.9 also used when there are dressing changes/suture removal?</p>	<p>follow-up care, followed by the condition requiring surgery codes. Could this advice be confirmed and written into ACS 2103? ACS discusses only the use of Z48.8 and it is not clear from the current standards and tabular list that Z47.9 is intended for follow up care following an orthopaedic procedure that involves simple postoperative convalescence (as one would have after any major operation). Without knowledge of the database question it might be construed that it is meant for when the follow up care itself is of an orthopaedic nature.</p> <p>Both Z47.1 and Z47.8 seem to relate to orthopaedic devices, external fixation etc. It does not seem totally appropriate to use orthopaedic follow up care unspecified when it is known that the care given is rest and normal mobilisation and review for fitness to return home (any required carers and mobility aids in place etc).</p> <p>Scenario 2 is when a patient could have had breast reduction surgery at one hospital and is transferred to another for convalescence before going home. Should Z48.8 be assigned (providing there is not attention to dressings/ sutures etc)? Z42 does not seem appropriate because the aftercare does not involve plastic surgery.</p> <p>If Z47.9 is confirmed as the correct code for care following an orthopaedic procedure, is Z47.9 also used when there are dressing changes/suture removal?</p> <p>The QCC seeks further clarification from the NCCH.</p> <p>Referral is made to ACS 2103 - Admission for Convalescence/Aftercare.</p>

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1007-01	Chemotherapy via Port a Cath	<p>This query is in relation to coding of 96207-00 for chemotherapy via POC. Is it more appropriate to use 96204-00 or 96207-00?</p> <p>In the Standards (page 54) under Implantable Vascular Access/Implantable Vascular Infusion Device it gives the example of a Port a Cath. If you go to the Procedures Tabular Book and look up 96204-XX it excludes chemo via an Implantable Infusion Device. It tells you to go to 96207-XX.</p> <p>So if the Standard is saying POC is an implantable infusion device isn't 96207 correct?</p> <p>NCCH Query 2131 (2005) advises to use 96204 and said it was going to do an article in Coding Matters....the only one found was Vol 6 No 2 (1999).</p> <p>If coders should be using 96204-00 for Chemo via POC, when would they use 96207-00? Also if they are to code this way, what then is an example of an implantable device or pump. Coders suggest a Standard or Coding Matters article that is clear and concise, is required to clear up all the confusion.</p>	<p>Interim Response: The QCC recommends that hospitals continue with their current practice.</p> <p>A query will be sent to the NCCH regarding the Coding Matters article that was to be written regarding this issue</p> <p>In addition, the QCC members suggest to the NCCH that there be an index entry that includes "port-a-cath".</p> <p>Note from Convenor: This issue has been addressed in Sixth edition.</p>
1007-02	ACS 1505 - Single Spontaneous Vaginal Delivery	<p>There are some procedure codes that are acceptable for use with the code O80 Single Spontaneous Delivery such as ARM for augmentation, episiotomy (without other complications) and induction codes (for social intent).</p> <p>Please refer also to Query 0801-07, NCCH queries 115, 457, 1439, Coding Matters Vol 5 Number 1.</p> <p>The current wording in ACS 1505 is misleading, "O80 Single spontaneous delivery is intended for single spontaneous vaginal deliveries: without abnormality/complication classifiable elsewhere in Chapter 15 Pregnancy, childbirth and the puerperium and without manipulation or instrumentation."</p> <p>Can this standard please be reworded to reflect the procedure codes that are acceptable with code O80?</p>	<p>The QCC will contact the NCCH suggesting that the standard is reviewed and that procedures are allowed to be added to the standard. The QCC recommends that a caveat regarding the need for further investigation where procedures are utilised in conjunction with O80 Single Spontaneous Delivery to ensure that the O80 code is still appropriate.</p> <p>NCCH Query: Would it be possible for mention to be made in ACS 1505 of the procedures that may be permissible with O80 such as ARM for augmentation, episiotomy (without other complications) and induction codes (for social intent)?</p>

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1007-03	Internal fixation 'status'	<p>Please refer to ACS 2104 - Example 4.</p> <p>Please clarify whether it is appropriate to assign Z96.64 Presence of orthopaedic joint implants, when a patient is transferred for rehabilitation following a fractured NOF or other part of femur that has been treated with an internal fixation device.</p> <p>Sometimes these patients have an internal fixation of the bone rather than joint replacement. Coders understand that a prosthesis allows function (in the case of a hip prosthesis it is a replacement of parts allowing movement) whereas a bone fixation is purely structural (holds bone in place but in itself doesn't perform a function)</p> <p>Should ACS 2104 - Example 4 state:</p> <p>"Note: An additional code from Z96.6 Presence of orthopaedic joint implants may be assigned where it is known that an orthopaedic joint implant has been used in the treatment of the fracture."?</p>	<p>The QCC considers that the wording within ACS 2104- Example 4 is misleading and that the NCCH should be asked to reword the example within the standard.</p> <p>NCCH Query: The note in Example 4 in ACS 2104 Rehabilitation is confusing to coders. The QCC would like to suggest that the note is changed to:</p> <p>Note: An additional code from Z96.6 Presence of orthopaedic joint implants may be assigned where it is known that an orthopaedic joint implant has been used in the treatment of the fracture.</p>
1007-04	Necrotic appendix stuck to lateral pelvic wall	<p>In a scenario where admission was for an abdominal procedure and there was documentation that this was converted to open and "necrotic appendix stuck to lateral pelvic wall" was noted. There is no documentation of adhesions or division. Should diagnosis and/or procedure codes be assigned to capture documentation such as 'stuck' or 'adherent' in addition to the laparoscopic appendectomy?</p>	<p>The QCC members consider that "stuck" does not always mean "adhesion".</p> <p>Therefore, the coder should clarify with the clinician regarding whether the appendix had adhesions and whether the adhesions were then divided. If this is the case, this should then be documented in the record or on a clinician clarification form.</p>
1007-05	Cervicopexy and rectotomy	<p>Consider the scenario of a patient having a uterovaginal prolapse. They had repair of a rectocele and cystocele, cervicopexy and rectotomy.</p> <p>What code should be used for rectotomy in this setting and what code should be used for cervicopexy?</p>	<p>The QCC recommends that the enquirer clarify with clinician whether the rectotomy and the cervicopexy would be considered components of the procedure.</p> <p>The QCC will ask the NCCH for a new procedure for cervicopexy. Members of the QCC also indicated that there were issues with coding perineorrhaphy and graft of the vagina. The QCC will also ask for new codes to be created for these procedures. This has been completed.</p>
1007-06	Uncontrolled BSLs & Type 1 DM with ketoacidosis	<p>When coding type 1 diabetes with ketoacidosis and there is documentation of uncontrolled diabetes or uncontrolled BSLs, should a code for diabetes with poor control be used in addition</p>	<p>The QCC recommends that both the type 1 diabetes with ketoacidosis and the uncontrolled component should be coded where documented.</p>

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QCC_ID	Query summary	Query	Member Response
		to the ketoacidosis code?	

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QCC_ID	Query summary	Query	Member's response
1107-01	Pressure Ulcer	<p>Please refer to NCCH Query ID: 2128</p> <p>A local decision was made in 2003 to code pressure ulcer when documented by nursing staff, usually by means of a pressure ulcer sticker with the grade indicated. However, coding pressure ulcer can result in the episode grouping to a higher DRG. The question has been raised as to whether, in a Casemix funded environment, hospitals would be penalised for over-coding if pressure ulcer is coded solely on the basis of nursing documentation. Tucked away in the introduction to ACS under the heading "How to use this document" is the following definition: "The term 'clinician' is used throughout the document [i.e. ACS] and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."</p> <p>(1) Coders believe that so crucial a definition of the term 'clinician' should actually be a standard in its own right. Would the QCC please ask the NCCH to consider this?</p> <p>(2) What is the opinion of QCC members with regard to coding pressure ulcer (assuming it meets the definition of additional diagnosis) based on nursing documentation alone? Is it justifiable under the ACS definition of 'clinician' quoted above?</p>	<p>Meeting Response:</p> <p>QCC Members agreed that skin integrity would be considered an area of nursing specialty and where issues pertaining to skin integrity are documented in the nursing notes, and the issue fulfils the requirement of ACS 0002, then the condition should be coded.</p> <p>It is intended that members of Statistical and Library Services (SLSC) will print this information pertaining to the definition of "clinician" in the next Codefile and will also create an article for Coders Insite.</p>
1107-02	Allergic Reaction (eye swelling) due to eating peanut butter	<p>What is the external cause code for food (eg peanut butter)?</p> <p>There are no external cause index entries for allergy - food or reaction - food. The table for drugs and chemicals has accidental poisoning X49 for food, foodstuffs, noxious, nonbacterial, NEC. X49 Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances has a list of includes notes but food NEC is not listed. Poisonous foodstuffs and poisonous plants are listed but there is no guidance as to whether this relates only to those generally considered poisonous to most of the population. Does this category include food that is poisonous / noxious only to certain people?</p>	<p>Meeting Response:</p> <p>QCC Members recommended that there should be codes for food allergy reaction.</p> <p>However, in the interim, where anaphylactic shock due to ingestion of food is documented, assign the following codes: T78.0 'Anaphylactic shock due to adverse food reaction' Y57.9 'Drug or medicament, unspecified' with appropriate place of occurrence code.</p> <p>A request for a new index entry for Allergy to food will be re-iterated:</p> <p>Exposure</p> <ul style="list-style-type: none"> - foodstuffs - Reaction

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		<p>3M Codefinder has a pathway option for food when coding allergic reactions and assigns X49.</p> <p>NCCH provides guidance when coding anaphylactic reaction to food in queries 732, 2118 and Coding Matters Volume 4 No 1 (July 1997). They advise external cause code Y57.9 Drug or medicament, unspecified for anaphylactic reaction to food. The external cause index has Anaphylactic shock, anaphylaxis (see also Table of drugs and chemicals) Y57.9.</p> <p>Should the coder follow this instruction and go to the table for food, foodstuffs, noxious, nonbacterial, NEC or the NCCH Coding Matters advice to use Y57.9?</p>	<ul style="list-style-type: none"> - - Allergic - - - food <p>The Codefinder Support Officer will put in a query to 3M regarding the code allocation in Codefinder.</p> <p>NCCH Query sent.</p>
1107-03	Pleural Effusion with CHF and pneumonia	<p>Consider the scenario where a patient presents with and is treated for CHF and pneumonia. Pleural Effusion was documented on the discharge summary as an Other Diagnosis but no drainage performed.</p> <p>Coding Matters Volume 7 Number 3 notes in the last paragraph on Congestive heart failure that it is not necessary to code pleural effusion unless specific treatment (eg drainage) is required.</p> <p>Does this advice apply to all diagnoses of Pleural Effusion or just Pleural Effusions with CHF?</p> <p>Can this information be incorporated into 10-AM Commandments or ACS?</p>	<p>Meeting Response: QCC members recommended that where a pleural effusion is only documented in radiology findings and no other supporting documentation is found; that it should not be coded unless clinical clarification is sought.</p> <p>Where pleural effusion is documented, the patient does not have CCF and the pleural effusion meets the criteria of ACS 0002, the committee recommends that the condition is coded.</p> <p>Where pleural effusion is caused by CCF it is not necessary to code the effusion unless specific treatment is required (please see Coding Matters Volume 7 number 3).</p>
1107-04	Place of Occurrence directive from NCCH workshop	<p>At a coding workshop, coders were directed by the NCCH to use the POO code Y92.22 Health Service Area for all external causes due to medical/surgical care and that this included prescription medications.</p> <p>Coders fully understand & agree with the logic of using Y92.22 for med/surg care irrespective of where the manifestation occurs. But coders are having difficulty applying this to prescription meds when the POO is actually not within a health</p>	<p>Meeting Response: The QCC recommends that where an adverse affect to a medication occurs that the external cause code should be Y92.22.</p> <p>However, in cases of overdoses or poisoning, the QCC recommends that the place of occurrence should be the location where the overdose or poisoning occurred.</p>

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		<p>service facility.</p> <p>For example: T2DM on insulin who has a hypoglycaemic episode at home. Patient had given themselves morning dose of insulin then did not eat lunch. Patient OD'd on own medication (either accidentally or purposely), not within a health service area.</p> <p>In these instances having an accurate POO code is important.</p> <p>Also if all such incidents are coded to Health service facility it will give a false impression of the quality of care of health care facilities.</p>	
1107-05	Index enhancement – Follow-up	<p>Coders would like to request a Volume 2 index enhancement at "Follow-up".</p> <p>Currently the index entry "Follow-up" states – "see Aftercare" which is misleading to coders when trying to code Z08 or Z09 Follow-up examinations after treatment. The Z08 or Z09 codes are currently reached through "Examination, follow-up" only.</p> <p>Please review the index entry "Follow-up" for future editions to include a pathway for these Z08 and Z09 codes. Thanks.</p>	<p>Meeting Response: The QCC agrees with this request and will send an index enhancement suggestion to the NCCH.</p> <p>NCCH Query: We would like to request a Volume 2 index enhancement at "Follow-up".</p> <p>Currently the index entry "Follow-up" states – "see Aftercare" which is misleading to coders when trying to code Z08 or Z09 Follow-up examinations after treatment.</p> <p>The Z08 or Z09 codes are currently reached through "Examination, follow-up" only.</p> <p>Please review the index entry "Follow-up" for future editions to include a pathway for these Z08 and Z09 codes.</p>
1107-06	Coding Matters FAQ vs PICQ	<p>PICQ has the following fatal error: Indicator No. Type Degree 101385 2 A This indicator identifies records containing a first or second degree obstetric perineal laceration/tear code without an obstetric suture/repair of first or second degree laceration/tear procedure code or an episiotomy code or other suture of current obstetric laceration without perineal involvement code, and the patient was not transferred, left against medical advice or died.</p>	<p>Meeting Response: The QCC will contact the NCCH to recommend a revision of Indicator no 101385 in light of the recommendation in Coding Matters Vol 13 no 2.</p> <p>NCCH Query: PICQ has the following fatal error: Indicator No. Type Degree 101385 2 A</p>

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		<p>ACS 1551 'Obstetric perineal lacerations/grazes' states that only obstetric perineal grazes and lacerations that are repaired need to be coded.</p> <p>The disease and procedure classifications are not perfectly aligned for the classification of non-perineal labial/vulval obstetric tears, as the condition is classified as a '1st or 2nd degree perineal laceration' but the repair procedure is classified as 'without perineal involvement'.</p> <p>Yet in Coding Matters Vol 13 No. 2 under FAQ Obstetrics the question is: Q. If a patient chooses not to have a perineal tear repaired, should a disease code still be assigned? A. An appropriate code from O70.- Perineal laceration during delivery should be assigned together with Z53.2 Procedure not carried out because of patients decision for other and unspecified reason.</p> <p>Is this coding matters advice correct and coders should ignore the PICQ or vice versa?</p>	<p>This indicator identifies records containing a first or second degree obstetric perineal laceration/tear code without an obstetric suture/repair of first or second degree laceration/tear procedure code or an episiotomy code or other suture of current obstetric laceration without perineal involvement code, and the patient was not transferred, left against medical advice or died.</p> <p>ACS 1551 'Obstetric perineal lacerations/grazes' states that only obstetric perineal grazes and lacerations that are repaired need to be coded. The disease and procedure classifications are not perfectly aligned for the classification of non-perineal labial/vulval obstetric tears, as the condition is classified as a '1st or 2nd degree perineal laceration' but the repair procedure is classified as 'without perineal involvement'.</p> <p>Yet in Coding Matters Vol 13 No. 2 under FAQ Obstetrics the questions is:</p> <p>Q. If a patient chooses not to have a perineal tear repaired, should a disease code still be assigned? A. An appropriate code from O70.- Perineal laceration during delivery should be assigned together with Z53.2 Procedure not carried out because of patients decision for other and unspecified reason.</p> <p>AS a result of this advice, coders are receiving fatal PICQ edits when they are following Coding Matters advice. Would it be possible to update PICQ with this new advice?</p>
1107-07	Ventilation Acquired Pneumonia	<p>Can you please advise the appropriate way to code VAP – Ventilation Acquired Pneumonia?</p> <p>MD Consult description – 'VAP is pneumonia that arises more than 48-72h after endotracheal intubation.'</p> <p>Suggestion 1 – Look up via complication, ventilation T81.8 + J18.x etc</p> <p>Suggestion 2 – Look up via pneumonia, resulting from a procedure J95.8 + J18.x etc</p>	<p>Meeting Response: Information received from clinician: VAP ventilator associated pneumonia is a hot topic; it is the leading cause of nosocomial morbidity in ICU. Essentially it is a nosocomial pneumonia occurring after intubation/ventilation.</p> <p>It is defined as a new pneumonia diagnosed after 72 hrs of initiation of ventilation, and is diagnosed clinically usually; the gold standard of bronchoscopy or biopsy is rarely used.</p> <p>There are some clinical scores (CPIS) which can be used for research purposes.</p>

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			<p>The mechanism is a combination of micro-aspiration, failure to cough and debility.</p> <p>The QCC will send a query to the NCCH incorporating this information and asking the NCCH how it would be best to code VAP.</p> <p>Interim Response: Other complication of medical and surgical care T81.8 + J18.9 + Y84.8 + Y92.22</p> <p>Secretariat Note (02/06/2009): Coding Matters 15 Number 3 provides the following response over-riding the Interim QCC response: <u>Ventilator associated pneumonia</u> What is the correct code to assign for ventilator associated pneumonia?</p> <p>Ventilator associated pneumonia (VAP) is a hospital acquired bacterial pneumonia in patients who are on mechanical ventilatory support through an endotracheal tube or tracheostomy tube for at least 48 hours.</p> <p>Pneumonia occurs as a result of microbial invasion of the normally sterile lower respiratory tract, often where there is a defect in host defences and/or a virulent or overwhelming invasion of organisms.</p> <p>Contaminates may also enter the patient's lungs from condensation on the intubation drainage tubing or because intubation itself bypasses the natural barrier between oropharynx and trachea. Bronchoscopy, tracheal suctioning, manual ventilation, the supine position of the patient and the use of paralytic agents may also play a role in the development of bacterial pneumonia in these patients.</p> <p>VAP complicates the course of up to 47% of intubated patients and may have a mortality rate as high as 50%.</p> <p>Following the guidelines in ACS 1904 <i>Procedural</i></p>

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			<p><i>complications</i> the correct code to assign for ventilator associated pneumonia (VAP) is J95.8 <i>Other postprocedural respiratory disorders</i> following the pathway: Pneumonia - postprocedural J95.8</p> <p>Assign also an additional code for the type of pneumonia from the choices listed under the lead term Pneumonia, plus the following external cause codes: Y84.8 <i>Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure, Other medical procedures</i> Y92.22 <i>Health service area</i></p>

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1207-01	Decompensation CHF secondary to pneumonia in a patient with severe RHD	<p>Should the CHF be coded as the PD and if so, which code should be used I50.0 or I08.3, or should pneumonia be the PD?</p> <p>Failure, Failed -heart (acute) (sudden) --with ---decompensation (see also Failure, heart congestive) --congestive I50.0 or --rheumatic (chronic) (inactive) -see condition, by valve, rheumatic i.e. I08.3 as documentation of MR, AR and TR</p> <p>If this code is used should I50.0 be coded additionally?</p>	<p>QCC Committee members felt that in this scenario that I50.0 – <i>Congestive Cardiac Failure</i> should be the principal diagnosis.</p> <p>Committee members also felt that I08.3 – <i>Combined disorders of mitral, aortic and tricuspid valves</i> + J90 - <i>Pleural effusion, NEC</i> + Z91.1 – <i>Personal history of non-compliance with medical treatment and regimen</i> should be coded as well.</p>
1207-02	Pelvic peritonitis secondary to PID - gonorrhoea	<p>What would be the correct codes and sequencing for 'Pelvic peritonitis secondary to PID – gonorrhoea'?</p> <p>The different index entries (as below) have caused confusion amongst coders. Option 1 Peritonitis - pelvic - - female N73.5; and Gonorrhoea -pelvis -- female pelvic inflammatory disease A54.2+ N74.3*</p> <p>OR Option 2 Gonorrhoea -pelvis -- female pelvic inflammatory disease A54.2+ N74.3* or -specified site not listed (see also Gonococcus) A54.8 Gonococcus, gonococcal - pelviperitonitis A54.2+ N74.3*</p> <p>There is also an excludes note for gonococcal pelviperitonitis at A54.8</p> <p>Other gonococcal infections following the pathway:</p>	<p>QCC Response: QCC Committee members agree that the correct code allocation for 'Pelvic peritonitis secondary to PID – gonorrhoea' is: A54.2 – <i>Gonococcal pelviperitonitis and other gonococcal genitourinary infections</i> + N74.3* - <i>Female gonococcal pelvic inflammatory disease</i></p> <p>Committee members liked the suggested enhancement and will forward it to the NCCH.</p> <p>NCCH Query Sent: Thank you for considering our query and suggested enhancement. The QCC has received a query about the correct coding for 'Pelvic peritonitis secondary to PID – gonorrhoea'?</p> <p>The different index entries (as below) have caused confusion amongst coders.</p> <p>Option 1 Peritonitis - pelvic - - female N73.5; and Gonorrhoea</p>

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		<p>Peritonitis -gonococcal A54.8+ K67.1* A54.8 excludes gonococcal pelviperitonitis (A54.2)</p> <p>A suggested enhancement to the index is: Peritonitis (adhesive)(fibrinous)(with effusion) K65.9 -gonococcal A54.8+ K67.1* -- pelvic A54.2+ N74.3*</p>	<p>-pelvis -- female pelvic inflammatory disease A54.2+ N74.3*</p> <p>OR</p> <p>Option 2 Gonorrhoea -pelvis -- female pelvic inflammatory disease A54.2+ N74.3* or -specified site not listed (see also Gonococcus) A54.8 Gonococcus, gonococcal - pelviperitonitis A54.2+ N74.3*</p> <p>There is also an excludes note for gonococcal pelviperitonitis at A54.8</p> <p>Other gonococcal infections following the pathway: Peritonitis -gonococcal A54.8+ K67.1* A54.8 excludes gonococcal pelviperitonitis (A54.2)</p> <p>A suggested enhancement to the index is: Peritonitis (adhesive)(fibrinous)(with effusion) K65.9 -gonococcal A54.8+ K67.1* -- pelvic A54.2+ N74.3*</p> <p><u>NCCH Response:</u> The correct code assignment for pelvic peritonitis secondary to pelvic inflammatory disease - gonorrhoea is:</p> <p>A54.2† Gonococcal pelviperitonitis and other gonococcal genitourinary infections N74.3* Female gonococcal pelvic inflammatory disease</p> <p>By following the index pathway:</p> <p>Gonorrhoea -pelvis (acute) (chronic) - - female pelvic inflammatory disease A54.2† N74.3*</p>

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QCC_ID	Query summary	Query	Meeting Response
			The indexing of the above condition will be reviewed for a future edition of ICD-10-AM.
1207-03	Obstetric Condition	<p>Consider the scenario where a patient has had an IOL because of hypohomocystinaemia and mthfr which is explained by clotting disorder which incurs clots on the placenta and in the past has been the cause of frequent miscarriages.</p> <p>Currently coders are using 043.8 but feel there is a better code?</p>	<p>QCC Committee members recommend the use of the following codes, as hypohomocystinaemia is an endocrine disorder:</p> <p>O99.2 - Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium E72.1 - Disorders of sulfur-bearing amino-acid metabolism Z35.2 – Supervision of pregnancy with other poor reproductive or obstetric history</p>