

QCC_ID	Query summary	Query	Decision	Response from NCCH
0205-01	Patient admitted for cystogram admission1 and self catheterization admission2	Could you please help us with the coding of these admissions Admission1 Patient admitted to Obstetrics Unit for a same day cystogram and trial of void post caesarian section (which had been complicated by a bladder perforation). Cystogram discovered there was no leakage from the repaired bladder but there were high residuals in bladder. IDC was removed prior to Cystogram and reinserted after Cystogram. Admission2 Patient has now been admitted to the Obstetrics Unit for training in self catheterization for high residuals	If the intent of admission 1 is to assess that the bladder has repaired itself assign the following codes PD Z09.0 Z46.6 O99.8 N99.8 R33 Y83.8 Y92.22 Z39.01 92119-00 36800-00 If the intent of the admission is for trial of void then assign the following codes PD Z46.6 Z09.0 O99.8 N99.8 R33 Y83.8 Y92.22 Z39.01 92119-00 36800-00 On the information provided for admission 2 the following codes should be assigned PD Z46.6 Z39.01 If the high residuals are documented assign R39.1 If high residuals is not documented then assign R33	
0205-02	# metacarpal and lacerator extensor muscle	16 year old boy fractured his shaft of 1st metacarpal and lacerated extensor muscles at that site with a power tool. The repair of the fracture was done by suture (see operation notes) Would this be coded as: -Repair of bone ( as it was suture and there was no mention of ORIF) -ORIF of MC (as technically it was reduced and internal fixation was sutures) or -Open reduction of fracture of MC?	From the information provided the committee agreed that consultation with the clinician is required to determine if the fracture repair is a repair by suture of bone or ORIF or open	
0205-03	Fluoroscopic guidance for epidural catheter	Should we be coding the fluoroscopic component for the insertion of an epidural catheter for pain management episodes where a contrast medium has been used or there is notation of 'image intensifier guidance'	The QCC could not reach a decision and decided to forward the query to the NCCH.	The NCCH supports the assignment of a code for 'fluoroscopy' as this procedure is not always performed with insertion of an epidural catheter. Assign:60506-00 [1999] 'Fluoroscopy in conjunction with surgical procedure' Note: the code title of 60506-00 [1999] will be amended in a future edition of ACHI to delete the term 'surgical'.
0305-05	Radiotherapy	Scenario: A patient is an inpatient at one hospital and goes to another facility to have palliative radiotherapy as an outpatient then returns to the original hospital on the same day. Should the radiotherapy be coded by the hospital where that patient was originally admitted. Note ACS 0016 All significant procedures undertaken from the time of admission to the time of separation should be coded. This includes diagnostic and therapeutic procedures. But is this relevant if the procedure is not performed on site and does not consume hospital resources?. Alternative view is that there may have been pre/post nursing care based around the radiotherapy treatment.	M. Snell consulted with hospitals in other states and territories and New Zealand. As the comments received were not consistent, M. Snell will discuss this at the April CSAC meeting and report outcomes to the QCC.. 1/6/06: This query has been taken to the Admitted/Non-Admitted National Working Party as an example.	

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0305-14	Subcapital, trochanteric fracture of femur	<p>PICQ indicator 101972 identifies records containing a fracture of the proximal femur with a reduction and internal fixation code but not the internal fixation of fracture of trochanteric or subcapital (proximal) femur code. When looking up the index for 'Fracture, proximal, femur' in the Alphabetic Index of Diseases, there is no specific index entry or essential modifier for 'proximal' fracture of femur. However when you look up 'Reduction, fracture, with internal fixation' there are index entries for 'proximal', 'subcapital' and 'trochanteric'. Reduction - fracture - - femur - - - with internal fixation - - - - neck 47519-00 [1479] - - - - proximal 47519-00 [1479] - - - - subcapital 47519-00 [1479] - - - - trochanteric 47519-00 [1479] For consistency between the Alphabetic Index of Procedures and the Alphabetic Index of Diseases could a nonessential modifier be included after subcapital for 'proximal' or a new index entry added under 'Fracture' for a 'proximal' fracture of femur?</p>	<p>The committee decided to forward the query to the NCCH for consistency between the Alphabetic Index of Procedures and the Alphabetic Index of Diseases. The QCC would like to suggest a nonessential modifier be included after subcapital for 'proximal' or a new index entry added under 'Fracture' for a 'proximal' fracture of femur.</p>	<p>INITIAL RESPONSE 02/06/2005 47519-00 [1479] 'Internal fixation of fracture of trochanteric or subcapital femur' is assigned for reduction and internal fixation of fractures of the neck of femur and pertrochanteric fractures (Codes in the range S72.0 - S72.11). These fractures may also be described as 'proximal' as they are anatomically closer to the body (trunk) than fractures of the subtrochanteric, shaft or lower end (distal) femur. 'Proximal' is too broad a term for the classification of fractures of the femur in ICD-10-AM Tabular List of Diseases. These fractures should be classified by following the index pathway 'Fracture, femur' and assigning a code for the specific site. SUBSEQUENT RESPONSE 10/03/2006 47519-00 [1479] 'Internal fixation of fracture of trochanteric or subcapital femur' is assigned for reduction and internal fixation of fractures of the neck of femur, pertrochanteric and subtrochanteric fractures (Codes in the range S72.0 - S72.2). These fractures may also be described as 'proximal' as they are anatomically closer to the body (trunk) than fractures of the shaft or lower end (distal) femur. National Centre for Classification in Health ICD-10-AM QUERY RESPONSE 'Proximal' is too broad a term for the classification of fractures of the femur in ICD-10-AM Tabular List of Diseases. These fractures should be classified by following the index pathway 'Fracture, femur' and assigning a code for the specific site.</p>
0305-03	Automated Auditory brainstem response	<p>It is now the practice at our hospital for newborns to undergo Automated Auditory Brainstem Response (AABR) which will measure the auditory systems response to sound to detect permanent hearing impairment. What would the best code be to represent AABR is it Z01.1 Examination of ears or hearing Or 11300-00 [1839] Brain stem evoked response audiometry</p>	<p>DSU advised that 11300-00 has been added to the edit which lists procedures acceptable with Z38.- Acceptable procedure on unqualified newborns. DSU agreed to confirm phototherapy was included in the acceptable procedures for unqualified newborns.</p>	
0305-13	Pneumonia with a history of AF	<p>If a patient is admitted with pneumonia, has a history of AF documented, and an ECG finding of AF is documented in the notes, should the AF be coded as an additional diagnosis if there is no other reference to this. Note ACS 0907 states</p>	<p>QCC members agreed that ECG would commonly be carried out in the scenario described, and that AF should not be coded unless treated.</p>	

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		ECG findings should only be coded if clinically significant, but would an ECG normally be performed for a patient with pneumonia and if not does this meet the criteria of diagnostic procedures or increased monitoring, bearing in mind that diabetes is coded if BSLs are documented		
0305-12	Acute renal impairment with diabetes	When coding diabetes with acute renal impairment on chronic renal failure (or impairment) what are the correct codes and the correct sequence? E11.29 N17.9 E11.23 N18.0 (N18.91) Or E11.23 N17.9 N18.0 (N18.91)	QCC agreed that the correct codes in this case are as per the index i.e.: E11.29 N17.9 E11.23 N18.0 (N18.91)	
0305-11	contrast radiography	Should radiography involving enemas or swallowed contrast, such as barium enema or gastrografin swallow be routinely coded when performed?	M. Snell agreed to discuss standardisation of data with S. Cornes. QCC discussions indicate that consistency between hospitals appears to be minimal.	
0305-10	IHD	When a patient presents with angina and has IHD listed as a history, should both be coded or is IHD only coded if specifically noted as a current problem? Note ACS 0940 Patients documented as having the current conditions on both ischaemic heart disease and angina can have both I25.9 Chronic ischaemic heart disease, unspecified and I20.9 Angina pectoris, unspecified assigned. Is there specific relevance placed on the term 'current' for IHD. Scenario: A patient presents with angina and has documented as a history IHD-old MI and or CABG. Are the correct codes I20.9, I25.9, I25.2 (and/or Z95.1) Or I20.9, I25.2 (and or Z95.1) Notes ACS 0940 in relation to IHD. The code should be used as a last resort. If ischaemic heart disease (IHD) is documented as a problem in the current episode of care, and there have been no interventions such as CABGs or PTCAs with or without insertion of stent, then it is acceptable to code the specificity of the disease (ie coronary atherosclerosis, I25.1) as documented in an earlier angiogram report, when available. However, where IHD is documented as a problem but there has been intervention, it is possible to assign both I25.1 Atherosclerotic heart disease and Z95.1 Presence of aortocoronary bypass graft or A95.5 Presence of coronary angioplasty implant and graft if there is sufficient detail about the condition of both the previously treated grafts and the	There was some confusion among QCC members regarding this query. The majority of members agreed that IHD needs to meet the additional diagnosis standard before it can be coded. Discussion centred around I25.2 providing more specificity and not requiring I25.9. DSU agreed to run frequencies for episodes where I25.2 and I25.9 exist together. M. Snell agreed to raise the use of I25.2 and I25.9 at CSAC.	

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		<p>native vessels. If the detail is not available but the IHD is still stated to be a problem, I25.9 Chronic ischaemic heart disease, unspecified and Z95.1 Presence of aortocoronary bypass graft may be both assigned. Does the last resort sentence apply only in relation to IHD vs CAD? Is the concept of history of IHD encompassed in I25.2 and Z95.1 or should it be coded separately? Again does where IHD is documented as problem apply to current or can this be applied when IHD is listed as a history when it is relevant to the admission?</p>		
0305-09	Multiple heart valves	<p>1. When coding reported diseases that are picked up via an echocardiograph, where the disease is described as mild (such as mild valve regurgitation), would the mild condition be considered clinically significant? 2. When coding reported diseases that have a combination of terms describing the disease (such as severe mitral valve regurgitation and mild aortic regurgitation) should we be coding the conditions in a combination code such as I08.0 Disorders of both mitral valve and aortic valves or should we just code the condition with the severe term?</p>	<p>1. The QCC members agreed that conditions documented as 'mild' are not considered clinically significant as directed by ACS 0907 and should not be coded. Where as conditions documented as 'moderate' or 'severe' are clinically significant and should be coded. 2. The QCC could not reach a decision regarding whether these conditions should be assigned one code if one or both of these conditions are documented as mild and the other as moderate or severe. Members agreed to forward both parts of the query to the NCCH</p>	<p>1. ACS 0907 ECHOCARDIOGRAPHY REPORTS states that 'Findings of this investigation should only be coded if the abnormalities are clinically significant.' This standard was first published in ICD-9-CM and was relevant for ICD-10-AM First Edition when 'clinical evaluation' was part of the definition for an additional diagnosis. However this term was deleted with changes to ACS 0002 ADDITIONAL DIAGNOSES for ICD-10-AM Second Edition. Clinical coders should follow ACS 0002 ADDITIONAL DIAGNOSES and ACS 0010 GENERAL ABSTRACTION GUIDELINES for the assignment of codes for diagnoses found on test results, therefore making ACS 0907 obsolete. ACS 0907 will be deleted from the Australian Coding Standards Fifth Edition. 2. Clinical advice states the following: "Yes it is clinically important to capture both conditions" (Lord R, personal communication, 4 May 2005). "Need to capture both and not just the more severe" (Quinn J, personal communication, 4 May 2005). Therefore, the NCCH supports the assignment of codes to capture all of the relevant conditions in the scenario cited, regardless of severity.</p>
0305-08	MI and CABG	<p>Scenario: A patient is admitted to tertiary hospital with an MI. Angiogram is performed on day 3 and shows CAD. The patient continues to recover and is transferred to another tertiary hospital on day 5 to have a CABG performed. There was no deterioration in condition. Should the PD at the second hospital be MI or CAD (with MI coded as an additional</p>	<p>QCC members agreed that MI should be coded as PD as per ACS 0940</p>	

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		diagnosis) Is this similar to the angina/CAD sequencing decision, or not really because the angina will still be likely to recur and this decision was based around angiograms which are diagnostic? The logic of assigning CAD as the PD in this case would that the CABG performed for the CAD and can have no effect on the MI that has just occurred. Are NCCH ?1256, 1532 relevant?. Similarly to the logic in 1532 a patient with MI may never have a CABG, but those found to have significant and operable CAD do.		
0305-06	CMV infection	Scenario. Patient had a heart transplant in 1997 which was complicated by CMV infection. The patient now has severe transplant vasculopathy secondary to this. Should this be coded as rejection with CMV coded as current (does it lie dormant with the possibility of flare up) or a sequelae?	In the scenario cited, the QCC agree that the rejection code should be coded. Members discussed the possibility of the Codefinder pathway assigning the rejection code in cases where it may not be appropriate to do so (ie sequelae). DSU will notify M Vidgen.	
0305-04	ventricular fibrillation	Should ventricular fibrillation be coded when coming off ( or soon after) cardio pulmonary bypass if DC is given. While this may be expected potential effect, not all patients have it and if it occurs, intervention is required. Note NCCH ?1759 scenario 2. Pending whether it is determined that VF should be coded, should the decision not to code the DC be reconsidered?	QCC members agreed that if VF occurs intra operatively, while coming off bypass, or before the patient has left the OT then it should not be coded	
0305-02	Closed Reduction internal fixation vs open reduction internal	I refer to NCCH query 1367 where a patient has a closed reduction with open fixation via a small incision. Can the descriptor 'mini-open' in association with a closed reduction be applied to the scenario described in this query; in which case it can be coded as CRIF? Do we need documentation that the incision is specifically distal to the fracture site in order to assign a code for CRIF?	QCC agreed that it is appropriate to code CRIF in the scenario described in this query	
0305-07	Pseudomonas bacteraemia	What is the correct code/s for pseudomonas bacteraemia A49.8 or A49.8 and B96.5? Scenario: Patient is paraplegic and diagnosed with a UTI 2 weeks ago. They have a PICC line and are on antibiotics. They are suffering from chills and a focus of infection is investigated. Klebsiella bacteraemia is diagnosed. Does the presence of symptoms - chills allow this to be coded as pseudomonas bacteraemia?	In the scenario described, QCC members agreed that without clinical confirmation of sepsis, and irrespective of other conditions, A49.8 only should be coded. The B96.5 code is to be used only where the site is specified. In the case described the site is unspecified.	
0305-01	Abbreviation of CA	Could the committee please advise the correct interpretation	The QCC consulted with Oncology clinicians and the	The following information may be found in the Alphabetic

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		<p>of the abbreviation 'CA', in the absence of any other defining documentation within a medical record. Should coders interpret this as meaning cancer or carcinoma. This issue impacts both on morphology code assignment and cancer registration.</p>	<p>clinicians advise that 'ca' can mean cancer or carcinoma, and reviewed the Australian Dictionary of Clinical Abbreviations, acronyms and symbols and 'ca' can mean cancer or carcinoma also. In the Merriam Webster medical dictionary 'ca' can also mean cancer or carcinoma Further consultation has occurred with the Queensland Cancer Registry and QUT in relation to the meaning of 'ca' and it is not clear to as to whether 'ca' should be coded to carcinoma (M8010/3) as opposed to cancer (M8000/3).suggested that in cases where histology report is not available and clarification cannot be obtained from the clinician, cancer (M8000/3) should be coded as a default. However, from documentation that exists within the classification this direction is not clear. This query will be forwarded to NCCH for direction and consistency.</p>	<p>Index of Diseases under the lead term 'Cancer': Note: The term 'cancer', when modified by an adjective or adjectival phrase indicating a morphological type, should be coded in the same manner as 'carcinoma' with that adjective or phrase. Thus, 'squamous cell cancer' should be coded in the same manner as 'squamous cell carcinoma', which appears in the list under 'Carcinoma'. Therefore, if the term 'cancer' is preceded by a term other than a morphological descriptor, assign the morphology code M8000/3. Inconsistencies in classification examples in the Australian Coding Standards will be amended for ACS Fifth Edition.</p>
0405-06	Index entries	<p>I cant seem to find an index entry in the table of drugs and chemicals that directs me to these codes: Y46.3 Deoxybarbiturates or Y59.2 Protozoal vaccines Deoxybarbiturates and thiobarbiturates are both listed as exclusions for code Y47.0 Barbiturates, not elsewhere classified. However there is an index entry in the table of drugs and chemicals for thiobarbiturate anaesthetic. All vaccines in blocks Y58 and Y59 are listed individually except for protozoal vaccines. Could we suggest an indexing change.</p>	<p>The committee agreed that these two drugs cannot be found by looking them up in the index and would like index entries created.</p>	<p>The NCCH recognises the need for amendments to this section of the Australian Classification of Health Interventions (ACHI). Amendments will be considered for a future edition of ACHI for 'patella resurfacing' and other orthopaedic procedures. In the interim, clinical advice indicates the following: 1. "the only item to cover the first patient is a revision" (Courtenay B personal communication 27 May 2005). The NCCH advises following the index pathway: Revision - joint replacement - - knee, total 49527-00 [1524] 'Revision of total arthroplasty of knee' 2. "The second patient depends if this was a primary procedure or a revision of a previous procedure... (if a redo)... it is the same as with the first patient. If it is a primary then it is 49534" (Courtenay B personal communication 27 May 2005).. Clarification should be sought from the surgeon to determine whether a primary or revision procedure has been performed. For a primary procedure, assign: 49534-00 [1519] 'Total replacement arthroplasty of patellofemoral joint of knee' For a revision procedure, assign: 49527-00 [1524] 'Revision of total arthroplasty of knee' With reference to</p>

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				the following procedures: - Partial revision of a total arthroplasty - Partial revision of a partial arthroplasty - Total revision of a total arthroplasty - Total revision of a partial arthroplasty ACHI does not differentiate between a 'partial' or 'total' revision. For 'revision of a total arthroplasty' of the knee, assign: 49527-00 [1524] 'Revision of total arthroplasty of knee' For 'revision of partial arthroplasty' of the knee, assign: 49517-00 [1518] 'Hemiarthroplasty of knee'
0405-03	EPS with Ablation	Our Cardiac Catheter Laboratory (CCL) queries our inability to use procedure codes from block [601] Destruction procedures on the Atrium and [609] Destruction procedures on the ventricle when performing Electrophysiology Study with radiofrequency ablation as 38212-01[665] does not reflect the complexity of the procedure nor adequately describes the procedures performed. (The HIC support the use of CMBS 38287, 38290,32893 (maps to 3851800[609] )by the Cardiologists performing these procedures in CCL NCCH # 257 directs us not to use [60] as they refer to open procedures - but was listed in 1998 (1st edition) and there has been progression in the methods used at the the time. NCCH # 1823 Maze Procedure describes the ablation procedures performed in the CCL. There is currently no procedure code for EPS with cryotherapy or microwave ablation- do we default to EPS with radiofrequency ablation? Are Cardiac Catheterisation, Venogram, Fluroscopy and or Pulmonary vein isolation considered components of the ablation or is it necessary to code the individual components when they are documented.	The committee agreed that the operation report would be required to determine the most appropriate code for electrophysiology studies with radiofrequency ablation. The query will be forwarded to the NCCH for advice in relation to a code for EPS with ablation performed in a Cardiac Catheter Laboratory. The committee would like to suggest an inclusion note for EPS ablation with microwave and cryotherapy. The committee felt that the excludes notes for radiofrequency ablation via electrophysiological study 38212-01 [665] in block Incision procedures on the atrium [600] and Destruction procedures on atrium[601] could be applied to block Destruction procedures on the ventricle [609]. The committee felt that Flurosocopy, and pulmonary vein isolation are considered inherent components and should not be coded separately and that venogram was the exception and could be coded separately. Does the NCCH agree with this?	The NCCH agrees there is a loss of specificity in assigning 38212-01 [665] Cardiac electrophysiological study with radiofrequency ablation for cardiac ablation procedures performed via EPS.The NCCH also agrees that: - there is currently no procedure code specifically for EPS with cryotherapy or microwave ablation and that the most appropriate code at present is 38212-01 [665] 'Cardiac electrophysiological study with radiofrequency ablation'. - fluoroscopy is routine and should not be coded separately. - the venogram should be coded as it is not routinely performed. - the pulmonary vein isolation, although not performed routinely, does not warrant a separate code, as it is considered part of the ablative procedure. - there should be an excludes note for radiofrequency ablation via electrophysiological study in - Destruction procedures on ventricle [609] as there is in Incision procedures on atrium [600] and -Destruction procedures on atrium [601]. These codes are currently the subject of a public submission and will be reviewed for a future edition of ACHI.
0405-02	Trans Oesophageal Echo	Are we correct in our interpretation of the inclusion on procedure code 55130-00 [1942] Includes that with sequential assessment of cardiac function before and after surgical procedure. Relates to occurring at the same theatre time as cardiac surgery. For example if a patient is admitted for the insertion of a pacemaker and has Trans Oesophageal Echo (TOE) 4 days post insertion (within the same episode of care) is the correct procedure code 5518-00[1942]	The committee agree that the inclusion note for the procedure code 55130-00[1942] includes that with assessment of cardiac function before and after surgical procedure relates to occurring at the same theatre time as cardiac surgery. The committee also agreed that the code 55118-00 [1942] should be used for a patient who has a Trans Oesophageal Echo 4 days post insertion of a pacemaker.	

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0405-05	Patellar Resurfacing	<p>Query 1 Attached is the operation report and Code L responses. History states patient had a TKR in 2002 and has had pain ever since. The surgeon planned for patella resurfacing and lateral retinacula release but had a full revision system available in case further treatment was needed. The patient had a patella replacement, lateral retinacula release and synovectomy and resurfacing of the patella. I note there is a code for resurfacing of hip but not knee. The item number used by the surgeon was 49534 Total Knee replacement arthroplasty of patella- femoral joint of knee I see on some internet sites that patella resurfacing is sometimes done as part of the TKR however I gather this was done at the original operation. Query 2 Attached is the operation report The second patient had patella resurfacing, polythelene exchange, lateral and medial and posterior release. This patient was coded to 49517-00 Partial joint replacement but the other option is 49527-00 Revision of knee total. Could you please advise on the most suitable procedure codes.</p>	<p>The committee agreed to forward the query to the NCCH as the committee could not reach a decision. Could the NCCH please assist with an explanation as it is unclear from the classification what is meant by the terms and the associated procedural components for each of the following: Partial revision of a total arthroplasty Partial revision of a partial arthroplasty Total revision of a total arthroplasty Total revision of a partial arthroplasty. The committee acknowledges that a resurfacing code is apparent for the hip but not for the patella. The committee would like to know if the NCCH considered developing resurfacing codes for all joints that could undergo arthroplasty's.</p>	<p>The NCCH recognises the need for amendments to this section of the Australian Classification of Health Interventions (ACHI). Amendments will be considered for a future edition of ACHI for 'patella resurfacing' and other orthopaedic procedures. In the interim, clinical advice indicates the following: 1. "the only item to cover the first patient is a revision" (Courtenay B personal communication 27 May 2005). The NCCH advises following the index pathway: Revision - joint replacement - - knee, total 49527-00 [1524] 'Revision of total arthroplasty of knee' 2. "The second patient depends if this was a primary procedure or a revision of a previous procedure... (if a redo)... it is the same as with the first patient. If it is a primary then it is 49534" (Courtenay B personal communication 27 May 2005).. Clarification should be sought from the surgeon to determine whether a primary or revision procedure has been performed. For a primary procedure, assign: 49534-00 [1519] 'Total replacement arthroplasty of patellofemoral joint of knee' For a revision procedure, assign: 49527-00 [1524] 'Revision of total arthroplasty of knee' With reference to the following procedures: - Partial revision of a total arthroplasty - Partial revision of a partial arthroplasty - Total revision of a total arthroplasty - Total revision of a partial arthroplasty ACHI does not differentiate between a 'partial' or 'total' revision. For 'revision of a total arthroplasty' of the knee, assign: 49527-00 [1524] 'Revision of total arthroplasty of knee' For 'revision of</p>

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				partial arthroplasty' of the knee, assign: 49517-00 [1518] 'Hemiarthroplasty of knee'
0405-07	Cerebral Palsy with HIE	Does cerebral palsy have to be documented as a result of hypoxic ischaemic encephalopathy to be coded as a sequelae or is cerebral palsy an expected manifestation?. If it is to be coded as a sequelae would this be as a complication of surgical and medical care?.	The committee agreed that if the cerebral palsy was caused by the HIE it should be documented. Clarification from the clinician should be sought to identify the casual link that the HIE caused the Cerebral palsy to code it as a sequelae. The committee also agreed to forward the query to the NCCH for an appropriate sequelae code for cerebral palsy as a result of HIE. For the first admission the committee agreed to code the Cerebral Palsy and the HIE and would like advice on what should be code for subsequent admissions.	From the information supplied, it cannot be assumed that the HIE and resultant cerebral palsy are the result of a complication of surgical and/or medical care. For this and subsequent admissions, code only the conditions documented (Cerebral palsy and/or HIE) as appropriate with reference to ACS 0001 PRINCIPAL DIAGNOSES and 0002 ADDITIONAL DIAGNOSES.
0405-08	Hemi Hepatectomy	There is no code available for hemi hepatectomy. Index lookup this procedure indicates that 'total' is a non essential modifier. Should the hepatectomy code be assigned in preference to a lobectomy code despite the fact the coder knows the procedure does not entail removal of the entire liver?	The committee agreed to code hemi hepatectomy to lobectomy. Clarification should be sought from the clinician in relation to whether the hemi hepatectomy was a lobectomy or segmental resection of the liver. The committee also agreed to forward the query to the NCCH in relation to whether the use of the code 30421-00 [953] trisegmental resection of liver Extended lobectomy of liver would be applicable in this instance.	Clinical advice indicates that 'hemi hepatectomy' is the same as 'lobectomy of liver' [Fletcher D personal communication 14 June 2005]. Therefore, where 'hemi hepatectomy' is documented, assign 30418-00 [953] 'Lobectomy of liver'. The NCCH will consider amendments to the Alphabetic Index for a future edition.
0405-09	Elective vs Emergency Caesarean Section	Discussion with other Clinical Coders has revealed different interpretations of Standard 1541 Elective and Emergency Caesarean Section. In order to assign a code for an 'Emergency Caesarean Section' the patient has to be in labour, had previously not been planned for a Caesarean Section, but presents with a condition necessitating the procedure?. Is this correct?. Alternatively, where a patient presents with PET, is not in labour and is admitted immediately for a caesarean section that this does not constitute an emergency procedure as the procedure was not considered necessary previously. Therefore an elective caesarean code is assigned. Is this correct?. Can the committee please assist with clarification an interpretation of this standard?.	Since receiving the query, the committee received advice regarding Elective and Emergency Caesarean Section. The March 2004 10am Commandments Australian Coding Standard 1541 Elective and emergency caesarean The NCCH has been alerted to the fact that some classification users find difficulty with interpreting and applying the definitions in Australian Coding Standard 1541 Elective and emergency caesarean. The most important point separating the two definitions of elective and emergency caesarean section in ICD-10-AM is the timing of the decision to perform the procedure. The urgency to perform the caesarean is not significant when deciding between these two definitions. With an elective caesarean section, the decision to	Article written for Coding Matters which addresses these issues

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			perform the procedure is made during the antenatal period. That is, there is never any intention that the patient will deliver vaginally. With an emergency caesarean section, the intention was for the patient to deliver vaginally (that is, a caesarean was not considered necessary prior to the onset of labour), but an emergency situation has meant that a caesarean has become essential. This definition does not include any patient in whom delivery by caesarean section had previously been planned. Extracted from NCCH ICD-10-AM, July 2004, 6: ICD-10-AM Commandments The committee agreed to hold this query over to the next meeting.	
0405-10	Post Op Haematoma	11 year old boy admitted for control of Post op haemorrhage. I have coded it using the codes below and it grouped to a DRG of 901Z. Extensive O.R. Procedure Unrelated to PD T81.0 Haemorrhage and haematoma complicating a procedure, not elsewhere classified Y83.8 Other surgical procedures Y92.22 Health service area 30663-00 Control of haemorrhage following male circumcision Is this a grouping issue?	The committee agreed that DSU would investigate this episode for males with a variety of ages. The committee also agreed that this query was a grouping issue and decided to forward this query to the Aust Dept of Health and Aged Care Casemix unit	
0405-04	Table of Drugs and Chemicals - Tramal/Tramadol	I produce reports of Adverse Effects of Medications (disease codes Y40.0-Y59.9) for our Pharmacy. They disagree with the use of code Y45.3 for Adverse effect in therapeutic use of Tramal/Tramadol and believe it would be best described by Y45.0 Opioids and related analgesia. Attached is a print out from MIMS	Given the previous advice and the nature of ICD-10-AM Classification and classifying drugs by the drug class and following the index, the QCC acknowledge that it may not seem appropriate. The NCCH are aware of this and are looking into other drug terminology for a future review of the classification.	
0505-01	IUFD at 35 weeks	I have a mother who had an IUFD at 35 weeks. They induced her and she delivered a stillborn. A query came out on Code L and there were various replies. All used O36.4 Maternal Care for intrauterine death but some included O60 Preterm delivery O09.5 34-36 completed weeks duration Z37.1 Single stillborn. Can you tell me how this would be coded	The committee agreed that on the information provided for this scenario the following codes should be assigned PD O36.4 Maternal Care for intrauterine death O60 Preterm delivery O09.5 34-36 completed weeks duration Z37.1 Single stillborn. Appropriate procedure codes. The QCC members also note that the codefinder pathway for intrauterine death does not prompt for the preterm delivery option O60. DSU to add to this suggestion to the pathway logic improvement register and will discuss with 3M.	
0505-02	Meniscus/Ligament	I refer to NCH query 2048 generated through this committee	The committee agreed to reconfirm the advice	The decision for query 2048 answered the specific

QCC_ID	Query summary	Query	Decision	Response from NCCH
	Tear	<p>re interpretation and applicaton of standard 1319 Meniscus/Ligament Tear of Knee, Nos. I would like to confirm that where the documentation states a cuase for the tear that this would then be coded to a current injury irrepctive of ant time frame or lack of time frame.Converesly, if there is no documentation as to how the injury happened then this would be coded as an old injury. 16/5/2006: New query sent to the NCCH Please see ACS 1319 and NCCH database queries 2048 and 2177. Thank you for considering this query. We have already taken into consideration ACS 1319 and NCCH database queries 2048 and 2177. The original query stemmed from the enquirer's observations that: 1) ACS 1319 must be applied in a large number of cases 2) documentation of "acute" tear is very rarely seen 3) following the current standard, most meniscal tears would be coded as 'old' We understand that ACS 1319 is a "default" position and it therefore should be utilised when the documentation is deficient and consultation with the clinician is impossible. Response 2177 advises that 'Coders should carefully read any documentation pertaining to the cause of an injury to determine if it indicates that the injury is current. Where documentation is deficient or coders are unsure if an injury is current, assume that the injury is old, as per ACS 1319. Having said that, there seems to be a wide range of what is considered as "old" or "current" by Coders when they are given a certain amount of information about the event. The current question is "what indicates that the injury is current?" Some Coders attempt to apply 'Coders' Creed' and would code recent injury e.g. within one month as current as this is the first examination and treatment since the injury, which in the Coder's mind is 'recent'. Another Coder may apply 'Coders' Creed' to determine that the same tear (one month old), is 'old' as the patient was not being admitted at the time of initial injury. Without defined times/other specific criteria there is likely to be debate surrounding terms such as current, recent and old. We accept that ACS 1319 is deemed to be a default position, however, it would appear that the current recommendation does not account for documentation of</p>	<p>provided by the NCCH. The difficulty arises as there is a difference in the meaning of 'acute' versus 'cause' Should ACS1319 be updated to reflect that if the cause is know then it would be coded as a current injury, irrespective of timeframes and if the cause is not known, then the injury should be coded as 'old. The committee agreed to forward the query to the NCCH. Following the response received from the NCCH on 19/12/2005 the QCC were not satisfied with the logic of the response and Julie Turtle will re-submit the query with further comment to the NCCH. 6/5/2006: New query sent to the NCCH Please see ACS 1319 and NCCH database queries 2048 and 2177. Thank you for considering this query. We have already taken into consideration ACS 1319 and NCCH database queries 2048 and 2177. The original query stemmed from the enquirer's observations that: 1) ACS 1319 must be applied in a large number of cases 2) documentation of "acute" tear is very rarely seen 3) following the current standard, most meniscal tears would be coded as 'old' We understand that ACS 1319 is a "default" position and it therefore should be utilised when the documentation is deficient and consultation with the clinician is impossible. Response 2177 advises that 'Coders should carefully read any documentation pertaining to the cause of an injury to determine if it indicates that the injury is current. Where documentation is deficient or coders are unsure if an injury is current, assume that the injury is old, as per ACS 1319. Having said that, there seems to be a wide range of what is considered as "old" or "current" by Coders when they are given a certain amount of information about the event. The current question is "what indicates that the injury is current?" Some Coders attempt to apply 'Coders' Creed' and would code recent injury e.g. within one month as current as this is the first examination and treatment since</p>	<p>scenarios cited. NCCH does not agree that where documentation states the cause for a tear that this would be coded as a current injury irrespective of the time frame. Coders should carefully read any documentation pertaining to the cause of an injury to determine if it indicates that the injury is current. Where documentation is deficient or coders are unsure if an injury is current, assume that the injury is old, as per ACS 1319 MENISCUS/LIGAMENT TEAR OF KNEE, NOS. 20/4/2007: The NCCH has researched this issue, including how it is dealt with in other classifications. Unfortunately it is impossible to be as definitive as you would like. Each case should be reviewed on its merits and coders should ultimately be guided by the documentation and seek clarification from the clinician. To publish timeframes for old and current is extremely difficult due to differences in treatment protocols for these injuries. Some patients with meniscal tears are treated conservatively while others are treated with surgical repair. Some may initially be treated conservatively but then require surgical repair at a laterdate. Coders should be guided by the definitions for current and old injuries in ACS 1906. If it still cannot be determined as to whether the injury is acute or not then follow ACS 1319 MENISCUS/LIGAMENT TEAR OF KNEE, NOS and assume the injury is old.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>'acute' being uncommon and that there is no standardisation in what is coded as "current" or "old". The outcome of this is that any data surrounding these codes are subject to the vagaries of how Coders apply the Coders' Creed. It is suggested that a time frame for "old" and "current", whilst not a perfect system, would at least ensure data standardisation. Could the NCCH please consider the institution of a time frame for meniscal tears?</p>	<p>the injury, which in the Coder's mind is 'recent'. Another Coder may apply 'Coders' Creed' to determine that the same tear (one month old), is 'old' as the patient was not being admitted at the time of initial injury. Without defined times/other specific criteria there is likely to be debate surrounding terms such as current, recent and old. We accept that ACS 1319 is deemed to be a default position, however, it would appear that the current recommendation does not account for documentation of 'acute' being uncommon and that there is no standardisation in what is coded as "current" or "old". The outcome of this is that any data surrounding these codes are subject to the vagaries of how Coders apply the Coders' Creed. It is suggested that a time frame for "old" and "current", whilst not a perfect system, would at least ensure data standardisation. Could the NCCH please consider the institution of a time frame for meniscal tears? 2177 sent on 29/4/2005 to NCCH. Received 19/12/05 16/5/2006: Please see ACS 1319 and NCCH database queries 2048 and 2177. Thank you for considering this query. We have already taken into consideration ACS 1319 and NCCH database queries 2048 and 2177. The original query stemmed from the enquirer's observations that: 1) ACS 1319 must be applied in a large number of cases 2) documentation of "acute" tear is very rarely seen 3) following the current standard, most meniscal tears would be coded as 'old' We understand that ACS 1319 is a "default" position and it therefore should be utilised when the documentation is deficient and consultation with the clinician is impossible. Response 2177 advises that 'Coders should carefully read any documentation pertaining to the cause of an injury to determine if it indicates that the injury is current. Where documentation is deficient or coders are unsure if an injury is current, assume that the injury is old, as per</p>	

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			<p>ACS 1319. Having said that, there seems to be a wide range of what is considered as "old" or "current" by Coders when they are given a certain amount of information about the event. The current question is "what indicates that the injury is current?" Some Coders attempt to apply 'Coders' Creed' and would code recent injury e.g. within one month as current as this is the first examination and treatment since the injury, which in the Coder's mind is 'recent'. Another Coder may apply 'Coders' Creed' to determine that the same tear (one month old), is 'old' as the patient was not being admitted at the time of initial injury. Without defined times/other specific criteria there is likely to be debate surrounding terms such as current, recent and old. We accept that ACS 1319 is deemed to be a default position, however, it would appear that the current recommendation does not account for documentation of 'acute' being uncommon and that there is no standardisation in what is coded as "current" or "old". The outcome of this is that any data surrounding these codes are subject to the vagaries of how Coder's apply the Coders' Creed. It is suggested that a time frame for "old" and "current", whilst not a perfect system, would at least ensure data standardisation. Could the NCCH please consider the institution of a time frame for meniscal tears?</p>	
0505-10	Medical Abortion	A female patient was admitted for insertion of Lam Tents used in medical abortion. The lam tent is inserted to soften the cervix	The query will be held over to the next month. D.Abbott to provide an operation to DSU.	
0505-03	Thrombocytopenia	Can the committee please provide some direction, please, when coding thrombocytopenia in patients with malignancies? On occasion these patients are admitted as day patients for platelet transfusion. Should the thrombocytopenia be assigned as the Principal Diagnosis or should we follow suit and include it as an additional diagnosis, as in the case of anemia in neoplastic disease, where it is sequenced under	The committee agreed to code the thrombocytopenia as the PD and the malignancy as the OD, as per current guidelines. As when looking up anaemia in neoplasm you are directed to code the anaemia in addition to the neoplasm but when looking up thrombocytopenia you are not directed to code the neoplasm. The QCC agreed to forward the query to	The NCCH agrees with the QCC's coding advice for the scenario cited: assign a code for the thrombocytopenia as the principal diagnosis with additional codes for the malignancy.

QCC_ID	Query summary	Query	Decision	Response from NCCH
		the malignancy codes.	the NCCH as the committee recognises that when using the index it takes you to thrombocytopenia as the PD and given this is a similar scenario to anaemia and associated neoplasm and it affects the DRG the committee felt it was worth asking this question of the NCCH. The committee agreed to forward the query to the NCCH	
0505-05	Excision of Meckel's diverticulum	Some patient's, admitted for excision of a Meckel's Diverticulum, undergo bowel resection with anastomosis. Is this inherent in 30375-09 Excision of Meckels Diverticulum?. There is no inclusion note to indicate this. Should we code excision or resection or both?. Where a patient presents with intussesception secondary to Meckel's diverticulum should we apply standard ACS0001 which states not to code the problem when the underlying condition is identified. A number of these patients have reduction of intussusception both in radiology and theatre with would appear to meet the additional diagnosis standard.	The committee agreed to forward the query to the NCCH to ask if the code 30375-09 includes anastomosis. If it doesn't the committee would like advice from the NCCH on the most appropriate anastomosis code. The committee also agreed that if intussusception is being treated it should be coded in addition to the Meckel's diverticulum.	Surgical Treatment of Meckel's diverticulum involves either a simple excisional technique or an anastomotic technique. The latter involves removal of a segment of small intestine that contains the diverticula followed by anastomosis of the ends of the intestine. For a simple excision of Meckel's diverticulum, assign: 30375-09 [896] 'Excision of Meckel's diverticulum' When the operation reports describes an anastomotic technique such as that described above, assign: 30566-00 [895] 'Resection of small intestine with anastomosis' NCCH agrees that as intussusception is not always present with Meckel's diverticulum, a code for intussusception should be assigned as an additional code if it meets the criteria in ACS 0002 'Additional Diagnoses'
0505-06	Postpartum Sepsis	Where a patient develops sepsis in the post partum period following self injection of a non sterile substance should the coder apply the post partum sepsis code ie O85 or just a sepsis code ie A41.x? Although the sepsis occurred in the post partum period it is unrelated to the birth.	M.Snell sent comments to K.Chen at the NCCH which was relevant to CSAC paper on puerperal sepsis. K.Chen to provide an answer back to M.Snell.	
0505-07	SPARC Procedure	A female patient was admitted with stress incontinence and underwent a sparc procedure. Could the committee please advise on the procedure code.	The committee agreed that the Suprapubic Arc (SPARC) procedure is the considered the same as the sling procedure for stress incontinence and agreed that SPARC should be coded to 35599-00 [1110] sling procedure for stress incontinence.	
0505-08	Intravitreal tramacinolone injection	Patient with non traumatic oedema of the eye had an invitreal tramacinolone injection The injection can be used prior or after cataract extraction the MBS number is 42740.	From the information provided in this scenario, the committee agreed to use the code 42740-03. [209] Administration of therapeutic agent into posterior chamber.	
0505-09	Limbal Tumour	A patient was admitted with a diagnosis Limbal Tumour. The	Given the clauses in the PD rule after study the QCC	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		tumour was excised. The histopathology revealed it was a pterygium. Should we be coding the procedure to the excision of limbal tumour or excision of pterygium	agreed that the PD should have been H11.0 Pterygium even though the clinician originally believed it to be a limbal tumour. The QCC also agreed that the correct procedure code is 46292-00. However this will be confirmed by the operation report and if necessary send to the NCCH for confirmation. D. Abbott to provide operation report.	
0705-05	PICQ indicator 101586	According to PICQ indicator 101586, Z99.2 Dependence on renal dialysis, cannot be coded in conjunction with a procedural code for dialysis. I presume that the logic behind this indicator is that a renal patient requiring dialysis is automatically dependant upon dialysis. Therefore the code is redundant. However, with the progression of technology and ability in regards to transplant. We are now seeing patients having transplants as an alternative treatment option to dialysis. It is not unusual for patients to have dialysis postoperatively through a port a cath. It is not currently possible to differentiate between acute renal dialysis and chronic renal dialysis delivered in this manner. In these instances it would be very clinically useful to differentiate between patients who are already dependant upon dialysis and those who are not. This would require that the Z99.2 code be able to be coded in conjunction with dialysis codes. Where do we stand with this?	Carried over to next meeting (see query 0805-05)	
0505-04	Transfusion of Intragam via a Port-A-Cath	Where patient's have Intragam administered via a port we have continued to code this as a transfusion based on: - NCCH query 1530 which states the blood transfusions via a port should not be coded as 13939-00 'Loading of an implantable infusion device or pump' - The code for intragam is situated within the transfusion block - Standard 0214 directs coders to code as a transfusion, where relevant Based on Query 2025 I would like to confirm that Intragam administered via a port a cath can now be coded to 13939-00 Loading of an implantable infusion device or pump.	The committee recognises that administering a blood product ie transfusion and the method of the administration ie via a port a cath are two separate processes. The committee would like to confirm with the NCCH that the following codes can be used to capture that a blood product was administered and the method of administration for a blood transfusion administered via port a cath. 13939-00[1921] Loading of an implantable infusion device or pump 13706-05 [1893] Transfusion of gamma globulin	For guidelines regarding administration of intragam, see ACS 0214 INTRAGAM: For infusion/transfusion of gamma globulin assign 13706-05 [1893] 'Transfusion of gamma globulin'. It is not necessary to assign a code from block [1921] 'Loading of drug delivery device'. Codes from this block should not be assigned for administration of blood or blood products. The NCCH is continuing to review the codes for pharmacotherapy. See also query 2131.
0705-04	Repair of tear *2 for medial and lateral meniscus	A patient presents with a tear in the lateral meniscus and medial meniscus. The patient has undergone a repair of the tears in the one operation do we code the repair twice.	The committee could not agree on this query given the advice on the NCCH database query ID 1581. The committee agreed to forward the query to	NCCH supports the advice in query 1581. For meniscectomies of the same knee, but a different meniscus (lateral and medial), please assign two codes.

QCC_ID	Query summary	Query	Decision	Response from NCCH
			the NCCH clarification on the ACS on multiple/bilateral and the NCCH query 1581.	ACS 0020 MULTIPLE/BILATERAL PROCEDURES is currently under review.
0705-03	Removal of Sutures	We were looking at the codes for Removal, Suture. When using codefinder or following the index when you choose surgical you are given the choice of by incision or non incisional. Non operative goes to non-incisional. What determines non-operative and surgical. Our usual scenario is that children go to theatre to have their sutures removed post cleft palate under GA as they wouldn't keep still long enough to have the sutures removed. There is no incision involved just simple removal.(usually admitted under plastics) when lookin up removal of sutures head you get the following: Removal -suture --nonoperative 92200-00 [1908] --surgical see removal foreign body by site	The committee agreed to assign the code 92087-00[1897] Removal of foreign body from mouth, without incision, based on the assumption that non-operative removal means non-incisional and that a suture is a foreign body. The committee agreed to forward the query to NCCH for clarification on whether a suture is classified as a foreign body. The committee would also like to clarify whether incisional removal implies surgical/operative removal and whether non incisional removal implies non surgical/non operative removal.	NCCH agrees: - that a suture is a foreign body - with the code suggested for the scenario cited: 92087-00 [1897] 'Removal of foreign body from mouth without incision' NCCH will review the use of the terms 'incisional/nonincisional', 'surgical/operative/nonsurgical/nonoperative' for a future edition of ACHI.
0705-06	Reoperation for Cardiac Procedure	When do you use the procedure code 38640-00[664] re-operation for cardiac procedure,not elsewhere classified? Do you only use this code when a person returns for a re-do CABG without adjustment of previous grafting?. Or is it possible to use this code when a patient returns for a re-do of any other cardiac procedure?. Can it also be used when a patient returns for a different cardiac procedure than was previously done?.	The committee agreed to use the code 38640-00[664] re-operation for cardiac procedure, not elsewhere classified as an additional code if a patient undergoes the same cardiac procedure for the second time. The committee also agreed that the code can be used for a redo CABG without adjustment of previous grafting? The committee also agreed the code 38640-00[664] can be used when a patient returns for a redo of any other cardiac procedure providing it is the same cardiac procedure that was originally performed.	
0705-07	IV Mabthera for Non Hodgkins Lymphoma	Please advise whether same day admissions for IV Mabthera for Non Hodgkins Lymphoma should be coded as Z511 and NHL and [1920] 96199-00 or Non Hodgkins Lymphoma only and [1920] 96199-00? 0044 CHEMOTHERAPY For coding purposes, chemotherapy is defined as: "The administration of any therapeutic substance (usually a drug), excluding blood and blood products." Classification Same-day episodes of care for chemotherapy for neoplasm For episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the patient is discharged on the same-day as the admission, assign: • Z51.1 Pharmacotherapy session for neoplasm as principal diagnosis • a code for the neoplasm	The committee agreed in this scenario to code PD Z51.1 pharmacotherapy session for neoplasm OD Non Hodgkins Lymphoma 96199-00 [1920]. The committee agreed to forward the query to the NCCH for clarification on the assigned codes and confirmation whether the chemotherapy definition mean blood products that are derived from donor human blood as opposed to blood products synthetically manufactured such as Mabthera (manufactured monoclonal antibody).	NCCH agrees with the following codes for the scenario cited: Z51.1 'Pharmacotherapy session for neoplasm' with an additional diagnosis for non-Hodgkin lymphoma appropriate morphology code 96199-00 [1920] 'Intravenous administration of pharmacological agent, antineoplastic agent' as per example one in ACS 0044 CHEMOTHERAPY. Mabthera (Rituximab) is classified in ICD-10-AM as an 'antineoplastic agent'. Therefore, it should be classified as pharmacotherapy (as above) and not as a blood product.

QCC_ID	Query summary	Query	Decision	Response from NCCH
		being treated as the first additional diagnosis (see also ACS 0236 Neoplasm coding and sequencing) additional diagnosis code(s) for any neoplasm related condition(s) being treated the appropriate procedure code. Mabthera is a manufactured monoclonal antibody (see attached article). Does NCCH intend this therapy to be considered pharmacotherapy?		
0705-08	Descriptive Morphology Discrepancy	Please find attached 2 printouts for the morphology differences along with path results. PDX Mucinous Adenocarcinoma of Rectosigmoid colon with Mets of Intraabdominal Lymph Nodes. M84803 Mucinous Adenocarcinoma M84806 Pseudomyoma Peritonei Our clinical advice is that the Pseudo Peritonei is only of the Peritoneal Tissue and not Lymph Nodes. Also that with the two site areas, eg Intraabdominal lymph nodes and retroperitoneum, the descriptor Pseudomyoma Peritonei seems to be incorrect. Would you kindly look into and advise.	The committee agreed to forward the query to the QCR for advice. The committee also agreed to forward the query to the NCCH for clarification of the description for M84806 at present the description is pseudomyoma peritonei and not mucinous adenocarcinoma metastatic.	M8480/3 Mucinous Adenocarcinoma and M8480/6 Pseudomyoma Peritonei are WHO ICD-10 codes and code descriptors. See also query 2110
0705-01	Pathway Error with inappropriate DRG 901Z	PDX D38.5 Neoplasm of uncertain or unknown behaviour of other respiratory organs M86931 Extra-Adrenal Paraganglioma NOS (CHEMODECTOMA) PR 4162000 [312] Removal of lesion of Glomus, Transtympanic approach 4151200 [305] Reconstruction of external auditory canal This block D38 is described as Neoplasm of uncertain or unknown behaviour of middle ear and respiratory an intrathoracic organs. Would you kindly have this pathway error adjusted to reflect the diagnosis. Pathology is attached.	From the information provided on the operation report and the pathology report the QCC agreed to use the following codes PD D44.7 Aortic body and other paraganglia PM86931 Extra-Adrenal Paraganglioma NOS (CHEMODECTOMA) 4162000 [312] Removal of lesion of Glomus, Transtympanic approach 4151200 [305] Reconstruction of external auditory canal. The QCC also agreed to forward the grouping anomaly to commonwealth to seek their opinion on the grouper logic.	
0705-02	Lumbar Puncture	Do we code lumbar punctures as we have been informed not to.	The committee agreed that Lumbar punctures are to be coded as they are not listed in the procedures not to be coded in ACS 0042.	
0805-01	Dislocation of hip prosthesis	Can the QCC please clarify Standard 1309 of the Australian Coding Standards with regard to coding a dislocated hip prosthesis? The standards state that code S73.0 Dislocation of hip with an additional diagnosis code of Z96.64 Presence of hip implant is to be allocated when a patient sustains a traumatic dislocated hip prosthesis. ACS examples of traumatic dislocations are falls out of bed or as a result of sudden movement such as twisting or a fall. The Wesley	This query generated debate between committee members. A number of considerations were discussed these included: Is displacement under T84.0 equivalent to dislocation? ACS 1309 definition of traumatic dislocation include bending down to tie shoes considered traumatic Dec 2004 Coding matters advice use of S & T codes to further describe the complications of surgical care. Given the above,	Awaiting copies of patient records from Wesley as at 13 February 2.5.06: NCCH recognises that ACS 1309 DISLOCATION OF HIP PROSTHESIS does not clearly address non- traumatic dislocations. NCCH will consider a review of this standard for a future edition. In the interim, for circumstances that don't meet any of the criteria in the standard, assign the following codes in order to maintain consistency of coding practice: S73.0-

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Hospital query is does traumatic also include normal day to day activities such as bending over to tie your shoes, clipping toe nails or getting out of bed in the morning. There is no documentation of sudden movement in any of the before mentioned activities.</p>	<p>the codes below have been selected to answer the query. PD T84.8 PEX Y83.1 PEX Y92.22 AS73.0 AEX X50 AEXU73.2 AZ96.64 Is this dislocation considered to be a mechanical complication or other complication? Could the NCCH please confirm if the above codes are correct? Note the codes are sequenced as per QLD requirements. The query will be forwarded to the NCCH. Hi Mary-Ellen, At last week's NCCH queries meeting we discussed the QCC query regarding 'dislocation of hip prosthesis' (your ref 0805-01). Would it be possible for you to forward deidentified clinical records for one of the cases described in the query (eg dislocation of hip prosthesis due to bending over to tie shoes or getting out of bed)? Many thanks Karyn Hi Ann - how are you today? Back in August you submitted a query to the coding committee regarding traumatic dislocation of a hip. The QCC agreed to forward your query to the NCCH as it was not an issue we could answer. The NCCH have email us today requesting copies of the patient record for this case. Are you able to provide these (de-identified)? Please call me if you have any questions. I am temporarily looking after these queries at present.</p>	<p>'Dislocation of hip' X50 'Overexertion and strenuous or repetitive movements' Y92.22 'Health service area' U73.2 'While resting, sleeping, eating or engaging in other vital activities' Z96.64 'Presence of hip implant'</p>
0805-02	Retained placenta with or without haemorrhage	<p>Can you please provide guidance with the correct diagnosis code for documentation of retained placenta with or without haemorrhage. Index Entry: Retained placenta (total) (with haemorrhage) O72.0 - without haemorrhage O73.0 - portions or fragments (with haemorrhage) O72.2 - without haemorrhage O73.1 Note Retained, placenta (total) (with haemorrhage) - O72.0 Third stage haemorrhage. With haemorrhage is in parentheses, so a haemorrhage does not need to have occurred in order for the coder to assign this code for documentation of retained placenta. O72.0 Third-stage haemorrhage Haemorrhage associated with retained or trapped placenta Retained placenta NOS BUT, there is a further index entry for Retained, placenta, without haemorrhage - O73.0. Retained placenta without</p>	<p>This query generated a lengthy discussion where it was decided to seek NCCH clarification. In addition to the original query, the issue of cumulative blood loss was discussed and whether it is appropriate to add together the amounts of documented blood loss in the record from delivery until the loss is stopped usually in theatre. Could the NCCH please confirm this practice is appropriate in order to assign the haemorrhage code when haemorrhage loss is greater than 500mls? The query will be forwarded to the NCCH 23/5/06: The NCCH asked that this direction be added to the standards in a later edition of ICD-10-AM.</p>	<p>The following Disease Index defaults: Retention, retained - placenta (total) (with haemorrhage) O72.0 'Third-stage haemorrhage' - - portions or fragments (with haemorrhage) O72.2 'Delayed and secondary postpartum haemorrhage' are consistent with WHO ICD-10. The index defaults to 'haemorrhage' as this is the most common occurrence with these conditions. Coders must peruse the clinical record for documented evidence of haemorrhage. Cumulative blood loss should be noted. If 'haemorrhage' is documented, assign the appropriate code for 'with haemorrhage'. If 'haemorrhage' is not documented, the following clinical advice should be followed (see also ACS 1528 POSTPARTUM HAEMORRHAGE): - if blood loss is less than 500ml,</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>haemorrhage This is confusing. Does the coder need to determine whether a haemorrhage has occurred? Should the documentation actually state no haemorrhage for O73.0 to be assigned? Does ACS 1528 Postpartum haemorrhage apply here so only estimated blood loss that is: Actually documented as a haemorrhage OR Equals 500ml or more and should be referred to a clinician for clarification So, in a situation where there is blood loss of 300ml with documented retained placenta, but no documentation of haemorrhage what code should be assigned?</p>		<p>assign the appropriate code for 'without haemorrhage' as this is considered to be normal postpartum blood loss - if blood loss is greater than 500ml, consult the clinician before assigning a code In answer to your specific scenario, 'blood loss of 300ml with documented retained placenta, but no documentation of haemorrhage', assign the appropriate code for 'without haemorrhage'. 29/5/06: The NCCH has created a task to review this standard for a future edition of ICD-10</p>
0805-03	Near total Thyroidectomy procedure code	<p>Can you please help with the correct procedure code assignment for Near Total Thyroidectomy According to our research, a near total thyroidectomy is complete removal of one thyroid lobe and isthmus, and leaving less than 10% of the contra lateral lobe (usually the posterolateral portion). Do you suggest we ignore the near total descriptor and assign: 30296-00 Total thyroidectomy Thyroid lobectomy, bilateral OR, should we assign two codes: 30306-00 Total thyroid lobectomy, unilateral AND 30310-00 Subtotal thyroidectomy, unilateral Our research also reveals that a subtotal thyroidectomy involves removal of more than half of the thyroid lobe. OR, request consideration for a new procedure code.</p>	<p>The committee agreed in this scenario to assign 2 procedure codes 30310-00 Subtotal thyroidectomy, unilateral 30306-00 Total thyroidectomy Thyroid lobectomy The committee agreed to forward the query to the NCCH for consideration of a new code for this procedure in a future edition. NCCH requested copy of op report on 19 Jan 2006 - Mater contacted with this request.</p>	<p>NCCH notes the definition of 'near total' thyroidectomy provided by the enquirer: "complete removal of one thyroid lobe and isthmus, and leaving less than 10% of the contra lateral lobe (usually the posterolateral portion). Further research describes this procedure as "intentionally leaving a small portion of thyroid tissue near parathyroid glands or at the entry of the recurrent nerve into the larynx." (www.thyroidmanager.org). NCCH is not able to provide a definitive answer on the coding of 'near total' thyroidectomy, as the terms 'near total' are not descriptive enough and definitions are not consistent. NCCH suggests that code selection should be made on a case by case basis in accordance with documentation of the procedure in the operation report. NCCH agrees with the codes suggested by QCC for documentation of 'complete removal of one thyroid lobe &amp; 90% removal of the contra lateral lobe'.</p>
0805-14	Request for Tabular code link to ACS 0936	<p>There is currently no ACS reference symbol within the Tabular list of Diseases at code Z95.0 Presence of cardiac device to ACS 0936 PACEMAKERS. Given that this would facilitate additional awareness of coding advice within ACS 0936 PACEMAKERS, thank you for considering including an ACS reference symbol within the tabular list at code Z95.0 Presence of cardiac device to ACS 0936.</p>	<p>The committee agreed to forward the query to the NCCH.</p>	<p>This task has been added to the NCCH task list</p>
0805-07	Cystoscopy and Bladder Washings	<p>Thank you for considering incorporating the following response from the NCCH Query Database regarding cystoscopy with bladder washings within subsequent editions</p>	<p>Members agree to forward to the NCCH for code also and adding a excludes note for code 36836-00.</p>	<p>This query has been added to the NCCH task list</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>of ICD-10-AM if the advice is still valid. NCCH Query 1357 (Nov 2000) Query: "Bronchoscopy with washings codes to 41892-00 [544] Bronchoscopy with biopsy therefore does cystoscopy with bladder washings code to 36836-00 [1097] endoscopic biopsy of bladder." Response: "Bladder washings are not considered a biopsy and are sometimes obtained via cystoscopic examination to diagnose bladder malignancies/infections. These washings are sent for cytological analysis. Assign a code for the cystoscopy together with 11921-00 [1862] Bladder washout test study." Although it is noted that there is an index pathway for Bladder washings, i.e. Washings, see Irrigation and Lavage – bladder (diagnostic) 11921-00 [1862] Bladder washout test study; providing additional information within the Tabular list would facilitate implementation of the coding advice given within the above query. Therefore, thank you for considering the following suggestions, though it is acknowledged that there may be other possible options. 1. Adding a 'code also' instruction at 11921-00 [1862] Bladder washout test study. Code also: Cystoscopy if performed (given that the above query indicates that a cystoscopy is not inherent within the above code and should be assigned if performed). 2. Adding an excludes note at 36836-00[1098] Endoscopic biopsy of bladder, e.g. Excludes: bladder specimens obtained via washing/lavage/irrigation of bladder (given that the above query highlights that the convention of coding bladder washings is different to the coding of washings obtained from other sites e.g. broncho-alveolar.</p>		
0705-09	Situational Crisis	<p>Thank you for advising which code to use for 'situational crisis' as this term is not currently indexed in ICD-10-AM although there is an array of seemingly synonymous terms indexed. Some of these terms include: Crisis State, Acute Situational Reaction, Acute Situational Disturbance, Acute Crisis Reaction all of which are indexed to F43.0 Acute Stress Reaction; and Situational Reaction, Situational Disturbance (transient) both of which are indexed to F43.2 Adjustment disorders. Given that situational crisis almost never seems to be described with additional diagnostic terminology regarding</p>	Forwarded to NCCH	<p>Clinical advice indicates that a situational crisis may be any current situation that is causing stress. It is not a disorder of legitimate diagnosis, but may occur as part of an acute stress reaction with symptoms that require medical attention. If, however, a stressor is ongoing and has gone beyond the usual, normal, acute stress, it becomes a problem of adjustment and the ongoing symptoms are now considered to have developed into a disorder. This may be described as a situational crisis, but the main problem is one of adjustment. Where</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>the duration (i.e. acute or chronic) and that situational crisis is diagnosed in cases that do not always appear to fit with the tabular list code descriptions at F43.0 and F43.2, an option may be to consider coding situational crisis to R45.89 Other symptoms and signs involving emotional state. Although it is appreciated that the mental health tabular code descriptions are not used for code assignment the above is mentioned as a general observation given that the term situational crisis appears to be an area of evolving terminology.</p>		<p>'situational crisis' is documented, coders should seek clarification from the treating clinician to determine if the patient has acute stress or an adjustment disorder. When documentation is incomplete and clinical advice is unavailable please assign F43.0 'Acute stress reaction'.</p>
0805-08	<p>Inconsistent Index and Tabular entries for Sperm count</p>	<p>Thank you for reviewing the index for sperm count i.e. Count – sperm Z30.8 Other contraceptive management as this appears inconsistent with the Tabular List descriptions at Z31.4 Procreative investigation and testing. Z31.4 Procreative investigation and testing has an inclusion term for sperm count NOS. Preliminary review suggests that the tabular list is correct and that sperm count NOS should be coded to Z31.4 Procreative investigation and testing. When reviewing the alphabetical index would it be possible to also consider including a sub-index for post vasectomy under the lead term Count – sperm, as there currently is no sub-index for post vasectomy sperm count. This would assist with confirmation of correct code assignment and supplement the preexisting Tabular list exclusion note at Z31.4 Procreative investigation and testing, Excludes: post vasectomy sperm count Z30.8.</p>	<p>The committee agree to forward to the NCCH</p>	
0805-09	<p>IV and subcutaneous post procedural analgesia</p>	<p>Thank you for confirming that the following codes should not be routinely coded unless there is a specific need to capture such data at the local facility level, 90030-00 [1912] Subcutaneous postprocedural analgesic infusion, 92518-00 [1912] Intravenous post procedural infusion, patient controlled analgesia, 92515-01 [1912] Intravenous post procedural analgesic infusion. ACS 0031 ANAESTHESIA states (within classification point number 5) that the forementioned procedures 'may be assigned if data on such interventions is required at the local level'. This therefore implies that these procedures are not required for national reporting and should not be routinely coded. Thank you for definitively confirming that the above procedures are procedures normally not</p>	<p>QCC forwarded query to NCCH</p>	<p>NCCH confirms that: 92518-00 [1912] Intravenous postprocedural infusion, patient controlled analgesia (PCA) 92518-01 [1912] Intravenous postprocedural analgesic infusion and 90030-00 [1912] Subcutaneous postprocedural analgesic infusion should not be routinely coded, but may be assigned if data on such interventions is required at the local hospital level</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		coded.		
0805-10	Index request- Anterior resection of rectum NOS	Thank you for reviewing previous advice in Coding Matters (Vol. 6. No. 3, Dec 1999) which states: "If 'anterior resection of rectum is the only documentation provided on the operation report, assume the resection is high and assign: 32024-00 [935]" High restorative anterior resection of rectum with intraperitoneal anastomosis. This code includes the following description: anastomosis is performed >10 cms from anal verge. However it is noted that subsequent editions of the index do not provide a default code for anterior resection of the rectum NOS, and if referring to the current ACSs as the principal guide to current coding conventions (e.g. ACS 0038 PROCEDURES DISTINGUISHED ON THE BASIS OF SIZE, TIME OR NUMBER OF LESIONS, which advises to assign the code for the 'smallest size' if there is no default in the index) the following code may be inadvertently assigned 32028-00 [35] Ultra low restorative anterior resection of rectum with sutured coloanal anastomosis – anastomosis is performed ≤ 6cms from anal verge. This resection usually involves a larger excision of rectal tissue because the resection has extended further down to the anal verge. Therefore, thank you for considering providing a default index for anterior resection of rectum not otherwise specified.	The committee agreed to forward the query to the NCCH.	This query has been added to the NCCH task list
0805-11	Index request - anatomical terms for malignant skin neoplasms	Thank you for considering providing index entries for the following anatomical terms that are commonly used to site the location of malignant skin lesions — postauricular, preauricular and glabella. Review of these terms indicates that postauricular should be coded to C44.4 Malignant neoplasm of scalp and neck or C43.4 Malignant melanoma of scalp and neck; and preauricular and glabella should be coded to C44.3 Malignant neoplasm of other and unspecified face or C43.3 Malignant melanoma of other and unspecified face.	The committee agreed to forward the query to the NCCH.	This query has been added to the NCCH task list
0805-12	Index request - cautery and diathermy of Little's area	Thank you for considering including an index for the term Little's area when coding cautery and diathermy to this site. This site is frequently documented without any further qualification regarding its exact location i.e. anterior or	The committee agreed to forward the query to the NCCH.	NCCH agrees that Little's area is on the anterior portion of the nasal septum MBS has an index entry for "Little's area, cautery of 41674". This MBS item number maps to ACHI code 41674-01 [374] Cauterisation of diathermy of

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>posterior nose. Although it is noted that the default code for nasal cauterization and diathermy to arrest haemorrhage is anterior, and that Little's area is also anterior, providing an index for this commonly used term would alleviate the need to consult reference material to verify that the location of Littles area is actually anterior and not posterior, especially given that the index prompts for posterior site if known.</p> <p>Cauterisation and Diathermy - nose, nasal - - for arrest of nasal haemorrhage 41677-00 [373] - - - anterior (with diathermy) (with packing) 41677-00 [373] - - - posterior (with diathermy) (with packing) 41656-00 [373] - - nasopharynx 41674-02 [419] - - septum 41674-01 [374] - - turbinates 41674-00 [374] Extracted from NCCH ICD-10-AM, July 2004, C. In addition, thank you for also giving consideration to indexing cauterisation and diathermy of Little's area when not associated with arrest of nasal haemorrhage. As mentioned above, Little's area is almost always documented without additional qualifying terms as to its specific location; therefore thank you for considering indexing this term to the appropriate code i.e. 41674-01 [374] Cauterisation or diathermy of nasal septum.</p>		<p>nasal septum. This code excludes: that for arrest of nasal haemorrhage. The NCCH will consider indexing this term in a future edition of ACHI. For documentation of cautery and diathermy of Little's area for arrest of nasal haemorrhage, assign 41677-00[373] 'Arrest of anterior nasal haemorrhage by packing and or cauterisation'</p>
0805-06	Fat graft with spinal surgery	<p>Thank you for reviewing previous advice given within the NCCH Query Database regarding fat grafts and spinal surgery (query number 1553, June 2002) which advises to not code fat grafts when performed in conjunction with spinal surgery. The query also advises to assign a code for procurement of fat if harvested from a separate site and to therefore assign 30168-00 [1666] Lipectomy, 1 excision. If this advice is still current would it be possible to include this coding advice within subsequent editions of ICD-10-AM as it is noted within the NCCH query response that this would be reviewed for possible inclusion within Fourth Edition.</p>	<p>Members agree to forward to the NCCH. confirm that this can apply to fat grafts with neurosurgery. ie coding procurement and not the graft.</p>	<p>Query 1553 relates to fat grafting in spinal surgery only. No subsequent queries have been received regarding fat grafting. Therefore, the advice in query 1553 is still applicable. NCCH will consider amendments to ACHI to include this advice and investigate the other issues raised by QCC. In response to your specific questions: 1. NCCH agrees that it is not necessary to assign an additional code for 'fat graft' when assigning codes from block [23] 'Cranioplasty' as this block includes 'procurement of fat graft'. 2. Block [23] 'Cranioplasty' excludes: that with intracranial procedure - omit cranioplasty code. Removal of an acoustic neuroma is an intracranial procedure. A craniotomy is performed to access the lesion and a fat graft is performed as a component of the repair of the cranium (ie a cranioplasty). As indicated by the excludes note in block [23], a code for the cranioplasty is not assigned when coding removal of acoustic neuroma and</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
0805-13	Index request NEMs (intrauterine and subdermal implant) with admission for removal of contraceptive device.	Thank you for considering indexing the following terms – intrauterine and subdermal implant, as nonessential modifiers within the relevant ICD index pathways for contraceptive management as this would facilitate confirmation of correct code assignment. This request is in response to general coding enquires which have highlighted that there has been preliminary uncertainty in assigning Z30.5 Surveillance of (intrauterine) contraceptive device for episodes when the contraceptive device is specified as a subdermal implant. Removal - device - contraceptive (intrauterine) (subdermal implant) Z30.5 Admission - contraceptive management Z30.9 - counselling and advice Z30.0 - device (intrauterine) (IUCD) (subdermal implant) - insertion Z30.1 - surveillance (check) (reinsertion) (removal) Z30.5	The committee agreed to forward the query to the NCCH.	hence the procurement of the fat graft is also not coded. This query has been added to the NCCH task list
0705-12	Diabetes with Hypernatraemia	Thank you for confirming that the excludes note within the tabular list at code E87.0 Hyperosmolality and hypernatraemia only applies to the term hyperosmolality and not to hypernatremia. The excludes note at E87.0 reads as Excludes: with diabetes mellitus (E11-14 with common fourth character . 0) and therefore suggests that if diabetes is present, the diabetic code mentioned above should be assigned regardless of the specific condition classified to E87.0 Hyperosmolality and hypernatremia. However, given that there is no index link for diabetes with hypernatremia (and as per the advice within ACS 0401 Diabetes Mellitus which states that only conditions indexed under Diabetes can be classified with complication categories within E10-14) it appears that this excludes note only applies to hyperosmolality and not to hypernatremia. Therefore would it be possible to modify the excludes note to reflect this specific detail i.e. Excludes: diabetes mellitus with hyperosmolality (E11-14 with common fourth character . 0)?	QCC agreed to forward this query to NCCH	12/9/06: Clinical advice received by the NCCH confirms that the excludes note at E87.0 Hyperosmolality and hypernatraemia applies to both conditions. The NCCH will consider indexing Diabetes with hypernatraemia, for a future edition of ICD-10-AM. NCCH advised that they have created a task to review the index under the lead term Diabetes, (subterm) with. Relevant excludes notes will also be reviewed and amended if necessary. NCCH further advised on 28 Feb 2006 that this query was reinstated on their query database for a response to be formulated to the QCC. The task will also remain on their database.
0805-04	Haemangioma	Patient admitted for excision of nasal septum haemangioma (front sheet and discharge summary) Operation report: excision of 1cm haemangioma (L) Anterior Nasal septum. Lig+ Adr injection. Incision around lesion. Vas gauze pack. R	The committee agreed that in this scenario to code the haemangioma to a pyogenic granuloma L98.0 as the pyogenic granuloma is a more specific form of haemangioma. The committee agreed to code the	NCCH agrees with the following codes for the case cited: L98.0 'Pyogenic granuloma' 90131-00 [377] 'Local excision of other intranasal lesion' with a code for the general anaesthetic NCCH will contact the

QCC_ID	Query summary	Query	Decision	Response from NCCH
		sept ok. General anaesthetic ASA II AUSLAB pathology reports lesion as pyogenic granuloma after much debate finally coded as L98.0 Pyogenic granuloma 90131-00[377] Local excision other internal lesion. 92514-29 [1910] GA. Is there a better way to code this as it groups to DRG J64B.	removal of the haemangioma to excision of vascular anomaly. The committee agreed to forward the query to the NCCH for clarification of the codes assigned. The committee agreed at the Feb 2006 meeting to request that the NCCH add this query to their task database.	Commonwealth Department of Health and Ageing in regards to the grouping issue.
0805-05	Z99.2	According to PICQ indicator number 101586, Z99.2-dependence on renal dialysis, cannot be coded in conjunction with a procedural code for dialysis. I presume that the logic behind this indicator is that a renal patient requiring dialysis is automatically dependent upon dialysis. Therefore the code is redundant. However, with the progression of technology and ability in regards to transplant, we are now seeing patients having transplants as an alternative treatment option to dialysis. It is not unusual for patients to have dialysis post-operatively through a portacath. It is not currently possible to differentiate between acute renal dialysis and chronic renal dialysis delivered in this manner. In these instances it would be very clinically useful to differentiate between patients who are ALREADY dependent upon dialysis and those who are not. This would require that the Z99.2 code be able to be coded in conjunction with dialysis codes. Where do we stand with this?	The committee determined that this issue needs to be raised with the NCCH so a query will be formulated by DSU. Until the issue is resolved the committee recommended that the PICQ indicator rule should be complied with.	The logic behind this indicator, is explained in Coding Matters, Vol11, No1 (June 2004, pg18). '.... Z99.2 Dependence on renal dialysis should only be used if documentation indicates that a patient is dependent on renal dialysis, but they do not receive dialysis during the episode of care, and the dependent status meets ACS 0002 Additional diagnoses.' The crux of the argument in the query submitted is that Z99.2 does not meet ACS 0002 and therefore should not be assigned. If a patient receives dialysis during the episode of care the excludes note at Z99.2 should be followed and a code for the dialysis assigned only. While we understand your issues the indicator is based on classification principles and it is not always possible to capture all these concepts.
0705-10	Z51.0 and Z51.1 as Additional Diagnoses	Thank you for confirming that Z51.0 Radiotherapy session and Z51.1 Pharmacotherapy session for a neoplasm should not be assigned as additional diagnoses for multi-day episodes of care (including overnight episodes of care) regardless of the patient being specifically admitted for chemotherapy and/or radiotherapy procedures. If the above interpretation of ACS 0044 CHEMOTHERAPY and ACS 0229 RADIOTHERAPY is correct could this specific detail be included within these standards as the above conclusion has been made by inference. I.e. ACS 0044 CHEMOTHERAPY provides classification advice on multi-day episodes of care but does not explicitly say that Z51.1 should not be assigned although it is inferred from a case example provided. As there has been a change in Z51.1 coding conventions between	Forwarded to NCCH	Multi-day episodes of care for chemotherapy should have a principal diagnosis code for the condition requiring treatment by chemotherapy. It is unnecessary to assign Z51.1 Pharmacotherapy session for neoplasm as an additional diagnosis. Multi Day inpatients receiving radiotherapy for malignant conditions should have the malignant condition sequenced as the Principal diagnosis. It is unnecessary to assign Z51.0 Radiotherapy session as an additional diagnosis.

QCC_ID	Query summary	Query	Decision	Response from NCCH
		ICD-10-AM editions providing this explicit classification advice would facilitate standardization of current coding conventions. Note, currently in Qld, edits do not allow the use of Z51.1 as an additional diagnosis for a multi-day episode where chemotherapy is administered.		
0705-17	ERCP with Bile Duct Washings	Thank you for confirming if previous advice regarding ERCP with bile duct washings is still valid and giving consideration then to future indexing of this procedure.NCCH query number 1399 (June 2001) advises to code this to 30484-00 [957] Endoscopic retrograde cholangiography with an additional code of 90323-00 [973] Other procedures on biliary tract.	Forwarded to NCCH	Added to NCCH Task Database on 2/11/2006. Reinstated on NCCH Query database on 28/2/2006 for response to be formulated to QCC. 2.5.06: The advice in query 1399 is still valid. Clinical advice states that 'bile duct brushings/washings are not considered to be a component of ERCP. Bile duct brushings/washings are considered to be a procedure in their own right.' For documentation of 'ERCP with bile duct washing' assign: 30484-00 [957] 'Endoscopic Retrograde Cholangiopancreatography' 90323-00 [973] 'Other procedures on biliary tract' The NCCH will consider reviewing codes for brushings/washings for a future edition ofACHI. 16/6/06: The NCCH have committed to put this information into the 10 Commandments at a future date.
0705-16	Pipelle Aspiration	Thank you for advising which code to use for Pipelle aspiration and giving consideration to adding a future index entry for this term.Pipelle aspiration is performed as a means of non-invasively sampling endometrium and is done without cervical dilation or anaesthesia.It involves inserting a pipelle (thin long tube with a plunger at one end) into the uterine cavity and aspirating endometrial tissue.After reviewing the options available, 35640-01[1265] Curettage of uterus without dilation appears to be the most appropriate code to assign, given that other endometrial biopsy codes: 35630-00[1259] Diagnostic hysteroscopy and 35620-00 [1264] Biopsy of endometrium are used when the procedure is performed endoscopically or via the open approach respectively.	Forwarded to NCCH. The committee agreed at the Feb 206 meeting to request that the NCCH add this query to their task database.	For documentation of 'pipelle aspiration of endometrium', NCCH suggests following the index pathway: Biopsy - endometrium (endoscopic) and assigning the default code: 35630-00 [1259] 'Diagnostic hysteroscopy'
0705-15	Acquired Absence of Urethra	Thank you for confirming which code should be assigned for acquired absence of urethra and giving consideration then to including a future index entry for this term.Although Z90.6 Acquired absence of other organs of urinary tract appears to	Forwarded to NCCH	The urethra is a component of the urinary tract. The NCCH agrees that 'acquired absence of urethra' should be classified to: Z90.6 'Acquired absence of other organs of urinary tract'. The NCCH will consider appropriate

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>be an appropriate code there is no ICD index for 'acquired absence of urethra', or any possibility of using default terms such as 'acquired absent of urinary tract NEC'. Therefore, given that there is no index link to Z90.6 Acquired absence of other organs of urinary tract, should N36.8 Other specified disorders of urethra be assigned for acquired absence of urethra (as per the index lead term Disorder – urethra – – specified NEC N36.8)?</p>		<p>additions to the Alphabetic Index of Diseases.</p>
0705-13	Diabetes with Acidosis	<p>Thank you for reviewing the tabular list excludes note description at E87.2 Acidosis and giving consideration to its modification. The excludes note at E87.2 reads as: Excludes: diabetic acidosis (E10- E14 with common fourth character .1). This excludes note directs code assignment to E1x.1x Diabetes Mellitus with acidosis irrespective of additional mention of the type of 'diabetic acidosis', however when directed to E1x.1x, a code from this range can only be assigned if the acidosis is specified as ketoacidosis or lactic acidosis. Therefore, would it be possible to consider modifying the excludes note description to reflect this specific detail. For example, Excludes: diabetes with lactic acidosis and ketoacidosis (E10- E14 with common fourth character .1). This would also facilitate application of advice within ACS 0401 Diabetes Mellitus as there has been general queries raised as to whether metabolic acidosis (or any other type of acidosis e.g. respiratory acidosis and acidosis NOS) when present with diabetes should be coded to E1x.1x. This uncertainty may have arisen in part due to the fact that despite there being no index link for Diabetes with metabolic acidosis the code for metabolic acidosis (E87.2 Acidosis) contains an excludes note for diabetes</p>	Forwarded to NCCH	<p>Following clinical advice the NCCH would like to confirm that ketoacidosis and lactic acidosis are subtypes of metabolic acidosis. The excludes note at E87.2 Acidosis should, therefore, exclude diabetic acidosis with ketoacidosis, lactic acidosis and metabolic acidosis as sub terms. If respiratory acidosis or acidosis NOS is documented they should be coded separately as they are not characteristic of diabetes. The NCCH will consider amending the excludes note at E87.2 Acidosis and the indexing of diabetic acidosis for a future edition of ICD-10-AM. Added to Task database on 2/11/2005 Reinstated on NCCH query database on 28/2/2006 12/9/06:</p>
0705-11	Venous Ulcers	<p>Thank you for clarifying the coding of 'Venous Ulcer' as this is not directly indexed although a related term is possibly available within the index ,Ulcer — varicose (lower limb, any part) I83.0 Varicose veins of lower extremities with ulcer. When searching for related coding advice it is noted that there is a directive within Coding Matters Mar 05 (Vol.11. No. 4) regarding coding 'Venous Eczema' to I83.1 Varicose veins</p>	Forwarded to NCCH. The committee agreed at the Feb 2006 meeting that a request be made to the NCCH to publish an article in Coding Matters on this topic.	<p>NCCH agrees that venous ulcer NEC should be classified as I83.0 'Varicose veins of lower extremities with ulcer'. NCCH will forward a submission to WHO URC regarding indexing of these terms.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>of lower extremities with inflammation, however there is no specific advice regarding the coding of 'Venous Ulcer'. Similarly, it is also noted that there is advice (NCCH query 2098) regarding the coding of 'Venous Stasis Ulcer' to I83.0 Varicose veins of lower extremities with ulcer (as per the index Ulcer — stasis (venous) I83.0), this query does not provide any specific advice on 'Venous Ulcer' not otherwise specified. If applying indexing conventions 'stasis' is the essential term required prior to code assignment to I83.0 Varicose veins of lower extremities with ulcer. Therefore, please confirm if 'Venous Ulcer' not otherwise specified can be coded to I83.0 Varicose veins of lower extremities with ulcer and also giving consideration to formalising a future index entry for this common diagnostic expression.</p>		
0705-14	Croup — acute spasmodic and acute stridulous	<p>Thank you for confirming the ICD-10 indexing of acute spasmodic and acute stridulous croup. The index for acute spasmodic croup leads to J05.0 Acute obstructive laryngitis [croup] (as per the index Croup – spasmodic – acute J05.0). However it is noted that code assignment for acute stridulous croup is not influenced by the descriptor 'acute' as there is no sub-index for acute within ICD-10. Therefore code assignment for acute stridulous croup leads to J38.5 Laryngeal spasm (as per the index Croup – stridulous J38.5). As the terms acute spasmodic and acute stridulous croup appear synonymous, thank you for confirming that there does not need to be a sub-index for acute stridulous croup.</p>	Forwarded to NCCH	<p>NCCH RESPONSE 14/06/06: The NCCH agrees that acute stridulous croup should be coded to J05.0 Acute obstructive laryngitis. The indexing will be amended in a future edition of ACHI. Added to NCCH Task Database on 02/11/2005. Reinstated on NCCH Query database on 28/2/2006 for response to be formulated to QCC</p>
0905-07	Situational Crisis	<p>Please advise what code should be assigned for situational crisis. Please see attached notes. Another scenario where code assignment for situational crisis is difficult, is where there has been long term problems such as financial or marital conflict and then the person loses their job or has another fight, and then takes an overdose. What criteria can coders use to know when F43.0, F43.2 or both should be used.</p>	<p>This issue has previously been submitted to the NCCH for advice. DSU to follow up the status of that query.</p>	<p>0705-09 Query response - similar to this query Clinical advice indicates that a situational crisis may be any current situation that is causing stress. It is not a disorder of legitimate diagnosis, but may occur as part of an acute stress reaction with symptoms that require medical attention. If, however, a stressor is ongoing and has gone beyond the usual, normal, acute stress, it becomes a problem of adjustment and the ongoing symptoms are now considered to have developed into a disorder. This may be described as a situational crisis, but the main problem is one of adjustment. Where 'situational crisis' is</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
				documented, coders should seek clarification from the treating clinician to determine if the patient has acute stress or an adjustment disorder. When documentation is incomplete and clinical advice is unavailable please assign F43.0 'Acute stress reaction'.
0905-01	Debridement of outer table of skull and orbit	Attached is the operation report and pathology reports. Patient was admitted for debridement of skull/orbital bone and which was done in conjunction with a radical resection of peri-orbital tumour (45811) and delay flap procedure. The item number the surgeon has used is 39906. For coding, the tabular index has no code for debridement of skull but at the second indent this item number corresponds to debridement for infection (which is not documented). Could you please provide advise on the correct codes. I have assigned the following codes. 31340-00 Excision of muscle, bone or cartilage involved with lesion of skin 31235-00 Excision of lesion of skin and subcutaneous tissue of other site of head x7 31230-00 Excision of lesion of skin and subcutaneous tissue of eyelid x3 42530-00 Delay of direct distant skin flap 39700-00 Excision of lesion of skull 92514-29 Anaesthetic	The committee agreed that the debridement of the skull/orbital bone would be a procedural component of 31340-00. A submission to the NCCH will be formulated by DSU however to alert them to the possible need for a new code for debridement of skull.	Task created in Task Database on 29/11/2005. Reinstated on NCCH query database on 28/2/2006 for response to QCC. 2.5.06: The NCCH concurs with the QCC in the assignment of 31340-00 [1566] 'Excision of muscle, bone or cartilage involved with lesion of skin' to classify the debridement of skull/orbital bone associated with excision of periorbital tissue. The assignment of 39700-00 [13] 'Excision of lesion of skull' was considered unnecessary as this component of the procedure is classified within 31340-00 [1566] 'Excision of muscle, bone or cartilage with lesion of skin'. The current index pathway for 31340-00 [1566] was considered adequate: Excision - bone -- for --- lesion of skin 31340-00 [1566]
0905-12	COAD	I would like to clarify a number of code assignments relating to COAD 1. Please see NCCH database query 1963. Is this saying that if only "exacerbation COAD" is written, the correct code is J44.9? Is this also however saying that if the coder suspects that the admission is for short term worsening they can either apply a 'Coders Creed' and assign J44.1, or seek Clinician clarification? (So is either code technically acceptable so long as the exacerbation is not a long progressive worsening?). Can the same judgment be made if the patient also has other conditions causing shortness of breath eg heart failure or anaemia? If the coder is able to judge short term worsening would this be evidenced by for example a patient who normally suffers COAD who is admitted with increased shortness of breath which resolves and then is discharged in a similar condition prior to the events leading to admission. Would it be acceptable to use J44.1 if there were several such admissions over the space of	The committee agreed that these three queries should be forwarded to the NCCH.	NCCH advised that a Coding Matters article will be published to provide further background and explanation of previous coding advice.

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		<p>say a few months (Are there any time guides?). If not specified as acute, would a length of stay of 'weeks' preclude the use of J44.1 (if so, again are there any time guides). Would it matter how severe the COAD was in the first place (eg if on home oxygen) so long as the coder could identify an admission for worsening and then significant resolution Also relation to this query, the strict look up of the index is that the correct code for "infective exacerbation of COAD" is J44.9. - - obstructive (chronic) J44.9 - - - with - - - - acute - - - - exacerbation NEC J44.1 - - - - lower respiratory infection (except influenza) J44.0 However ACS 1008 states "Infective exacerbation of COPD does not require an additional code to reflect the infective description unless the infective condition is a condition in its own right, such as pneumonia. In this case the pneumonia should be coded as an additional diagnosis. If there is no documented infective disorder, a diagnosis of 'infective exacerbation of COPD' or 'chest infection exacerbating COPD' should be assigned the code J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection". In this standard there is in no mention of the need to have 'acute' documented. This it at odds with the index. Is the correct code for infective exacerbation of COAD J44.0 and if so can the index be modified to reflect this or a note made that the standard overrides the index with respect to this particular point. 2. Please see NCCH database query 1895 Is this saying that if a patient either has COAD and is admitted with pneumonia (or is admitted with other conditions and has COAD and subsequently develops pneumonia), but the COAD is not stated to be exacerbated, then the correct codes are J18.9 (or specific pneumonia code) and J44.9? 3. Please see NCCH database query 1963 Please advise the correct codes for COAD with emphysema when there is no mention of exacerbation or infection? If the correct code for COAD with either emphysema or asthma when there is no mention of exacerbation or infection is J44.8, can the index (and tabular or standard) be updated to reflect this. Currently the code given is J44._ and without clear and prominent direction it is likely that large numbers of coders are doing two</p>		

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0905-10	Pruritis during Pregnancy	<p>different things.</p> <p>Could the NCCH please consider adding a NEC note to the ICD-10-AM index entry, Pregnancy -complicated by -- conditions in ---L00-L99,O99.7 as this index entry does not prompt coders to search elsewhere within ICD-10-AM index for the appropriate code when coding pruritis during pregnancy (ie O26.88 Other specified pregnancy related conditions, as per the ICD-10-AM index pathway Pregnancy - complicated by ---pruritis (neurogenic) O26.88; and L29.9 prurities, unspecified, as per the ICD index pathway Pruritis, pruritic L29.9</p>	A submission will be formulated to the NCCH by DSU	
0905-04	Sequencing of codes for admissions for minor injuries and mental health conditions	<p>Please advise the correct codes for the attached scenario. Some patients may have a wound which requires a procedure which qualifies as an admission eg suture of deep tissues, and it would seem appropriate to sequence the wound as the PD and psychiatric condition as other diagnosis. Others may have only minor wounds (still requiring suturing) which would normally just be sutured in ED and the patient allowed home, but the patient is admitted for treatment of their psychiatric condition. When a patient presents with a wound and the patient receives treatment for an associated psychiatric condition should the wound be sequenced as the PD only if there is documentation that the patient was admitted for treatment of the wound specifically or should the wound be used as the PD in all cases using the same logic as ACS 0503 drug overdose. 0530 DRUG OVERDOSE When an admission is occasioned for treatment of a drug overdose and the patient subsequently receives treatment for an associated psychiatric condition in the same episode of care, the overdose should be sequenced as the principal diagnosis. Note that in most states the episode of care will continue to be regarded as an 'acute' care type (refer to the National Health Data Committee. (2001) National Health Data Dictionary, Version 10, AIHW) and therefore will be coded as one episode of care.</p>	The committee agreed that this query should be forwarded to the NCCH.	<p>1. NCCH agrees that conditions documented in emergency departments immediately prior to admission are applicable to the admitted episode of care. However, some states may have a different position to this one. Coders should always apply the guidelines in ACS 0001 PRINCIPAL DIAGNOSIS when determining the principal diagnosis for an episode of care. Note: in applying ACS 0001, the condition chiefly responsible for an attendance at an Emergency Department may not be the condition chiefly responsible for occasioning an episode of admitted patient care. For example, for the scenario cited; 'patient treated for scalp wound in the emergency department and subsequently admitted following confusion and bizarre behaviour (due to mental condition)', assign: A code for the mental condition as the principal diagnosis A code for the scalp wound as an additional diagnosis 2. ACS 0530 DRUG OVERDOSE is only applicable when an admission is occasioned for treatment of a drug overdose and the patient subsequently receives treatment for an associated psychiatric condition in the same episode of care. The purpose of ACS 0530 is to create standardisation for these types of admissions. 3. As above See also query 2216</p>
0905-11	Exhaustion during Pregnancy	Could you please confirm that two codes are required when coding exhaustion during pregnancy ie O26.88 Other	The committee agreed that this query should be forwarded to the NCCH.	14/06/06: The NCCH confirms that O26.88 Other specified pregnancy-related conditions is a Type 1

QCC_ID	Query summary	Query	Decision	Response from NCCH
		specified pregnancy related - conditions and R53 Malaise and fatigue as Codefinder currently assigns only O26.88. Although it is noted that O26.88 has an inclusion note at R53 Malaise and fatigue for pregnancy, it is presumed that this is a Type I exclusion note and therefore R53 would still need to be assigned as this adds additional information to the codeset.		exclusion at R53 Malaise and fatigue. For multiple condition coding R53 Malaise and fatigue would be used as an additional code to fully describe the diagnostic statement. Please refer to ACS 0033 Conventions used in the Tabular List of Diseases and ACS 0027 Multiple Coding.
0905-08	Zadecks Procedure	Could you please advise on the most appropriate procedure code to assign for a Zadecks procedure. Currently there is no procedure index entry for Zadecks. Preliminary investigation suggests that this is a radical ingrown toenail excision. Thank you for confirming that 47918-00 [1632] Radical excision of ingrown toenail bed can be assigned when a Zadecks procedure is documented without any further qualifying information and then giving consideration to creating an index entry for this common term.	The committee agreed that this query should be forwarded to the NCCH. After reviewing the NCCH response to this query at the Feb 2006 meeting, the QCC decided to ask the NCCH to publish an article on this topic.	29/11/2005 Task created in task database. NCCH requested to also respond to specific query re the use of 47918-00 [1632] Radical excision of ingrown toenail bed when a Zadecks procedure is documented without any further qualifying information, as an interim solution. Additional Response 4/4/06 NCCH supports the code suggested by QCC for Zadek's procedure: 47918-00 [1632] 'Radical excision of ingrown toenail bed'. NCCH will consider the addition of Zadek's procedure to the Alphabetic Index of ACHI for a future edition.
0905-09	Index request for delivery complicated by injury or damage to pelvic joint or ligament	Could the NCCH please consider adding subterms under the lead term devliery for injury and damage to pelvic joints and ligaments. When coding injury or damage to pelvic joint ot ligament complicating pregnancy the appropriate code is located under the lead term damage or injury. Damage -pelvis --joint or ligament, during delivery O71.6 or Injury -pelvis, pelvic (floor) --joint or ligament, complicating delivery O71.6 However these index entreies may be overlooked when coding as they are outside the delivery section in ICD-10-AM	A submission will be formulated to the NCCH by DSU. Awaiting M. Duncan to formulate query as at 28/2/2006.	Task created in task database
0905-06	? Drink Spiking	Please advise the correct codes for these scenarios: There is a problem in adequately reflecting some presentations for ? drink spiking. A typical situation is that the patient has been in a situation where drink spiking was either possible or likely. They may or not have been drinking an excess amount of alcohol and this is often not clearly documented. They may develop symptoms such as headache, nausea, vomiting and present to hospital, suspecting that they may have had their drink spiked. In cases where the clinician uses an admission diagnosis of ? drink spiking and symptoms resolve with no treatment given (this may or not be that the effects wear off) and no specific tests have been undertaken, following ACS	The committee were undecided on how to correctly code this scenario and determined further investigation was required prior to providing final advice. DSU to consider issues further and report back at next meeting. The query will be forwarded to the NCCH. After reviewing the NCCH response to this query at the Feb 2006 meeting, the QCC decided to ask the NCCH to publish an article on this topic.	1. For the scenario cited, assign codes for the symptoms documented. A decision on whether Z03.6 'Observation for suspected toxic effect from ingested substance' is assigned as an additional diagnosis to flag cases where documentation states '?/suspected drink spiking' should be made at the local hospital level. 2. Where clinical documentation does not support or suspect drink spiking, assign only codes for the symptoms documented. NCCH does not support the assignment of external cause codes for these cases.

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		0012 only the symptoms are coded. However does Z03.6 as the Principal Condition and associated external cause codes (drug NOS and alcohol) and symptom codes as additional, better reflect the situation? Can Z03.6 be used if bloods taken or urine tested or is it to be reserved for strictly 'observation' only. In cases where the patient feels their drink may have been spiked, but where this is not reiterated by the clinician, should the symptoms only be coded? or a code from Z03.6 and associated external cause codes (drug NOS and alcohol) as per the question above?		
0905-13	Cause of Death and ACS 0002 Additional Diagnosis	Patient admitted with cellulitis of the toe with PVD. The patient was planned for discharge after having being admitted for two weeks. On the day the patient was to be discharged the treating team went to the patient's bed and found the patient dead. 'Myocardial Infarction' (duration period of minutes) was listed as cause of death on the death certificate. The patient had a history of IHD but during this admission there was no further mention of this condition, or any mention of MI anywhere in the record other than the death certificate. Should the myocardial infarction be coded, or should the MI not be coded given that it does not meet the criteria of an additional diagnosis? The committee acknowledged that although the MI does not appear to fulfil the additional diagnosis criteria, it was proposed that from an epidemiological perspective it would be important to code conditions that resulted in death even though the criteria of an additional diagnosis may not be fulfilled. However, the QCC agreed that this issue should be forwarded to the NCCH.	Forwarded to NCCH	
0905-05	Alcohol with minor OD	ACS 1903 TWO OR MORE DRUGS TAKEN IN COMBINATION Medication combined with alcohol An adverse reaction to a drug taken in combination with alcohol should be coded as poisoning by both agents. Please advise whether this standard applies when a patient has been admitted intoxicated, having taken a minor overdose which after assessment/observation does not require investigation or treatment. I understand that a reaction to a drug can be exacerbated or altered by alcohol and hence capturing the	The committee agreed that this query should be forwarded to the NCCH.	1. F10 'Mental and behavioural disorders due to use of alcohol' excludes overdose. If documentation in the clinical record states 'overdose', assign an appropriate poisoning code (see ACS 0503 DRUG, ALCOHOL AND TOBACCO USE DISORDERS, General classification rules). 2. As above, if documentation states 'overdose', assign an appropriate poisoning code. Codes from Z03 'Medical observation and evaluation for suspected diseases and conditions' are only assigned for conditions

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		<p>combination is important. However if there are no symptoms of the minor drug overdose does the same coding rule apply? Also for minor overdoses with no symptoms (stated minor) should poisoning codes still be used or is Z03.6 a better alternative?</p>		<p>documented as 'suspected' conditions.</p>
0905-02	Colonic Stent	<p>PAH would like to have input into the coding of insertion of a colonic stent. These are traditionally inserted for obstruction caused by neoplasms. They are not normally done endoscopically. There is a code for insertion of duodenal stent (92068-00- endoscopic insertion of duodenal prosthesis). There is no code currently for insertion of colonic stent, endoscopic or otherwise. Could we please forward to the NCCH for their input. In response to QCC query 0905-02, the Data Services Unit is preparing a submission to the NCCH for new procedure codes to be created for endoscopic insertion of rectal, colonic and colorectal junction stents. In the interim could the QCC recommend how to code these procedures and also review previous coding advice on endoscopic insertion of rectal stents? QCC query 0203-03 suggests assigning the following codes for endoscopic insertion of rectal stent, 90314-00 [942] Other procedures on rectum, 32084-00 [905] Fibreoptic colonoscopy to hepatic flexure and 92066-00 [1894] Insertion of rectal tube. However as the procedure description specifically mentions stent and given that a rectal stent and tube are different devices could the QCC further evaluate if the code for rectal tube should be assigned when coding 'endoscopic insertion of rectal stent'? Could the QCC also recommend how to code endoscopic insertion of a colonic stent? Should this be coded to 90310-00 [925] Other procedures on large intestine with an appropriate colonoscopy code? Or would 32094-00 [917] Endoscopic dilation of colorectal stricture be considered more reflective of the procedure (as per the index entry, Dilation - colon - - stricture - - - and rectal stricture (endoscopic) 32094-00 [917]), although it is acknowledged that 'dilation' and 'stricture' may not necessarily be documented, and that the stenting component is still not captured within the code. Additionally, it is noted that the above Index entry does not provide a code</p>	<p>A submission to the NCCH will be formulated by DSU to request a new code for insertion of colonic stent</p>	

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		<p>number at the indent after - colon - - stricture (i.e. Dilation - colon - - stricture) so as to enable a code to be assigned when there has been dilation of a colonic stricture without dilation of a rectal stricture . Therefore, it is suggested that there be an index entry for Dilation - colonic - - stricture (endoscopic) 32094-00 [917] Endoscopic dilation of colorectal stricture as this would facilitate code assignment. What code/s should be assigned for endoscopic insertion of a colorectal stent (i.e. stent placed at the colorectal junction)? Should this be coded to 90310-00 [925] Other procedures on large intestine. Or would it be considered more reflective to assign 32094-00 [917] Endoscopic dilation of colorectal stricture as proposed above, AND to then also assign Other procedures on large intestine in an attempt to capture the stenting component?</p>		
0905-03	Z75.3 Unavailability and inaccessibility of health-care facilities	<p>Is it possible to create a new QHAPDC edit to identify episodes with ICD code Z75.3 Unavailability and inaccessibility of health-care facilities and a discharge code other than 16 Transfer? ACS 0012 states that if a patient is transferred for further investigation of a suspected condition, the transferring hospital should assign the suspected condition code as well as Z75.3 as a 'flag' to identify patients transferred because of a suspected condition. Z75.3 should not be used for ALL transfers as the discharge status provides that information.</p>	<p>The committee agreed that this issue should be investigated further by analysing the data to determine the extent of the problem prior to implementing the edit. M.Duncan summarised her recent review of the use of Z75.3 Unavailability and inaccessibility of health-care facilities and discharge status other than 16 – Transferred to another hospital. DSU had received a request to create an edit for those instances where Z75.3 exists and the discharge status is not 'transferred to another hospital'. M. Duncan advised that an extract from QHAPDC for the year 2004/2005 revealed that there were 817 instances where Z75.3 existed with a discharge status other than 'transferred to another hospital'. The table below is an itemised summary of these occurrences. Discharge Status Number of episodes with a Z75.3 code  01 – Home/usual residence 564  04 – Other health care establishment 195  05 – Died in hospital 7  06 – Care type change 23  07 – Discharge at own risk 4  09 – Non-return from leave 1  12 – Correctional facility 1  15 – Residential aged care service 13  19 – Other 9  M. Duncan advised that she contacted 10 hospitals to follow up</p>	

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			<p>on the local use of Z75.3. As a result 166 episodes of care were reviewed by the reporting hospital, of these 3 had a 'reported' discharge status of '05' – Died in hospital, and the remainder had a 'reported' discharge status of '01' – Home/usual residence. The most significant finding reported by hospitals reviewing these episodes of care, was that the discharge status reported within HBCIS was incorrect. Over 50% of the episodes that were reviewed, the patient had been transferred to another hospital but had a reported discharge status of home in the HBCIS module. There were two reported episodes where the actual discharge was to a hostel or nursing home. Of the episodes where the patient was transferred to another hospital, some facilities reported that they had assigned Z753 in circumstances that were not governed by ACS 0012 Suspected Conditions. Lack of reporting capabilities in the HBCIS module was mentioned as a reason for assigning Z75.3 for those transfers that did not fulfil ACS 0012. These facilities indicated that they have since changed practice as a result of a coding audit and/or this QCC query request. The committee members made the following recommendations based on the findings of this study. A request should be submitted to enhance the HBCIS ICD coding screen to include the display of the patient's Separation Mode. Coders can therefore check to ensure that the Separation Mode recorded in the patient's medical record has been accurately recorded on HBCIS. A request will also be made to change the position of '16 – Transfer to Acute Facility' on the list of valid separation modes in HBCIS. Currently this option appears towards the end of the list which may explain why it is often not selected when it should be. The NCCH will also be approached to reword ACS 0012 to make it clear that Z75.3 should only be used for transfers because of a</p>	

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			<p>suspected condition. It was felt that the current wording allowed various interpretations of the appropriate use of this code. This also explained why the code has been applied in cases outside the intention of the ACS. It was also suggested that the NCCH could be asked to include additional codes at the fourth digit level at Z75.3 to indicate various reasons for the unavailability of the health care facility. Alternatively this information (reason for transfer) could be captured in HBCIS. The committee also recommended that an article be published in Codefile on this topic prior to the introduction of the recommended new edit.</p>	
1005-06	<p>Pathway Error with inappropriate DRG 901Z (4.2)</p>	<p>PDX M771 Lateral epicondylitis PPX Patient admitted for Arthroscopic Release of Elbow Due to pathway error for this procedure, the Arthroscopic aspect of this procedure changes the DRG from I19Z to 901Z DRG printouts are attached x 3</p>	<p>Committee members advised that this was a problem in the V4.2 grouper which has been rectified in V5.0. However, would probably code the supplied operation report (which is documented as: Arthroscopic release of Elbow lateral position, standard arthroscopy, ant/post capsulectomy, Full ROM,) to 90570-00 [1555] Division of joint capsule, ligament or cartilage, NEC, as per the index, Release- capsule- -joint NEC 90570-00 [1555]; with an additional arthroscopy code. Additionally have noted that there appears to be a Codefinder bug within the Capsulectomy pathway (i.e. automatically defaults to arthrorectomy, yet the index specifies 'See also' arthrorectomy, rather than 'See' arthrorectomy). This will be further investigated with 3M</p>	
1005-08	<p>Female Prolapsed Urethra</p>	<p>Could the QCC consider forwarding to the NCCH a request for an index entry to be created for 'female prolapsed urethra'? Currently the index leads to N36.3 Prolapsed urethral mucosa when coding prolapsed urethra in a female patient. However, if coding urethrocele in a female patient the index leads to N81.0 Female urethrocele. Given that these terms are by definition the same condition (i.e. a prolapsed urethra is a urethrocele) could a sub-index entry be made for female under the lead term Prolapsed urethra as this would</p>	<p>Investigation into condition is being undertaken</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>facilitate code assignment to N81.0 Female urethrocele when coding prolapsed urethra in a female patient. Although it is noted that there is a Tabular List exclusion note at N36.3 Prolapsed urethral mucosa (Excludes: urethrocele, female) which subsequently redirects code assignment to N81.0 Female urethrocele, this may not be applied if interpreted to mean only if the term "urethrocele" is specifically documented. Therefore, could the QCC also consider recommending if the edit category attached to N36.3 Prolapsed urethral mucosa should be changed from a warning to a fatal. Currently there is a warning edit for this code in female patients, however given the above discussion regarding the exclusion note at N36.3 it would seem appropriate to categorize this edit type to a fatal.</p>		
1005-05	Stryker Infusion	<p>Could you please provide advise the correct code for stryker when used to reinfuse blood during a procedure. Stryker is a company name and collection system use for joint replacements. A drainage tube drains the joint and the blood is collected in a receptacle and there is enough it is reinfused. I have coded it to autologous blood transfusion.</p>	<p>When stryker receptacle is used for reinfusing blood the committee agreed to assign the code 92060-00 [1893] autologous blood transfusion</p>	
1005-01	Laryngopharyngectomy with intestinal graft repair	<p>Patient had Laryngopharyngectomy with graft from the intestine to repair. How is this coded? Laryngopharyngectomy and plastic reconstruction? (what does this code include?) Free flap? How is the harvesting of the jejunum coded? We have only coded for the time being, 30294-01 Laryngectomy and plastic reconstruction AND 45562-00 Noninnervated free flap.</p>	<p>The committee agreed that in this scenario to assign the following codes: 30294-01 Laryngectomy and plastic reconstruction 45562-00 Noninnervated free flap 45502-02 microanastomosis of artery and vein The committee agreed to not to assign a code for the harvesting of the jejunal flap as the committee felt that the harvesting of jejunal flap is encompassed in the free flap code. The committee agreed to forward the query to the NCCH for confirmation of the codes assigned and clarification of plastic reconstruction in the code title Laryngectomy with plastic reconstruction? The committee would like the NCCH to consider creating an index entry under procurement for jejunal flap see free flap.</p>	<p>NCCH suggests the following codes for the case cited: 30294-00 [529] 'Laryngopharyngectomy and plastic reconstruction' 45562-00 [1674] 'Noninnervated free flap' 45502-02 [1695] 'Microsurgical anastomosis of artery and vein' 30375-24 [901] 'Suture of small intestine' 45562-00 [1674] 'Noninnervated free flap' instructs coders to 'code also when performed: repair of secondary defect, noncutaneous, by suture (see Index: Suture, by site)'. Therefore, NCCH suggests the assignment of 30375-24 for repair of the graft site in the jejunum by following the index pathway: 'Suture, intestine, small'. NCCH agrees that the harvesting of the jejunal flap is inherent in the free flap code (see ACS 0016 GENERAL PROCEDURE GUIDELINES, Procedure components) and therefore should not be assigned a separate code. The term 'plastic reconstruction' in the code title for 30294-00 [529] 'Laryngopharyngectomy and plastic reconstruction' is a</p>

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				derivative of the MBS item description which is the basis of this ACHI code. This code does not include the flap used to reconstruct the site and should, therefore, be coded as above. NCCH already has a task on the database to review the codes and ACS for flaps/free flaps.
1005-03	Fatal Error regarding diagnosis for division of preputial adhesions	Documented Diagnosis: Preputial adhesions after circumcision Documented Procedure: Division of penile adhesions Coded as: N47 Redundant prepuce, phimosis and paraphimosis Adherent prepuce Tight foreskin AND 90402-01 Division of penile adhesions This coding results in a fatal DSU edit: ICD-H579 Code 90402-01 can only be used in conjunction with Q55.8 This is not a congenital condition as the adhesions developed after an elective circumcision.	The committee agreed that the range of acceptable diagnosis codes for division of penile adhesions edit should be extended to include N47 Redundant prepuce, phimosis and paraphimosis. The committee also agreed to extend the edit to include N99.8 Other Postprocedural disorders of the genitourinary system when Preputial adhesions are documented as a post procedural complication.	
1005-07	Pathway query to Irvine-Gass Syndrome	Patient has Irvine-Gass Syndrome. You can follow pathway with the Codefinder by entering Irvine-Gass Syndrome which takes you to H35.8 Other Specified Retinal Disorders. However you cannot get to this by entering Syndrome Irvine-Gass. I also query the code H35.8 as Irvine-Gass is generally a post procedural complication according to the literature. So possibly H59.8 would be assigned with H35.8. Irvine-Gass Syndrome is actually macular accumulation of fluid/edema causing cystlike spaces therefore H35.3 Degeneration of macula and posterior pole (oedema macula cystoid) may be more suitable instead of H35.8. See Supporting Information Below: Macular Edema, Irvine-Gass emedicine Background: Macular accumulation of fluid/edema causing cystlike spaces after ocular surgery (typically cataract surgery) is referred to as Irvine-Gass syndrome. The fluid may be intercellular in the outer plexiform and inner nuclear layers of the retina or intracellular, causing Müller cell degeneration with intracellular vacuolation. The definition of macular edema should be differentiated into clinical macular edema based on biomicroscopic examination and angiographic cystoid macular edema (CME) based on fluorescein angiography. Angiographic CME does not necessarily affect visual acuity. CME occurs in association with a variety of ocular conditions	From the literature supplied the committee felt that Irvine Gass Syndrome is a postprocedural condition and agreed to assign H59.8 and H35.8 or H53.3 to further describe the condition. The committee felt that the H35.3 is the most suitable code would like confirmation from the NCCH on the codes assigned. The committee would like the NCCH to consider creating an index entry under syndrome for Irvine Gass.	NCCH suggests the following codes for documentation of Irvine Gass syndrome: H59.8 'Other postprocedural disorders of eye and adnexa' H35.8 'Other specified retinal disorders' NCCH will consider the addition of index entries for this condition for a future edition.

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>and is a frequent and serious complication of intraocular inflammation. Multiple remissions and exacerbations of macular edema or persistent macular edema may result in foveal receptor damage and macular degeneration with permanent impairment of central vision. Pathophysiology: Several theories have been implicated in the pathophysiology of Irvine-Gass syndrome. The most popular theory involves intraocular inflammation, for example, when CME complicates uveitis or traction/distortion of the iris. Inflammatory mediators, such as the prostaglandins and leukotrienes have been implicated in the pathogenesis. In the prostaglandin pathway, inflammation causes the enzyme phospholipase to release arachidonic acid from cell walls. Subsequently, cyclooxygenase converts the arachidonic acid to prostaglandins. The enzyme phospholipase is inhibited by steroids, and the cyclooxygenase is inhibited by aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs). The prostaglandins have vasoactive effects causing vasodilation, increased capillary permeability, and breakdown of the blood-retinal barrier. This results in weakening of tight endothelial junctions in retinal capillaries and decreased pumping of retinal fluid from the retinal pigment epithelium. Leukotrienes account for an alternate pathway where the enzyme lipoxygenase converts the arachidonic acid to leukotrienes, which are chemotactic agents. However, the exact role of leukotrienes in CME remains unclear. Vitreomacular traction is another etiologic factor and sometimes is identified in patients with CME that undergo vitrectomy. Finally, ultraviolet light may play a role given that angiographic evidence of CME is higher in eyes without ultraviolet light filter on the intraocular implant lens. Frequency: In the US: Incidence of Irvine-Gass syndrome is variable depending on the type of surgical procedure performed and the clinical series reported. Overall, the incidence is approximately 50% after intracapsular cataract extraction, 20% after extracapsular cataract extraction (ECCE), and 10% after phacoemulsification surgery. However, studies have reported that the occurrence of clinically significant macular edema varies between 1.5-</p>		

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>2.3%. Internationally: Studies have reported similar incidence of Irvine-Gass syndrome internationally and in the United States. Mortality/Morbidity: The natural history is variable. Pseudophakic CME often resolves spontaneously, and 90% of eyes improve to 20/40 or better visual acuity in cases with a posterior chamber intraocular lens (IOL). However, remissions and exacerbations of macular edema can result in foveal receptor damage and macular degeneration with permanent impairment of central vision. Race: Irvine-Gass syndrome occurs less frequently in African Americans compared to Caucasians. Sex: No sexual predilection exists. Age: Old age is a risk factor. It occurs infrequently after extracapsular cataract extraction in children. However, if lens extraction in infants is accompanied by an anterior vitrectomy, then significant and persistent macular edema may occur. History: Patients presenting with Irvine-Gass syndrome often have a history of prior intraocular surgery in the same eye. Risk factors may be present in the affected eye. The patient usually presents with gradually decreasing vision. Physical: Biomicroscopic examination reveals the characteristic cystic spaces in the foveal region. Evidence of intraocular inflammation may be present in some cases. Also, ciliary flush and papilledema may accompany CME. Causes: The following risk factors have been associated with Irvine-Gass syndrome: Intraocular surgery complicated by rupture of the posterior capsule, vitreous loss, or insertion of a flexible open-loop anterior chamber IOL Secondary lens implantation (4.6% incidence) Intraocular lens exchange (18% incidence) Old age Ocular inflammatory diseases or preexisting uveitis is a risk factor. CME was the major cause of visual loss in 74% of eyes with visual acuity of 20/40 or less in patients with pars planitis, sarcoid, juvenile rheumatoid arthritis, or other types of uveitis. Penetrating keratoplasty secondary to pseudophakic bullous keratopathy. Most studies report an incidence of 20-40% depending on the type of IOL and surgical technique used. YAG capsulotomy is associated with an increased risk of CME (0-5.6%). Topical epinephrine therapy Associated with choroidal melanomas Topical latanoprost use after</p>		

QCC_ID	Query summary	Query	Decision	Response from NCCH
		cataract surgery		
1005-04	Coding Matters Commandment attached to lock O75	Can QCC please advise whether the Coding Matters Commandment Premature rupture of membranes and long labour/delivery (Vol 7 no 2) should be applied to all codes in O75. O75 is a NEC category and should be used rarely as there will usually be other conditions documented which cause delay of delivery, eg uterine inertia, obstruction, delayed second stage etc. Such conditions should be coded in preference to a code from O75. O75.5 should be assigned where there is a delayed delivery NOS (either onset of labour is delayed or the labour itself may be long) following artificial rupture of membranes. The rupture could be either before labour (induced, ARM) or during labour (augmentation). This code should be used rarely, as in most cases a combination of methods, both surgical and medical, will be used to induce and/or augment labour. O75.6 should be assigned rarely and only where there is a delayed delivery NOS (either onset of labour is delayed or the labour itself may be long). We assume that this commandment is aimed at the use of O75.5 & O75.6 only as there are other codes in the O75 category that have nothing to do with the delay of delivery (O75.2 Pyrexia during labour NEC). The first sentence can be confusing to coders who don't routinely code obstetrics and will result in forlorn search for a better code for maternal sepsis, pyrexia etc. The commandment is attached to both 3M Codefinder and NCCH eBook. Can we suggest a corporate Queensland Health Codefinder Note attached to O75.	The committee felt that the advice in Coding Matters on Premature rupture of membranes and long labour/delivery (Vol 7 no 2) applies to codes O75.5 and O75.6 and not the whole of the O75 block of codes. The committee would like to seek clarification from the NCCH and suggest possible amendment to the article.	
1005-02	Safyre T Procedure	Could you please advise the correct code for suburethral sling for stress incontinence using Safyre T device. I have coded the procedure to 35599-00[1100]	The committee agreed to assign the code 35599-00 [1100] when Safyre T devices is used to treat stress incontinence	
1105-01	Pd sequencing for in admissions for treatment of Obstructive sleep apnoea by tonsillectomy for adeno-tonsillectomy	Can the QCC please confirm the sequencing of the PDX for admissions for children undergoing tonsillectomy/adeno-tonsillectomy procedures for the treatment of Obstructive Sleep Apnoea (OSA). This query is in response to a recent external audit in which the Auditor queried the use of OSA as the PDX Large tonsils and adenoids are the most common cause of OSA in children. We also treat children in our	The committee agreed that you would code the Obstructive Sleep Apnoea as the Pdx and the tonsillitis/large tonsils as the additional diagnosis as per NCCH query 2067. Coders should be reminded however that there must be a documented link between the OSA and the procedure.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Respiratory and Sleep Medicine Unit with congenital conditions as Prader-Willi Syndrome and craniofacial abnormalities causing OSA with some undergoing tonsillectomy/adeno-tonsillectomy. ACS 0635 Sleep apnoea and related disorders instructs the Coder to sequence OSA as PDx with an additional diagnosis code for the underlying cause when specified. Please note, a code for OSA is not routinely assigned in tonsillectomy/adeno-tonsillectomy admissions. Chronic tonsillitis still accounts for around 50% of paediatric admissions for tonsillectomy/adeno-tonsillectomy in our hospital. OSA is diagnosed at this hospital by polysomnography and then referral is made for surgery if appropriate. Often a follow-up polysomnography is performed to assess the success of the procedure. In addition to ACS 0635, our clinical advice and NCCH Database Query 2067 OSA, also confirms the appropriateness of sequencing OSA as the PDx. NCCH Query 2067 states that OSA, when documented as the reason for procedure, is the correct PDx in an admission for ENT surgery in an adult (including tonsillectomy, palatal advancement, uvulopalatal flap and hyoid suspension).</p>		
1105-02	Lumbar microdisectomy	<p>Could the QCC provide advice as to whether lumbar microdisectomy should be coded as: Percutaneous lumbar Discectomy: 48636-00 [52] Or Lumbar Discectomy: 40300-00 [52] Microdiscectomy involves a small 2 cm incision through which an endoscope (or an operating microscope) is introduced. The disc is then removed under either microscopic or endoscopic vision. Additionally, does the QCC have any advice as to how it would best capture the endoscopic nature of this procedure when performed?</p>	<p>The committee agreed that in the absence of a specific code for microdiscectomy coders should use the discectomy code ie for a lumbar procedure - 40300-00 [52]</p>	
1105-03	Definition of clinician	<p>Could we please ask the NCCH for a definition of "clinician"? It is becoming more difficult to distinguish between the documentation of clinical specialists. Within the ACS it is written that we can use documentation from a midwife to code various conditions, however, the documentation from other nurses and Allied Health professionals is deemed not sufficient to inform the coding process. The current</p>	<p>Committee members agreed that further clarification is required and agreed to submit examples of these scenarios to DSU.</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		parameters are ill-defined and need to be established more clearly.		
1105-04	Partial Hydatidiform Mole	<p>Scenario 1 30 year old female admitted with partial hydatidiform mole and had a suction curette. Coding standard 1504 advises the procedure code to use however that HM may lead to spontaneous abortion are you supposed to add a code from O03.9 when the admitting diagnosis states incomplete abortion. The codes I have used are O01.0, O09.1 O03.9, 35643-01, 92514-19 Scenario 2 Patient admitted nine days later with continuous bleeding. Further pathology states products of conception having features of Partial Hydatidiform mole. Codes used were as O01.0, O09.1, O08.1, 35643-01 and 92514-19. Please advise how to code this situation.</p>	<p>Committee members agreed this query needed to be sent to the NCCH 3.5.06 NCCH Query as follows: 1105-04 Hydatidiform Mole leading to a Spontaneous Abortion Should a spontaneous abortion code be assigned in addition to a hydatidiform mole code when a hydatidiform mole leads to a spontaneous abortion? Although the QCC noted that ACS 1504 Hydatidiform Mole states that a hydatidiform mole may lead to a spontaneous abortion, the committee was undecided if a spontaneous abortion code should be assigned as an additional diagnosis when a hydatidiform mole results in a spontaneous abortion. Reasons proposed for not assigning a spontaneous abortion code included the fact that the hydatidiform mole codes (O01.x) are within the Block range O00-O08 Pregnancy with Abortive Outcome, and therefore it was believed that the abortive component was inherent in the hydatidiform mole codes. However, given that a hydatidiform mole may not always lead to a spontaneous abortion, it was suggested that assigning a spontaneous abortion code would enable these cases to be differentiated from those hydatidiform moles that do not lead to a spontaneous abortion. Additionally, the committee noted that there is no exclusion note at the spontaneous abortion code for hydatidiform mole, which might otherwise preclude assigning a spontaneous abortion code with a hydatidiform mole code (c.f. code O02.1 Missed Abortion which does have an exclusion note for hydatidiform mole).</p>	<p>The NCCH advises that it is unnecessary to assign a spontaneous abortion code in addition to a hydatidiform mole code when it has led to a spontaneous abortion. Follow the advice given in ACS 1504 HYDATIDIFORM MOLE.</p>
1205-02	Prostatic Adenoma (N40 + M8140/0)	<p>This query is in regards to prostatic adenoma. NCCH advice is that prostatic adenoma should be coded to N40 + 8140/0. Unfortunately, when you try to place the combination of these two codes into HBCIS system, it will not allow the combination</p>	<p>The committee agreed to forward the query to BAS for enhancement to the HBCIS ICD coding screen to allow codes outside the C and D chapter for neoplasms that do not always require a morphology</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		of codes as it doesn't recognise the N40 as a cancer code. Is there a way to correct this within the HBCIS system, as currently the only way to get HBCIS to accept your codes, is to remove the morphology codes.	such as N40 to be used with M8140/0 adenoma	
1205-03	Snake Bite	Patient admitted with snake bite to the toes following stepping on a snake at home. The clinician has documented a ?nonpoisonous snake bite. Envenomation was undertaken and was negative. Could the committee please provide advice on the codes used. I have assigned the following codes: S91.1 Open Wound of Toe (s) without damage to the nail W59.1 Bitten or crushed by snake, unknown whether venomous or unvenomous Y92.09 Other and unspecified place in home U73.9 Unspecified activity	The committee agreed that from the information provided ACS 1923 should be followed. The committee agreed to assign the following codes: S91.1 Open Wound of Toe (s) without damage to the nail W59.1 Bitten or crushed by snake, unknown whether venomous or non-venomous Y92.09 Other and unspecified place in home U73.9 Unspecified activity.	
1205-06	Irukandji	Can the NCCH please consider providing an index entry for Irukandji or an entry under Marine animals when a coder looks up bite. -bite -marine animal or -bite --Irukandji The issue is that a coder would have to know that Irukandji is a jellyfish.	The committee deemed it not necessary to create a specific entry under bite marine animal for Irukandji. The committee agreed that the following look up is the most appropriate: Sting -Jellyfish T36.6 Contact -jelly fish ---Irukandji X26.01	
1205-07	Self inflicted laceration to unspecified part of the forearm	Patient presents with self inflicted laceration to unspecified part of the forearm. During the admission, patient cuts the same forearm (again unspecified part). Cannot code more than one place of occurrence for the one S code, in this case S51.9 cannot be followed by Y92.8 and Y92.22. We have only assigned codes for the first injury. Please advise on how we code to reflect both injuries. After further clarification with the coder., I have ascertained that the patient's principal diagnosis was an eating disorder and on both occasions of self harm a razor blade was used on the same body part. The problem lies where we try to assign two places of occurrences as additional diagnoses for the injuries and even after omitting one of the duplicated external cause codes and of the activity codes, the two places of occurrence codes are not accepted. From looking at the documentation attached it seems that the patient had only dressings performed for each injury and no suturing. I have advised the coder to code the injury once (initial injury only) as I would not consider the injury that occurred whilst in hospital to be of great significance due to	More information is being sought	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		the fact that no suturing was performed. Please advise however, on what codes would be used in a case where a patient has had significant treatment for the above mentioned scenario.		
1205-09	Systemic Mastocytosis	Could the QCC review the following index entries as they are inconsistent with each other. If using the lead term Mastocytosis Q82.2 would be assigned. However if using the lead term Mast Cell or Disease the following would be assigned C96.2 Malignant mast cell tumour and M9741/3 Malignant mastocytosis, as the term malignant does not need to be specified prior to assigning the code i.e. Mast Cell -disease, systemic tissue (M9741/3) C96.2 and Disease systemic tissue mast cell (M9741/3) C96.2.	The committee felt that the terminology of systemic mastocytosis is still current from the literature searches conducted. The committee agreed to forward the query to the NCCH for confirmation of what codes are to be assigned for systemic Mastocytosis and possible creation of an index entry for mastocytosis systemic Mastocytosis -malignant -systemic	
1205-01	Low grade papillary carcinoma	Could the QCC please give advice as the comparability of low grade papillary urothelial carcinoma and urothelial , papillary, non invasive? Are they the same?. Thankyou for ou consideration of this issue	The QCC agreed to forward the query to the Cancer Registry for clarification of whether low grade papillary urothelial carcinoma and urothelial carcinoma, papillary, non invasive are the same and what morphology codes should be assigned. Could the Cancer Registry please confirm if Low malignant potential is the same as low grade carcinoma	
0206-04	Parkinsonism and Orthostatic hypotension	Could the NCCH please consider an index entry under Hypotension -with --parkinsonims G90.3 to complement the existing look up of Parkinsonism -with --orthostatic hypotension(idiopathic) (symptomatic) G90.3	The committee agreed that the NCCH should be contacted to request a review of these index entries	The index entry suggestion for parkinsonism and orthostatic hypotension has been logged and will be considered for a future edition of ICD-10-AM
0206-08	IV dextrose given to neonate	Please advise the correct code to indicate IV dextrose given to a neonate 96199-07 [1920] Intravenous administration of pharmacological agent, nutritional substance or 96199-08 [1920] Intravenous administration of pharmacological agent, electrolytes	After discussion with two major obstetric teaching hospitals the QCC will support that IV dextrose be considered a nutritional substance 96199-07 [1920]	
0206-05	admitted to the safehouse	I would like to confirm the correct admission care type and coding for patients admitted for Safehouse. These patients (mainly in the aboriginal communities) are admitted usually overnight, but sometimes 2to 3 days for protection against someone in the community that may be drunk/angry. The only documentation contained in the medical record is admitted for safe-house or something similar. There is no evidence of any	The committee suggested that the Northern Territory be contacted to determine how they code these cases. The Data Services Unit will be asked to confirm the correct Care Type. Jill Burgoyne, NT rep on CSAC was contacted re these cases. In the NT they are not admitted to hospitals, instead they go to specially dedicated refuges. 29/6/06:After much	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		physical examination or physical injury	deliberation, it was decided that the safe house admissions should be boarder admissions except in circumstances where there has been an injury and the patient is recieving treatment for such, then this would be an acute admission codeed with S (injury) codes. It was decided that an additional code should be assigned (Z76.8) to be able to identify safe house admissions from other acute and boarder admissions.	
0206-06	Sickle Cell Disease with Beta Thalassemia	Can the QCC please raise the following index anomaly regarding Sickle Cell Disease with Beta Thalassaemia with the NCCH. If you search under Disease, Sickle Cell, Thalassaemia, there is no option of selecting beta thalassaemia and the code assigned is D56.8. If you search under Thalassaemia, beta, sickle cell, the code assigned is D57.2. There is no exclusion note under under D56 that would lead you to the correct code. Disease -sickle-cell D57.1 - - with - - - crisis D57.0 - - - other abnormal haemoglobin NEC D57.2 - - elliptocytosis D57.8 - - spherocytosis D57.8 - - thalassaemia D56.8 Thalassaemia (anaemia) (disease) D56.9 - with other haemoglobinopathy NEC D56.9 - alpha D56.0 - beta (severe) D56.1 - - sickle-cell D57.2 Code assignment via Codefinder is correct and consistent for either pathway regardless of what lead term is used by the coder.	Committee concensus was that the most appropriate code was D57.2. This decision will be forwarded to NCCH for ratification as the committee could not be certain whether there was an error in the index or whether there was a particular reason for the different codes provided based on the different look up sequence	Sickle cell beta thalassaemia occurs in a child who has one parent with thalassaemia or trait and one with sickle cell anaemia or trait. The correct code for this condition is D57.2 Double heterozygous sickling disorders. This term was reclassified from D56.1 Beta thalassaemia in ICD-10 AM First Edition following a recommendation from the Australian Collaborating Centre (AIHW/NCCH) at the WHO Meeting of the Heads of Collaborating Centres for the Classification of Diseases in Copenhagen, 1997. It would appear that the correct indexing of sickle cell beta thalassaemia to the new code of D57.2 Double heterozygous sickling disorders was not completed at the time of the proposal. This will be amended in future editions of both ICD-10 and ICD-10-AM.
1205-05	Endometritis	patient with endometritis with retained products of conception. The histology report comes back with chronic endometritis. The doctor does not document endometritis as these are mostly day only cases. Should this be coded and if so how?. Principal diagnosis is this the complication at delivery rather than the reason for delivery.	Further information being sought	
1205-08	Polycythemia	The default code for polycythemia is D45 M9550/3 Polycythemia vera. However, clinical review of this terminology indicates polycythemia NOS should not be coded to polycythemia vera unless the polycythemia has been further specified. Could the QCC review this classification issue.	The committee agreed that the NCCH should be approached to alter the default code as D45 M9550/3 Polycythemia vera does not appear to be clinically appropriate. A public submission is to be created (24/5/06). Public Submission sent 31/5/06	

QCC_ID	Query summary	Query	Decision	Response from NCCH
0206-01	DRG Grouper V4.2 Anomaly	Pt admitted for release of contracture of scar secondary to burns PDx L90.51 Scar condition & fibrosis of skin, due to burn, T95.1 Sequelae of burn &/or frostbite of trunk 45519-00 Revision of burn scar or burn contracture *3 45406-00 Split skin graft to burn of other sites involving less than 3% of body 29/6/06: Using this code allocation, which the QCC has deemed to be correct, the resulting DRG is 901Z. Could the mapping of this codeset to 901Z please be reviewed?	Committee confirmed this was the correct code assignment. Data Services Unit to advise the Commonwealth of the grouper issue. Further information sought from enquiry hospital. Nil further information able to be given. 29/6/06: Submission made to Casemix- grouper anomalies for review of codeset. 30.6.06:This problem has been corrected in version 5.2. Your case will group to ADRG Y02.	
0206-14	Hyperbaric therapy	Please refer to the attached article (search MD consult in CKN for hyperbaric AND teeth Effects of radiation on normal tissue: consequences and mechanisms. Stone HB - Lancet Oncol - 01-SEP-2003; 4(9): 529-36 From NIH/NLM MEDLINE NLM Citation ID: 12965273 (PubMed) Full Source Title: The Lancet Oncology Authors: Stone HB; Coleman CN; Anscher MS; McBride WH Please advise the correct codes in relation to these hyperbaric treatment scenarios. Patients who have carcinoma treated by excision and radiotherapy often present with radiation related conditions such as "poor healing wounds" "soft tissue injury" osteoradionecrosis and xerostomia. In these cases the condition is being coded with Y84.2 to indicate the effects of radiation treatment. However what are the best codes to reflect "poor healing wounds" or "soft tissue injury"? Should L59.8 be used and if soon after surgery should it be preceded by T81.8? (what timeframes would constitute soon after surgery)? Please see ACS 0245- "In cases where complete remission is documented and there is no evidence of the patient receiving any form of treatment for the malignancy or for side-effects of therapy, a code for 'history of malignancy' should be assigned, when it is relevant to the current episode of care." Is the intent of this standard that the original carcinoma be coded on each admission of treatment , or should a history of carcinoma code used? Does it depend on whether the patient is still undergoing radiation treatment or if it is suspended because of the effect (as might happen for a patient whose chemotherapy for carcinoma is withheld due to excessive vomiting)? In some cases the radiation therapy has been completed months or years earlier and the side-effect of therapy has no impact on treatment of	Committee agreed that the NCCH should be approached to write a Coding Matters article on this topic.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>the carcinoma itself which has been excised (potentially years earlier) Some patients who are to undergo surgery are admitted for hyperbaric therapy because they have had a history of poor healing wounds related to radiotherapy. Others have hyperbaric treatment prior to having carious teeth removed. It would appear that the nature of this treatment is prophylactic (to avoid osteoradionecrosis). Should this be coded as Z29.8 (other prophylactic measure) Z92.3 (personal history of irradiation) Z code to indicate personal history of carcinoma (is this relevant?) Please see NCCH query 1932. This advises that when there are multiple treatments given within an episode, a code for each treatment needs to be assigned reflecting the time for each individual dive. Some coders may not be aware of this question and if there is a coding standard or Coding Matters article developed, could this advice please be included. The hyperbaric unit at one hospital has advised that the majority of dives are &gt;90 minutes and &lt; 90 minutes. Could the above information be written as a standard or coding matters article?</p>		
0206-13	Newborn of diabetic mother	<p>Please see ACS 1602- Newborns with a diabetic mother sometimes experience a transient decrease in blood sugar which is usually attributable to the maternal condition. This diagnosis, code P70.1 Syndrome of infant of a diabetic mother or P70.0 Syndrome of infant of mother with gestational diabetes, should be confirmed by laboratory reports and clarified with the clinician (see also ACS 0401 Diabetes mellitus and impaired glucose regulation). Please advise whether documentation of "baby of GDM mum for monitoring" for a preterm neonate with low birthweight (33/40 1528g) where there are laboratory reports document a glucose of 2.5 (low) on the second day, glucose within the normal range two days later, and a high of 6.4 one day after that -but normal on the same day and thereafter should be coded as P70.1 or Z03.79, or does this require Clinician clarification? Is there a distinction if the Clinician writes "GDM monitoring" to mean that the mother had GDM so the baby is at risk of syndrome of infant of mother with gestational diabetes and must be monitored, or whether the baby has syndrome of infant of</p>	<p>The committee advise that P70.0 and P70.1 would be used with clear documentation such as "syndrome of infant of a diabetic mother." Committee members discussed, that although IV dextrose had been given, this may have been for the low birth weight and that clinician clarification is required. Clinical guidance will be sought to establish to whether documentation of "baby of a gestational diabetic mum for monitoring" and one single hypoglycaemic reading can be regarded as 'syndrome of infant of a diabetic mother, or all whether these require individual clarification.</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>mother with gestational diabetes and therefore requires monitoring? Is the one low glucose level on the laboratory report in conjunction with the documentation supplied, enough to substantiate use of P70.1? This baby was given IV dextrose but that could easily have been for the low birthweight , although no particular feeding difficulty was mentioned. Please note that in the specific episode, the Clinician had not ticked hypoglycaemia on the perinatal data sheet. The perinatal data sheet is usually well completed but there were some episodes where information was found in the notes but not checked on this form.</p>		
0206-03	Contact lens keratitis	<p>Could the committee please advise on the correct codes for contact lens Keratitis I have used the following codes: H16.0 or H16.8 Y84.8 Y92.2 Could we pass this onto the NCCH to consider creating an index entry for contact lens keratitis</p>	<p>The committee agreed that these were the correct codes. The Data Services Unit will contact the NCCH to request an index entry.</p>	<p>The index entry suggestion for contact lens keratitis has been logged and will be considered for a future edition of ICD-10-AM 27/6/06: The NCCH has decided to instate this query as a coding query. 14/03/2007: The NCCH advises that the correct codes to assign for contact lens keratitis are: H16.9 Keratitis, unspecified Z97.3 Presence of spectacles and contact lenses Indexing this condition is not warranted nor is the application of codes Y84.8 Other medical procedures or the place of occurrence code as the presence of contact lenses is not considered to be a medical procedure.</p>
0206-10	Injection of Bone Substitute Material (BSM)	<p>Patient admitted with # NOF repair with Richards Pin and Plate. At operation # was very difficult to reduce - see op report. On 21/12/2005 patient taken back to theatre due to delayed healing of bone for injection of alpha BSM (Bone Substitute Material) under GA - see op report. On looking up reference material for BSM it is described as osteoconductive and is injected into the # site to provide stabilisation - see extract from McGraw-Hills. After much discussion the following 3 codes were selcted as possibilities for injection of BSM: 90589-00 Repair of Bone NEC 92139-00 Insertion of bone growth stimulator (although this section seemed to pertain to devices and the literature implies BSM is not a stimulator) 48200-00 Bone graft to femur Would the committee please advise a suitable procedure code.</p>	<p>Committee consensus was that this should be coded as a bone graft, but this decision will be forwarded to NCCH for ratification.</p>	<p>The NCCH concurs with the decision to code 'injection of alpha bone substitute material (BSM) into femur' to: 48200-00 [1488] Bone graft to femur The NCCH will consider indexing this procedure for a future edition of ACHI.</p>
1205-10	Dysdiadochokinesia	<p>Could the NCCH please consider creating an ACS and index</p>	<p>The committee agreed that the NCCH should be</p>	<p>The NCCH has requested that this be sent in as a query</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>entry for Dysdiadochokinesia. Dysdiadochokinesia is the inability to perform rapidly alternating movements. This term may be documented as a neurological finding in some patients who have an underlying neurological disease. As dysdiadochokinesia is usually a sign of an underlying disease it would generally not be coded unless it was considered significant in its own right, as per the general advice in ACS1802 Signs and Symptoms which advises not to code symptoms and signs unless they represent important problems in medical care in their own right. Providing further specific advice within the ACSs on dysdiadochokinesia would facilitate coding standardisation when coding these cases. For example, similar to the advice in ACS 1336 Hypertonia and ACS1342 Hyperreflexia which states that these conditions should only be coded if clinically significant. Could the QCC also review the classification of dysdiadochokinesia and then give consideration to suggesting an index entry be created for this term. Although dysdiadochokinesia may be described as a dyskinesia it is also considered to be test for coordination ability, and therefore it may be considered more reflective to code this to R27.0 Other and unspecified lack of coordination rather than G24.9 Dystonia unspecified, Dyskinesia NOS.</p>	<p>approached to create an ACS and index entry for dysdiadochokinesia. 15/6/06: Could the NCCH please consider creating an ACS and index entry for Dysdiadochokinesia. Dysdiadochokinesia is the inability to perform rapidly alternating movements. This term may be documented as a neurological finding in some patients who have an underlying neurological disease. As dysdiadochokinesia is usually a sign of an underlying disease it would generally not be coded unless it was considered significant in its own right, as per the general advice in ACS1802 Signs and Symptoms which advises not to code symptoms and signs unless they represent important problems in medical care in their own right. Providing further specific advice within the ACSs on dysdiadochokinesia would facilitate coding standardisation when coding these cases. For example, similar to the advice in ACS 1336 Hypertonia and ACS1342 Hyperreflexia which states that these conditions should only be coded if clinically significant. Could the QCC also review the classification of dysdiadochokinesia and then give consideration to suggesting an index entry be created for this term. Although dysdiadochokinesia may be described as a dyskinesia it is also considered to be test for coordination ability, and therefore it may be considered more reflective to code this to R27.0 Other and unspecified lack of coordination rather than G24.9 Dystonia unspecified, Dyskinesia NOS.</p>	<p>rather than an index entry suggestion. Further to the above: The NCCH agrees that the most appropriate code for dysdiadochokinesia is R27.8 Other and unspecified lack of coordination. This should be coded following point f) of ACS 1802 SIGNS AND SYMPTOMS which states: Although symptoms are generally not coded when a more definitive diagnosis exists, there are cases where symptoms should be coded...f) certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right. Creation of a new standard for this condition is not warranted, however, the indexing issue will be referred to the WHO Update Reference Committee.</p>
0206-02	Grouper anomaly	<p>Patient was admitted for elective replacement due to end of life or battery but had an underlying LV dysfunction which required Bi-Ventricular pacing. When only a generator replacement is code the DRG is F17Z Cardiac Pacemaker Replacement. When an electrode is inserted at the same episode, the DRG is changed F12Z Cardiac Pacemaker Implantation. We feel that the electrode code should not override the generator code, that this is actually an admission</p>	<p>Committee recommended that the Data Services Unit should contact the Commonwealth to review the grouper logic for these cases. Response from DoHA: The pacemaker DRGs F12Z, F17Z and F18Z have been reviewed in version 5.2.</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		for replacement and upgrade to Bi-Ventricular. The existing left ventricle electrode was retained insitu.		
0206-07	Sickle Cell Disease with Crisis with Beta Thalassaemia	Please advise on the most appropriate combination of codes to describe Sickle Cell Disease with Crisis with Beta Thalassaemia. Should we use? D57.0 Sickle-cell anaemia with crisis PLUS D57.2 Double heterozygous sickling disorders OR D57.0 Sickle-cell anaemia with crisis PLUS D56.1 Beta thalassaemia		
0406-02	Intra-operative fluroscopy	Do you code fluoroscopy/image intensifier when used in surgical procedures ie reduction of fractures, reconstruction of knee. Code is 60506-00 [1999] Fluroscopy in conjunction with surgical procedure	Individual responses by committee members indicate that some coders would be likely to code this while others would not. The committee have referred this query to the newly established QCC working party formed to give guidance on standard practice for coding non surgical procedures that are not covered by a specific standard and not listed in the in NCCH ACS 0042 (procedures not normally coded). The guidance paper produced will be referred to the in NCCH the ratification prior to distribution to coders. Awaiting Action In the interim coders are advised to seek local advice from their coding manager or continue current practice (ensuring that this is consistent within the local coding unit)	
0406-01	Cardiac Monitoring during surgery	I have a query in regards to cardiac monitoring ie cardiac venous pressure monitoring via CVC during cardiac surgery. Do we code cardiac monitoring, or is it considered part of the operation ie CABG Codes 13818-00 [657] Cardiac pressure monitoring 116600-00 [1850] Cardiac intracavity blood pressure 116600-01 [1850] Pulmonary arterial pressure 116600-02 [1850] Central venous pressure 116600-03 [1830] systemic arterial pressure	The committee advise that cardiac cardiac venous pressure monitoring via CVC is an inherent part of CABG and therefore does not need to be coded additionally.	
0406-06	DRG O61Z Query	I would like to clarify whether there is a DRG anomaly with O61Z. Recently we had an admission of a lady with an infective breast abscess postpartum with a staph aureus infection. She went to theatre for incision/drainage of the abscess and was an inpatient for 7 days whilst receiving IV antibiotics. The DRG assigned for this admission was O61Z – Postpartum and Post Abortion W/O OR Procedure. We're	The committee advised that although the procedure was performed in theatre, 35510-00 [1742] is not considered by the considered by the DRG classification to be an 'operating room' procedure. Use of the term operating room procedure within the AR- DRG classification does not relate to where individual patients actually have their procedure	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>confused with the description "W/O OR Procedure", as clearly she did go to theatre and as a result of this DRG and the fact that the patient was an inpatient for 7 days, we lose with regard to funding with MBF, as for the 7 days we are only able to bill for \$703.00. The procedure alone is worth more than this. Hence, our query – is there an anomaly with O61Z? We feel it should fall into DRG O04Z Postpartum and Post Abortion and OR PR.</p>	<p>performed, but rather to a group of procedures determined by clinicians as normally requiring use of operating room resources as opposed to other areas (e.g. those that can sometimes be performed in clean rooms or doctors rooms) The coding of O91.11, Z39.0 and 33510-00 should group to O61Z.</p>	
0406-03	Ampullectomy	<p>Patient has an ampullary tumour and is taken to theatre for an endoscopic ampullectomy. Notes state that the ampullectomy is performed with a braided snare. The pancreatic duct is cannulated and a stent placed after pancreatic duct sphincterotomy. Biliary sphincterotomy extended. Specimen collected with Roth basket. There is no index entry for ampullectomy (excision ampulla of vater). Please advise the best procedure code. Should this procedure be indexed? Operation report attached.</p>	<p>Committee members discussed that there is no exact code for ampullectomy. The 'best fit' code to capture the ampullectomy from the operation notes provided for this patient was considered to be 30484-02 [968]. The committee decision for this query will be forwarded to the NCCH for their information.</p>	<p>4/10/06 The NCCH advises that the correct codes to assign for the case cited is: 30458-02 [968] Local excision of lesion of sphincter of Oddi and either 30484-00 [957] Endoscopic retrograde cholangiopancreatography [ERCP] or 30484-02 [974] Endoscopic retrograde pancreatography [ERP] The NCCH will consider reviewing the indexing this procedure for a future edition of ACHI. REVISED ADVICE FROM THE NCCH 27/02/2007: The NCCH advises that the correct codes to assign for the case cited is: 30484-00 [957] 'Endoscopic retrograde cholangiopancreatography [ERCP]' or 30484-02 [974] 'Endoscopic retrograde pancreatography [ERP]' as appropriate. Both these codes contain an includes note for 'excision of lesion.' The NCCH will review this issue for a future edition of ACHI.</p>
0406-04	Slipped Upper Femoral Epiphysis - incorrect index entry	<p>Coding SUFE traumatic, current. Index entry leads to S72.01. Tabular indicates S72.02 Slipped, slipping - epiphysis M93.9 - - traumatic (old) M93.9 - - - current — code as Fracture, by site [Extracted from NCCH ICD-10-AM, July 2004, S.] this part is correct but - Fracture - femur, femoral S72.9 - - birth trauma P13.2 - - cervicotrochanteric section S72.05 - - condyle(s), epicondyle(s) NEC S72.41 - - distal end — see Fracture, femur, lower end - - epiphysis - - - head S72.08 - - - lower (separation) S72.42 - - - upper (separation) S72.01 [Extracted from NCCH ICD-10-AM, July 2004, F.] Tabular ÅS72.01 Fracture of intracapsular section of femur ÅS72.02 Fracture of upper epiphysis (separation) of femur [Extracted from NCCH ICD-10-AM, July 2004, Injury and Poisoning.]</p>	<p>The committee agreed that there is an index error and that traumatic slipped upper femoral epiphysis should be coded to S72.02. The error has been rectified in the fifth edition however NCCH will be notified of the error in the fourth edition.</p>	<p>The fourth edition error for the indesing of traumatic slipped upper femoral epiphysis will be corrected and published in future errata.</p>
0406-05	Prophylactice IV Fluids	<p>1. For oncology patients that present for chemotherapy then</p>	<p>In relation to question 1- the committee advise that</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>stay overnight for prophylactic IV fluids (ie there is no dehydration or other complication requiring the IV fluids) could the committee: • Advise if it is appropriate to use Z29.8 Other specified prophylactic measures as additional diagnosis • suggest an alternative • Advise to use nothing 2. For oncology patients that present only for IV fluids overnight (ie reason for admission) could the committee: • Advise if it is appropriate to use Z29.8 Other specified prophylactic measures as additional diagnosis • suggest an alternative • Advise to use nothing Example includes patients that receive radiotherapy elsewhere and are admitted to NGH for post radiotherapy prophylactic IV fluids (ie there is no dehydration)</p>	<p>the principal diagnosis should be the carcinoma and that Z29.8 is not required additionally. No procedure code is necessary. In relation to question 2- the committee advise that the principal diagnosis should be the carcinoma and that Z29.8 is not required additionally. No procedure code is necessary.</p>	
0206-15	Tobacco/opiod dependence	<p>Please advise whether patients documented as “smoker” should have a code for tobacco dependence assigned if there is documentation that they are trying to give up, or are using Nicorette (or similar) patches. If a patient is on a ‘methadone program’ can opioid dependence be coded?</p>	<p>The committee agreed to clarify the definition of “dependence on smoking” and circumstances when it can be coded with the NCCH.</p>	<p>It is correct to assign patients who are stated as being 'on the Methadone programme' to F11.2 Mental and behavioural disorders due to use of opioids dependence syndrome if it meets the criteria outlined in ACS 0002 ADDITIONAL DIAGNOSES. The index pathway is Dependence -due to --methadone F11.2 14/03/2007: The NCCH sought clinical advice on this matter to which there was a mixed response. It appears that technically it would be correct to allocate F17.2 Mental and behavioural disorders due to use of tobacco, Dependence syndrome. However, distinguishing between the use of F17.2 Mental and behavioural disorders due to the use of tobacco, Dependence syndrome or F17.1 Mental and behavioural disorders due to the use of tobacco, Harmful use or Z72.0 Tobacco use, current, which includes the definition hazardous use is problematic. The NCCH advises that, at this time, the code for tobacco dependence should NOT be used for patients documented as 'trying to quit' or where the use of Nicorette or the like is documented. ACS 0503 DRUG, ALCOHOL AND TOBACCO USE DISORDERS is being reviewed for a future edition of ACS.</p>
1205-04	Admitted for revision and debulking of a skin flap	<p>Patients are referred to a plastic surgeon for repair of the defect for their expertise of reconstruction. I have had conflicting advice from coders for when a patient is admitted</p>	<p>The committee agreed that from the documentation provided for this scenario the neoplasm related to the procedure should be coded as the primary diagnosis</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>for revision /debulking of a skin flap. Patient admitted for revision/debulking of a skin flap (usually nasolabial) Coded to the original admission BCC or SCC if known Coded as deformaty of nose Coded as either of the above with an additional code of Z42.0 Follow up care involving plastic surgery of the head and neck Or Z42.0 as the PD with an additional diagnosis of one of the above. FURTHER CLARIFICATION SORT FROM HOSPITAL. RESPONSE WAS: I spoke to the Surgeon and his explanation is "when you transfer a flap for vascularity and nerves you cannot "debulk" the fatty tissue from it as this will interfere with that same vascularity, So he transfers the flap, leaves it to heal and initiate its own blood supply to surrounding tissues and then some months later removes the fatty tissue to improve the contour of the flap to match the normal facial structures. The surgeon's terminology is debulking/revision. So I suppose it is for unacceptable appearance although it is also a planned procedure/ so does that perhaps mean that it could still be coded for the original carcinoma excision. NCCH Query base responses were varied including Deformity Nose (which is similar to a Example 3 Page 176 Vol 5) Z42.0 Plastic Surgery C44.3 M8090/3 code to cancer I think our main problem is deciding when is a procedure "cosmetic" just because it is done by a "Plastic Surgeon"</p>	<p>as this was a planned subsequent procedure at the time of the initial procedure.</p>	
0206-12	Thecal compression and decompression	<p>Please advise the correct codes to use when the documentation provided is: Summary, notes, MRI- symptom was tingling in arm, C5/6 ACDF, degenerative prolapse, degeneration cervical, disc protrusion with compression. The MRI says thecal sac compression. Procedure –anterior cervical decompression anterior fusion Alternatives considered were M50.0 and 40332-00 and 40332-00 Or M50.1 and G55.1 and 40332-00 In the procedure index decompression spinal canal says see decompression spinal cord. Can myelopathy be 'taken' from the documentation of thecal sac compression and the procedure of decompression? Is there a code for thecal compression where there is no mention of nerve roots or spinal cord and no procedure performed? Would this depend on the level?</p>	<p>Further documentation has become available for this episode. In the specified scenario it was documented that there was no myelopathy. Thecal compression should be coded only if it has been documented in the chart with no other associated condition.</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
0206-16	Alcohol intoxication vs poisoning	Unconscious/coma state following excessive ingestion of alcohol beverage, SVT's and admitted to Intensive Care Unit. Under what circumstances should a coder select as principal diagnosis, the code for acute alcohol intoxication F17.~ (I think) and when (under what circumstances) should a coder select the Poisoning by alcohol code? ICD-9 combinations were - 305.00 or 980.0. The basis of this query is relevant in both ICD-9 and ICD-10 Under the information provided in the description of the diagnosis box, what would be the appropriate code to select?	A similar query has previously been submitted to the NCCH and the committee agreed to re-submit this query with the previous query number- 941.	
0506-01	Entropion Repair	There appears to be conflicting advice between the ACHI index, and a paragraph in the NCCH's Good Clinical Documentation Guide regarding entropion repair. At page 609 of the GCDG, In the example for impact on DRG assignment, there is a comment that states "Default code (cauterisation) for repair selected when no further information provided". The ACHI index however does not contain such a default code, and ACS 0741 Ectropion / Entropion does not provide this either. Is the NCCH in support of the repair by cauterization code to be used when there is no further information? Would this advice also cover ectropion repair when further documentation is not available?	The committee agreed to request that the NCCH add this query to their task database.	Clinical advice has confirmed that cauterisation should not be used as a default code for repair of ectropion or entropion, when no further information is provided. Coders should be guided by the documentation as to the type of repair and clarify with the clinician if in doubt. The Good Clinical Documentation Guide will be revised for a future edition and the advice to use cauterisation as a default removed.
0206-11	Coding Symptoms	ACS 1802 point f "certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right. This last point is of particular importance as some 'symptoms' because of their significance require coding as well as the underlying cause." Please advise whether use of the code R40.2 unconsciousness NOS can/should be used in conjunction with conditions that may not normally/always result in unconsciousness? Do the following examples provide correct guidance? -It is not appropriate to add R40.2 in a scenario where a patient has a faint with brief loss of consciousness -It is appropriate to add R40.2 for patients who take an overdose when there is documentation of loss of consciousness whether this is brief or prolonged. This adds information and also management is different to that for more minor overdoses where there is no	The committee agreed that in this scenario, the significant manifestations should be coded if consumptive in line with ACS 0002 and ACS 0027. It was discussed that loss of consciousness would usually require increased nursing care and monitoring.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		loss of consciousness.		
0206-09	Angina with previous MI	<p>ACS 0940 "If a patient is admitted with unstable angina and progresses to a myocardial infarction in the same episode of care, assign a code for the myocardial infarction only. However, if the patient develops postinfarction angina, I20.0 Unstable angina may be sequenced as an additional code"</p> <p>PICQ indicator 100154 "This indicator identifies records with unstable angina as principal diagnosis and a myocardial infarction code. ACS 0940 'Ischaemic heart disease' states that, where a patient admitted with unstable angina progresses to a myocardial infarction in the same episode, the myocardial infarction is coded but not the unstable angina. The exception is when the patient develops postinfarction angina, where the unstable angina code may be added. Thus, unstable angina will not normally be principal diagnosis with myocardial infarction. These records would be correct if the patient has returned within 4 weeks of an infarct with post-infarction angina. Please confirm that the correct sequencing for a patient admitted with angina (Prinzmetal or unspecified) who has had previous admission for myocardial infarct (NSTEMI) within the previous 4 week period is: Principal I20.1 Additional I21.4 There is uncertainty regarding the application of the standard with some Coders being unsure whether the reference to "additional code" in the standard applies across admissions or only to post infarction angina occurring in the same episode as the infarction. Could the standard be reworded to reflect the intent explained in the PICQ indicator?"</p>	<p>Hospitals to provide examples (eg procedure notes and operation notes) which will be attached to this query when it is forwarded to the NCCH for clarification. 8/06/06: This query will be sent on to NCCH to clarify whether angina can be coded as the primary diagnosis within 4 weeks of an MI. We would also like to ask that a more specific example be added to the standard.</p>	
0606-20	DRG assignment	<p>Coding Case Study Admission 12/8/05 – 5/9/05 This patient was diagnosed with colonic polyps in July 05. His past history included: • Adenocarcinoma L lung 1989 • Brain tumour 1990 • Multiple PE on warfarin • LUTS for TURP booked for September 05 He was booked for colonoscopy and polypectomy on 19/8/05 and admitted on 12/8/05 for heparinization prior to the procedure. On admission he complained of worsening urinary symptoms. Routine bloods revealed raised creatinine and urea levels. He was catheterised and strict urine measures implemented. The</p>	<p>Error DRGs are an essential part of ARDRGs. The group supported the QE11 code assignment for this scenario</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>diagnosis on 15/8/05 was acute on chronic renal failure due to urinary outlet obstruction. The scheduled colonoscopy was cancelled and the treatment continued for the renal and urinary problems. By 18/8/05, his renal function returned to baseline. He had remained on heparin infusion and was assessed for a TURP by the anaesthetist. The TURP was carried out on 25/8/05. The heparin infusion continued and was ceased and warfarin recommenced on 4/9/05. He was discharged with a catheter insitu on 5/9/05. The codes used in this case are: PD K63.50 Z53.0 N17.9 N18.90 Z92.1 R33 N40 T83.5 Y84.6 Y92.22 N39.0 B95.6 B95.2 PP 37203-00 (1165) 92508-39 (1909) 92515-39 (1910) 36800-00 (1090) Using the colonic polyps as the PD and TURP as the procedure a DRG of 903Z is attained. The query being, no payment is assigned this DRG. Could the grouping function be reviewed regarding this case type.</p>		
0606-01	Nasogastric Intubation	<p>Can nasogastric intubation be coded when it is the only procedure specifically performed for gastrointestinal obstruction even though the admission was for an unrelated condition? Nasogastric intubation is listed as a procedure not normally coded (ACS 0042) but should it be coded when used for decompression?</p>	<p>This procedure is not normally coded, but if a facility wishes to code nasogastric intubation, a standardised approach per hospital is encouraged. The majority of the forum at QCC would not utilise this code.</p>	
0606-18	DRG assignment error with carotid artery stenting	<p>Patient admitted with carotid stenosis. Procedure performed ICA (internal carotid artery) angioplasty and stent placement. Codes assigned : Pdx: I 65.2 PP: 35309-06 [754] DRG assignment = 901Z extensive O.R. procedure unrelated to principal diagnosis Do we need to have this DRG assignment investigated?</p>	<p>E.Skubis advised that the AIHW will correct this issue in version 5.1 with a new code addition in the MDS.</p>	
0606-06	Unstable Diabetes	<p>When coding unstable diabetes should documented hypoglycaemic episodes be coded additionally? If so, does this include when there is only minor documentation and one or two readings?</p>	<p>If both diabetes and hypoglycaemia are documented, both codes should be assigned. However documentation of "low BSL" or a low value is not sufficient documentation to support hypoglycaemia code assignment. If seemingly significant, clarification should be sought. A diagnosis of hypoglycaemia must be clearly documented in order to assign this code.</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
0606-05	Lithium Toxicity	Please advise the correct code for 'lithium toxicity' documented on the summary as the principal diagnosis. The patient presented with confusion which after study was attributed to a combination of lithium toxicity, hypercalcaemia and dementia. They had taken their prescribed dose, but blood lithium was at a toxic level. The lithium level was described as critically high on pathology results and lithium toxicity was diagnosed. Should confusion be the principal diagnosis with an external cause code for adverse effect of lithium as the patient was taking their prescribed dose and was being monitored yet had developed toxicity? Alternatively, should accidental overdose of lithium (prescribed dose) be the principal diagnosis with dementia and confusion as additional?	Unless clearly documented as resulting from an overdose, Lithium toxicity should be coded by using a condition code to indicate the adverse effect and external cause codes indicating adverse effect in therapeutic use. Codes should be assigned based on the documentation in the patient record.	
0606-04	Poor Mobility	Some coders assign a code for poor mobility in addition to the condition resulting in the poor mobility to add extra information that the condition has resulted in poor mobility and that this is often the main focus of care. The code for poor mobility is "other and unspecified abnormality of gait and mobility". Can this still be used when specific conditions are assigned?	A suggestion will be forwarded to NCCH that poor mobility be added as an index entry as Z74.0. If there is a known condition responsible for the poor mobility, this must be coded. Z74.0 may be assigned additionally in those circumstances where there is documentation indicating that the issue of mobility is significant. This code should not be used universally, and must meet ACS 0002. 5.7.06: The Queensland Coding Committee (QCC) request that there be an index entry created for poor mobility at Z74.0. Poor - contractions, labour O62.2 -- affecting fetus or newborn P03.6 -fetal growth NEC P05.9 --affecting management of pregnancy O36.5 -mobility Z74.0 - personal hygiene R46.0 -prenatal care, affecting management of pregnancy Z35.3 -urinary stream R39.1 -vision NEC H54.7 The QCC recognise that if there is a known condition responsible for the poor mobility that this must be coded. Z74.0 may be assigned additionally in those circumstances where there is documentation that the issue of mobility is significant.	
0606-03	Cardiac Arrest	While the patient was admitted for rehabilitation, they suffered a myocardial infarct and cardiac arrest. Resuscitation was	If cardiac arrest or cardio-respiratory arrest is documented, it should be coded whenever	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		attempted but was unsuccessful. ACS 0904 says that arrest should only be coded when resuscitation is attempted but does not specify that arrest and resuscitation should be always coded when resuscitation is attempted. Please advise if cardiac arrest should be always coded when resuscitation is attempted. Does this include post MI?	resuscitation intervention is undertaken (regardless of patient outcome). In accordance with ACS 0904 arrest is not coded if there is no resuscitation attempt. If the underlying cause is known, the arrest is sequenced as an additional diagnosis. This decision to be published in the next version of Codefile.	
0606-02	Palliative care Episodes	The patient was admitted for palliative care with metastases to multiple sites from a breast carcinoma that had been previously removed. ACS 0224 directs that in palliative care episodes the principal condition is a diagnosis resulting in the relatively shortened prognosis. Palliative episodes receive a per diem payment regardless of DRG but coding of different metastatic sites as the principal diagnosis does result in different DRG assignment. Can guidance be given as to whether this has any importance for palliative patients and if so how the principal diagnosis should be selected for patients with metastatic carcinoma admitted where it is not clear which site is responsible for the shortened prognosis	J.Turtle to contact S.McAlister after investigating CSAC minutes and the paper on grouper logic by M.Snell.	
0606-09	What constitutes a Clinician?	Please consider these scenarios with the document regarding who constitutes a 'Clinician' When abstracting, can documentation by health professionals other than Doctors such as effusions and presence or not of heart failure from Radiology reports be used? Can Nursing documentation such as on ACAT forms e.g that the patient had glaucoma and legal blindness be used, if not specifically supported in the medical notes.	Still need qualification of what constitutes a clinician. DSU to liaise further with the NCCH regarding this issue. The QCC would not support utilising forms, such as the ACAT form, to inform the coding process. Please refer also to ACS 0010 General Abstraction guidelines.	
0606-14	Duplex collecting system in neonate	The baby had a duplex collecting system detected antenatally. Should this be coded in the birth episode if there is no discussion of it being problematic but in this admission the baby is referred for later follow up.	The QCC recommends that neonatal conditions must meet the criteria of ACS 0002 unless they meet the criteria of some other specialty standard.	
0606-08	Definition of an anaesthetic form	There remains some confusion as to the rigidity of what constitutes an anaesthetic form and what 'exceptions' are allowed e.g. drugs documented on operation notes in the body of the record. Can the standard be reworded particularly to take into account advice given in the NCCH query database 1304 and 1611 regarding sedation?	Forward to NCCH Interim Recommendation: The QCC recommends that, until the NCCH makes a decision in regards to this issue, that the enquirer utilise relevant information that is documented upon the form that is normally used for recording of anaesthetics on the day of the procedure.	The NCCH confirms that all anaesthetics (except local) should be coded, regardless of who performed the sedation or where it is documented, as per previous advice given in Q1611. This includes sedation administered by Emergency Department doctors or intensivists for intubation, cardioversion or fracture

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>25/07/2006 Forwarded to the NCCH: Please clarify whether anaesthetic (except local) should be coded when performed, regardless of the specialty of the Clinician administering the anaesthetic and the procedural location. Please consider revision to ACS 0031 to reflect this advice. When coding of anaesthetic was first introduced, it was emphasized at education workshops that there was a requirement that the anaesthetic be documented by an Anesthetist on an 'anaesthetic form'. This is not stated in the current standard but some coders continue to apply the advice originally given. The standard is clear that ASA scores can only be determined by anaesthetists but this information is only in the 'definitional' area of the standard (as opposed to the 'classification' area) and does not clarify that the scoring must relate to the time of surgery. The current standard highlights 'visits to theatre' and it is not clear that anaesthetic can be coded when administered in other settings. Could the NCCH please clarify: 1. Whether all anaesthetics (except local) should be coded, regardless of the specialty of the Clinician giving the anaesthetic, the setting in which it is given and where this is documented (providing that it is documented by the clinician administering the anaesthetic) e.g. 1) sedation given by ED doctors or intensivists for intubation or cardioversion should be coded even if the sedation is documented only in progress notes or ICU forms 2) sedation given by Clinicians performing endoscopies should be coded even if documented only on operation notes/proformas signed by the surgeon 3) sedation given by ED doctors for fracture reduction should be coded when documented. 2. Whether documentation in appropriate areas of an anaesthetic form of drugs given or airway support, can be used to assign specific anaesthetic codes (e.g. sedation or GA) without actual documentation of</p>	<p>reduction or when administered by endoscopists and the only accompanying documentation is in the progress notes, ICU forms or endoscopy reports. The NCCH is aware that where documentation is lacking coders may be tempted to assign anaesthetic codes based on type of drugs given or the type of airway support used. However, coders should where possible, verify these practices with the clinician and address the documentation issues involved before assigning anaesthetic codes based on this documentation. Lastly, ASA scores should only be assigned when documented by a clinician on the anaesthetic form as per guidelines in ACS 0031 Anaesthesia. The previous advice given in Q1728 which states " the ASA score used to calculate the two-character extension of the anaesthesia code must be documented on an anaesthesia/operation form at the same time the procedure took place" still stands. ACS 0031 Anaesthesia is being reviewed for a future edition of the ACS.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>'sedation' or 'GA' 3. Whether ASA scores should only be coded when documented by an anaesthetist and that the default of '99' should be used for anaesthetics given by other Clinicians. Please confirm that Coders should not use their judgement, or documentation by clinicians other than the anaesthetist, that a procedure is an 'emergency' procedure as the basis for assigning ASA scores. Please advise whether the ASA score must be clearly current at the time of surgery e.g. If the assessment has been made by an anaesthetist at a prior clinic or postponed surgery and not updated, the default code '99' should be used (as advised in query 1728). Additionally, what constitutes an anaesthetic form and what 'exceptions' are allowed e.g. drugs documented on operation notes in the body of the record. Can the standard be reworded particularly to take into account advice given in the NCCH query database 1304 and 1611 regarding sedation? Please consider revision of the standard at the 'classification' area to incorporate this advice.</p>	
0606-07	Stabilisation of anticoagulants	<p>ACS 0303 gives direction for patients admitted for stabilisation of anticoagulants but does not give advice for patients not specifically admitted for INR stabilisation. Some patients are admitted with certain conditions but during admission have their warfarin monitored and withheld as INR is high. Does the standard apply generally for high INR/warfarin monitoring or only if admitted for this?</p>	<p>The QCC asks the enquirer to refer to NCCH Query 2170:” The “excludes” note in D68.3 'Haemorrhagic disorder due to circulating anticoagulants': Excludes: long term use of anticoagulants without haemorrhage (Z92.1) is consistent with WHO ICD-10. The advice in ACS 0303 ABNORMAL COAGULATION PROFILE overrides the above excludes note. In cases where patients are admitted and treated for INR, overwarfarinisation or prolonged/abnormal bleeding time, assign D68.3 'Haemorrhagic disorder due to circulating anticoagulants', regardless of whether the patient has a haemorrhage or not.”</p>	
0606-10	Re-Feeding Syndrome	<p>How should 're-feeding' be coded. The Dietician documented malnutrition and re-feeding syndrome and several of its features e.g. hypomagnesaemia. There is no index entry for re-feeding syndrome. Can malnutrition and significant effects</p>	<p>Send to the NCCH Interim Recommendation: The QCC supports, that where conditions fulfil ACS 0002, they should be coded as diagnosed by the clinician. It is not sufficient to code from the dietician's notes.</p>	<p>Refeeding syndrome is a syndrome consisting of metabolic disturbances that occur as a result of reinstatement of nutrition to patients who are starved or severely malnourished. Patients can develop fluid and</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>of re-feeding syndrome be coded? The problem with doing this is that NCCH query 1586 directs not to code malnutrition when documented only by the Dietician. Please see <a href="http://www.mja.com.au/public/issues/183_06_190905/fun10340_fm.html">http://www.mja.com.au/public/issues/183_06_190905/fun10340_fm.html</a> And <a href="http://www.ccmtutorials.com/misc/phosphate/page_07.htm">http://www.ccmtutorials.com/misc/phosphate/page_07.htm</a> (not peer reviewed but simple and seems consistent with other google finds for refeeding syndrome)</p>	<p>12/09/2006: Sent to NCCH Please advise correct coding for 're-feeding' . 1. In this scenario, there was documentation by the Dietitian of "malnutrition", "refeeding syndrome" and several of its features e.g. hypomagnesaemia. There is no index entry for re-feeding syndrome. Please advise the correct code for refeeding (syndrome) if documented by the treating doctor. 2. Can this be coded if documented only by the dietitian? Can malnutrition and significant effects of re-feeding syndrome be coded? The problem with doing this is that NCCH query 1586 directs not to code malnutrition when documented only by the dietitian. Some information about refeeding syndrome was researched at: <a href="http://www.mja.com.au/public/issues/183_06_190905/fun10340_fm.html">http://www.mja.com.au/public/issues/183_06_190905/fun10340_fm.html</a> and <a href="http://www.ccmtutorials.com/misc/phosphate/page_07.htm">http://www.ccmtutorials.com/misc/phosphate/page_07.htm</a> (not peer reviewed but simple and seems consistent with other google finds for refeeding syndrome) 3. Please advise whether there have been further developments with regard to coding malnutrition when documented only by the dietitian. The advice given in query 1586 does not appear in Standards or 10-AM-Commandments. Some hospitals have written requests by ICU intensivists to code malnutrition when documented by a dietitian (particularly when receiving Total Parental Nutrition other than long term), regardless of whether there is further documentation by other clinicians. Please advise whether it is appropriate to follow these requests/ generic advice. If so, can this be published as a standard in order to allay coder confusion and promote standardization?</p>	<p>electrolyte disorders, especially hypophosphataemia, along with neurologic, pulmonary, cardiac, neuromuscular and haematologic complications. Code the component features of Refeeding syndrome separately as per the guidelines in ACS 0005 Syndromes. In ICD-10-AM/ACHI/ACS Sixth edition it will be permissible to assign a code for malnutrition when documented by the dietitian. However for consistency, in the interim, follow the previous advice given in Q1406 and Q1586 which specifies that a diagnosis of malnutrition may only be coded when recorded by a dietitian if it has been verified by the primary treating clinician.</p>
0606-19	Principal Diagnoses for Obstetric cases	Question 1. Please advise what rules apply when determining the principal diagnosis for obstetric cases in the delivery admission. Please consider the following scenarios: Scenario 1. Admitted 40/40 with mild PIH. Progressed to labour next day with no intervention. Persistent POP therefore Caesarean	Refer to the NCCH DSU to organise for a formal query to be sent to the NCCH 12/09/2006 Forwarded to the NCCH: Thank you for considering our query with regards to the principal diagnosis for Obstetric Cases. Question 1. Please advise what rules apply	The assignment of principal diagnosis in obstetric admissions can be problematic as it is often a combination of codes that describes the delivery process as a whole. There is currently no standard which advises that the diagnosis related to delivery should take

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>performed. Scenario 2. Admitted 40/40 with pre eclampsia. Progressed to labour next day with no intervention. Given Magnesium Sulfate for pre eclampsia. Persistent POP therefore Caesarean performed. Please also refer to • NCCH 5th edition training online pre workshop question 4 (p158) - A patient is admitted for induction post dates and delivered by forceps for foetal tachycardia. They have an episiotomy extended by a first degree tear. Sequencing given in the answers (p190) is labour and delivery complicated by foetal heart rate anomaly as the principal diagnosis with additional diagnoses being first degree tear and prolonged pregnancy. • NCCH 5th edition training at the workshops exercises</p> <p>obstetrics 1- The patient is admitted with premature rupture membranes with labour induced and commencing within 24 hrs. The patient had a first degree tear sutured. Sequencing given in the answers is premature rupture of membranes as the principal diagnosis and first degree tear as additional. Please give advice regarding the selection of the principal diagnosis in delivery episodes. We are aware of standard 1515 (if a patient is admitted with an antepartum condition that requires treatment for more than 7 days prior to birth, this should be sequenced as the PD). Where this standard does not apply there are various practices in application of the PD:</p> <ul style="list-style-type: none"> <li>• Some Coders would say that as there is no speciality standard, ACS 0001 (Principal Diagnosis) should be followed.</li> <li>o Of this group, some would say that the patient was literally admitted with pregnancy complicated by PIH (scenario 1) or pre eclampsia (scenario 2) and so this should be the PD.</li> <li>o Others interpret that because the standard requires the reason for admission after study it could justly be said the patient was admitted at term to manage her delivery episode that was complicated by both PIH(scenario 1) or pre eclampsia (scenario 2) and POP. In scenario 1, they would then apply the concepts discussed in “2 or more diagnoses that equally meet the definition for PD” and look at therapy provided and consider that the Caesarean delivery for POP was the most resource intensive intervention and hence code this.</li> <li>• There are another group of Coders who continue to</li> </ul>	<p>when determining the principal diagnosis for obstetric cases in the delivery admission? Please consider the following scenarios: Scenario 1. Admitted 40/40 with mild PIH. Progressed to labour next day with no intervention. Persistent POP therefore Caesarean performed. Scenario 2. Admitted 40/40 with pre eclampsia. Progressed to labour next day with no intervention. Given Magnesium Sulfate for pre eclampsia. Persistent POP therefore Caesarean performed. Please give advice regarding the selection of the principal diagnosis in delivery episodes. We are aware of standard 1515 (if a patient is admitted with an antepartum condition that requires treatment for more than 7 days prior to birth, this should be sequenced as the PD). Where this standard does not apply there are various practices in application of the PD:</p> <ul style="list-style-type: none"> <li>• Some Coders would say that as there is no speciality standard, ACS 0001 (Principal Diagnosis) should be followed. Of this group, some would say that the patient was literally admitted with pregnancy complicated by PIH (scenario 1) or pre eclampsia (scenario 2) and so this should be the PD. Others interpret that because the standard requires the reason for admission after study it could justly be said the patient was admitted at term to manage her delivery episode that was complicated by both PIH (scenario 1) or pre eclampsia (scenario 2) and POP. In scenario 1, they would then apply the concepts discussed in “2 or more diagnoses that equally meet the definition for PD” and look at therapy provided and consider that the Caesarean delivery for POP was the most resource intensive intervention and hence code this.</li> <li>• There are another group of Coders who continue to apply a concept from 1st edition ACS 1515 “In all other cases a diagnosis related to the delivery should be sequenced as principal diagnosis.” This sentence has been deleted but because the PIH /pre</li> </ul>	<p>precedence when assigning the principal diagnosis for obstetric admissions. When selecting the principal diagnosis for an obstetric admission where there is no specific advice in the specialty standards follow ACS 0001 Principal Diagnosis. The advice in ACS 1530 Premature Delivery is related to premature deliveries only and was not intended for general application. Selection of principal diagnosis for obstetric admissions will be reviewed for a future edition of the ACS.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>apply a concept from 1st edition ACS 1515 "In all other cases a diagnosis related to the delivery should be sequenced as principal diagnosis." This sentence has been deleted but because the PIH /pre eclampsia was not present for seven days they continue to apply this concept and would put the POP as the PD. Question 2. Please advise whether preterm delivery (or the underlying reason for pre term delivery) should always be sequenced as the principal diagnosis (unless there is an antenatal condition treated for more than 7 days (as per ACS 1515). ACS 1530 states If the reason for early delivery is documented in the clinical record, code this as the principal diagnosis, followed by O60. If no reason is documented, assign code O60 as the principal diagnosis. Is the use of 'principal diagnosis' in this standard only intended to be in the context of when the only conditions being coded are pre term delivery and the reason for pre term delivery (no other pregnancy/delivery/puerperal related conditions), or is it intended to have general application such as in episodes where there may be both preterm delivery and other complications e.g. those leading to Caesarean delivery.</p>	<p>eclampsia was not present for seven days they continue to apply this concept and would put the POP as the PD. Question 2. Please advise whether preterm delivery (or the underlying reason for preterm delivery) should always be sequenced as the principal diagnosis (unless there is an antenatal condition treated for more than 7 days (as per ACS 1515)? ACS 1530 states: If the reason for early delivery is documented in the clinical record, code this as the principal diagnosis, followed by O60. If no reason is documented, assign code O60 as the principal diagnosis.</p>	
0206-17	CIN 2 vs CIN 3	<p>Patient is referred by her GP to Gynaecology Outpatients due to CIN 3 found on a Pap Smear and/or Cervical Biopsy. Patient is seen and organized to have a Lletz procedure (Large Loop Excision of Transformation Zone). Results of the procedure: CIN 2. What condition is coded as the Principle Diagnosis? Or are they both coded?</p>	<p>The QCC recommends that in the scenario quoted that the CIN 3 be coded as the principal diagnosis. There is no need to code out the CIN 2.</p>	
0706-04	Eyelid retraction repair with full-thickness postauricular skin graft	<p>Could the QCC please follow up QCC query 1003-02, by referring to the NCCH, highlighting the need to amend the ACHI index, and to confirm whether code 42860-02[234] is correct and the only code required for this procedure. The indexing remains the same in 5th Edition. No clinical documentation is available. Query 1003-02 is as follows: I have found the ICD-10-AM index to be very confusing in relation to coding of repair of eyelid retraction. This patient has had a repair of lower eyelid retraction with full thickness postauricular skin graft. Depending on which lead terms are used to look up the index, will lead to different codes with</p>	<p>Forward to the NCCH and ask to update the ACHI as previously requested.</p>	<p>The NCCH agrees that the correct code to assign for eyelid correction/repair with skin graft is the appropriate code from block [234] Graft to eyelid and that the addition of 45451-00 [1649] Full thickness skin graft of eyelid is unnecessary. The current indexing is deficient in this area and will be reviewed for a future edition of ACHI.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>different essential and non-essential modifiers. 1 Repair -eyelid --retraction 42863-00 [236] The index then continues from this point with options for procedures performed using scleral grafts, meaning that if scleral grafts were not used, then the code would be 42863-00 Recession of eyelid. 2 Recession -eyelid --retractors 42863-00 [236] ---with graft to eyelid (Gore-Tex) (non-autogenous) (scleral) ----lower (one eye) 42860-02 [234] This pathway lists scleral and the other methods of grafts as non-essential modifiers, hence using this pathway, we would be correct to use '42860-02 Graft to lower eyelid, with recession of lid retractors, one eye'. 3 Graft -eyelid --with recession of lid retractors (Gore-Tex graft) (non-autogenous graft) (scleral graft) ---lower (one eye) 42860-02 [234] --skin - see Graft, skin, eyelid This index entry may lead to confusion on whether to assign code 42860-02 or a code found using index outlined below: 4 Graft -skin --eyelid ---full thickness 45451-00 [1649] I note the excludes note at 42863-00 [236], and as a result of this, and by choosing to follow index option 2 as above, I have assigned 42860-02 for this case. Does the QCC support the use of this code for this case? For the NCCH: If the use of a skin graft is included in code 42860-02 [234] (and other similar codes in the same block) a) Could this be added as a non-essential modifier at index entries 2 and 3 above; b) Could the essential term of scleral graft at Repair, -eyelid, --retraction, be removed and replaced with just 'graft' or a series of non-essential modifiers for various grafts; and c) Could an index entry at Graft, -skin, -eyelid, be added to redirect the coder elsewhere in the index, if the skin graft is being used in conjunction with repair of eyelid retraction; and d) Could an excludes note at codes 45451-00 [1649] and 45448-00 [1645] be added. If the use of a skin graft is not included in code 42860-02 [234] (and other similar codes in the same block), could the NCCH please advise of the correct coding for this case.</p>		
0706-02	Amyloidosis with end-stage widespread organ deposits	Discharge summary states "Amyloidosis end-stage with widespread organ deposits." Background history states "End-stage systemic amyloidosis with cardiomyopathy; GI deposits; pancreatic deposits; hepatic deposits; peripheral neuropathy;	Forward to the NCCH Interim response: The QCC recommends that where the additional conditions fulfil ACS 0002 that they should be coded additionally for further specification of progression of disease	Amyloidosis is a group of diseases that result from the abnormal deposition of a particular protein, called amyloid, in various tissues of the body. Amyloidosis that affects tissues throughout the body is referred to as

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>restrictive pulmonary disease and OSA." Haematologist referral to palliative care states "End-stage AL Amyloid with significant cardiac, liver and gut involvement. Issues are symptomatic cardiac disease with effusion (on home O2 + Diuretics) and pain in abdo, ? Hepatosplenomegaly". Patient died a few days later and death certificate states "cardiac amyloid". The codes assigned were D47.7 and M9769/1 with I43.8 Cardiomyopathy in other diseases classified elsewhere, K93.8 Disorders of other specified digestive organs in diseases classified elsewhere, and K77.8 Liver disorders in other diseases classified elsewhere, plus Z51.5 for palliative care. The questions are: 1. Should additional codes be assigned to the AL Amyloid codes D47.7 and M9769/1 to describe the spread of the disease and organs affected; and 2. If the answer to question 1 is yes, then should additional codes be assigned for all organs affected or only those that appear to affect patient management (which can be difficult to ascertain, especially in palliative care patients)?</p>	<p>25/07/2006: Forwarded to NCCH Thank you for considering our query with regards to the use of codes in the following scenarios. Documentation in a patient discharge summary states "Amyloidosis end-stage with widespread organ deposits." Background history states "End-stage systemic amyloidosis with cardiomyopathy; GI deposits; pancreatic deposits; hepatic deposits; peripheral neuropathy; restrictive pulmonary disease and OSA." Haematologist referral to palliative care states "End-stage AL Amyloid with significant cardiac, liver and gut involvement. Issues are symptomatic cardiac disease with effusion (on home O2 + Diuretics) and pain in abdomen? Hepatosplenomegaly". The Patient died a few days later and death certificate states "cardiac amyloid". 1. Should additional codes be assigned to the AL Amyloid codes D47.7 and M9769/1 to describe the spread of the disease and organs affected; and 2. If the answer to question 1 is yes, then should additional codes be assigned for all organs affected or only those that appear to affect patient management (which can be difficult to ascertain, especially in palliative care patients)?</p>	<p>systemic amyloidosis. Systemic amyloidosis can cause serious changes in virtually any organ of the body. Primary amyloidosis, or AL, occurs when a specialized cell in the bone marrow (plasma cell) spontaneously overproduces a particular protein portion of an antibody called the light chain. The deposits in the tissues of persons with primary amyloidosis are AL proteins. The correct code to assign for AL amyloidosis is D47.7 Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue and M9769/1 Immunoglobulin deposition disease. As the disease is by nature systemic there is no need to assign secondary neoplasm codes, however, manifestations of the disease which are conditions in their own right should be coded if they meet the criteria outlined in ACS 0002 Additional Diagnoses.</p>
0606-12	Respiratory Distress Syndrome	<p>How should "mild respiratory distress syndrome" or "respiratory distress syndrome" which does not seem to meet the severity described in the explanation area of ACS 1614 be coded?</p>	<p>The QCC recommends that where respiratory distress syndrome is documented that the code P22.0 Respiratory distress syndrome be allocated regardless of severity.</p>	
0706-03	Stress incontinence with Cystectomy and creation of ileal conduit	<p>Could the QCC please note the following DRG assignment, as it seems inappropriate to assign this to a female reproductive system DRG, due to the procedure being a urinary system procedure. The patient underwent a cystectomy and formation of an ileal conduit for stress incontinence. I have assigned codes: N39.3 Stress incontinence N31.2 Flaccid Neuropathic Bladder N39.0 UTI, 36600-02[1129] - Formation of incontinent intestinal urinary reservoir, and 37014-00 [1102] - Total excision of bladder. These codes result in a DRG of N11A Other Female</p>	<p>Forward to DoHA as a DRG anomaly</p>	

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		Reproductive Sys O.R. Procs Age >64 or W Malignancy or CC. I do not know how these same codes would currently group if the patient was male. QCC Secretariat note: When coding a male patient the DRG allocated is M01Z- Major Male Pelvic Procedures		
0606-17	Mental/behavioural and aging assessment codes	Should codes for mental/behavioural and aging assessment be used. ACS 0042 (Procedures normally not coded), states that "where there is a specific need to code any of the listed procedures for research or other purposes, these codes may be assigned." But is this similar to use of allied health codes for which there is a standard?	The QCC recommends that if there is specific need to code mental/behavioural and aging assessment codes at a local level for research or other purposes, the hospital may decide to allocate these codes.	
0606-16	Rapid progression to "SVD"	There is documentation of "very rapidly progressed to SVD" (second stage being ten minutes on the partogram) and "blistered nipple". Can 'rapid second stage' be assigned without a specific diagnosis of precipitate labour? Should blistered nipples be coded when there is no actual documentation of extra nursing care and monitoring? Can this be 'taken' in a similar way to the assumption that dementia will require extra care.	The QCC recommends that where "rapid" second stage is documented in the record, O62.3 can then be applied as per the index. The condition of blistered nipples is required to meet the requirements of ACS0002 prior to code allocation	
0606-15	Newborn of Hepatitis C positive Mother	Is any code needed to reflect a newborn who is documented in the birth admission as requiring later testing as the mother is hepatitis C positive?	The QCC recommends that neonatal conditions must meet the criteria of ACS 0002 unless they meet the criteria of some other specialty standard.	
0606-13	"exceptionally large baby"	Can exceptionally large baby be coded when there is documentation of large for gestational age and the birthweight is greater than 4500g? Weight is a non essential modifier and this code cannot be reached without the term 'exceptional'.	The QCC recommends that when exceptionally large baby is documented code to P08.0. When there is documentation of large for gestational age and the birthweight is greater than 4500g, use P08.1-other heavy for gestational age infants	
0606-11	Monitoring/observation of Newborn	Scenario: The baby has a condition which is coded eg jaundice but is also observed for other unrelated potential conditions eg risk of sepsis as the mother was group B streptococcus positive or the baby's blood sugar level is monitored as the mother had gestational diabetes. ASC 1611 directs that Z03.7 should only be used for otherwise healthy newborns and should be the only diagnosis additionally to Z38.0. How should monitoring/observation for conditions not found be coded in babies who have other unrelated conditions	The QCC has sent this query to the NCCH for their consideration. NCCH Query: In this case scenario the newborn has jaundice which is coded, however the newborn is also currently being observed for other unrelated conditions for example, risk of sepsis. The mother is positive for Group B Streptococcus and the newborn's blood sugar levels are also being monitored as Mum has gestational diabetes. ACS 1611 directs that "Z03.7- Observation and evaluation	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		coded?	<p>of newborn for suspected condition not found codes are for use in limited circumstances on records of otherwise healthy newborn, who are suspected to be at risk for an abnormal condition which requires study, but after examination and observation, it is determined that there is no need for further treatment or medical care". Therefore, how should monitoring/observation for "conditions not found" be coded in the presence of "unrelated conditions", which are coded. ACS 1611 further states that:" A code from Z03.7- is to be used as a principal diagnosis, except when the principal diagnosis is required to be a code from category Z38 Liveborn infants according to place of birth, in which case Z03.7- is to be the only additional diagnosis". The QCC acknowledges that ACS 1611 directs that "Z03.7- Observation and evaluation of newborn for suspected condition not found are for use in limited circumstances". However the QCC feels that in particular circumstances, Z03.7 may be added to the coding string to reflect an episode of care where there exists suspected conditions being observed that may/may not require further treatment/medical intervention. The QCC seeks NCCH ratification for the above advice.</p>	
0706-01	Specified activity	When do we use U73.8 - specified activity? Is it only for children playing and suicide?	<p>NCCH Response: U73.8 Other specified activity is for use when an activity is specified but does not fit into any other category. We will place this into Codefile 10/6/06:Further qualification to NCCH Would it be reasonable to give advice as follows: "U73.8 - other specified activity, is for use when an activity is specified but could not possibly fit into any other category. If an activity COULD possibly fit within another activity category, and it is simply lack of documentation of this information that prevents you from doing so, then code unspecified." U73.8 Other specified activity is for use when an activity is specified but does not fit into any other specified</p>	U73.8 Other specified activity is for use when an activity is specified but does not fit into any other category.

QCC_ID	Query summary	Query	Decision	Response from NCCH
			category in the ACTIVITY code range (U50 - U73). If the coder decides they have enough information to adequately specify an activity U73.8 can be assigned. If there is not enough information available to allocate this code (usually due to a lack of documentation) then U73.9 Unspecified activity should be assigned. Please also consider the fourth paragraph under ACTIVITY on Page 464 of the ICD-10-AM Tabular List which states For the code range V00-V99 Transport accidents, where the activity at the time of the accident is not specified as sport, leisure or working for an income, assign U73.9 Unspecified activity. The QCC has recommended that the further clarification from the NCCH be printed in a future Codefile with examples of use.	
0806-01	Anoxia at birth	45 year old male admitted for Rehabilitation, he had mental retardation due to anoxia at birth. This is all the information available, please advise codes required.	QCC agreed that the PD should be Z50.- with F79.9 and P21.9 as the additional diagnoses assuming that anoxia occurred at birth. Allied Health notes and the clinician should be queried for extra information.	
0806-02	Diabetes and IHD	Diabetic coding with Ischaemic Heart disease and Cardiomyopathy, ischaemic. As both these terminologies can be used by Doctors, is it possible to code both IHD and Cardiomyopathy, ischaemic with Diabetes Secretariat Comment: The question is: are the terms ischaemic cardiomyopathy and IHD interchangeable when coding Diabetes with Ischaemic cardiomyopathy?	The group agreed that Ischaemic Cardiomyopathy and IHD are not interchangeable. For Ischaemic Cardiomyopathy (IC) with diabetes = E11.53 If IC is used to further define a diagnosis of IHD, do not code the IHD. If IC and IHD are both present, use both codes with IHD being the additional diagnosis code.	
0806-03	Colonic Stent	This query relates to query 0905-02. The query refers to insertion of colonic stent. Previously: Please find following a query regarding coding of insertion of a colonic stent. These are traditionally inserted for obstruction caused by neoplasms. They are not normally done endoscopically. There is a code for insertion of duodenal stent (92068-00- endoscopic insertion of duodenal prosthesis). There is no code currently for insertion of colonic stent, endoscopic or otherwise. Could we please forward to the NCCH for their input Previous actions: In response to QCC query 0905-02, the Data Services Unit is preparing a submission to the NCCH for new	Clarify with NCCH the codes to use for the following locations 1) Colonic 2) Rectal 3) Colo-Rectal junction. In the interim, use 903100-00 Other procedures of the large intestine for colonic stent and the colonoscopy procedure code (specify the endoscopy code to the level the scope went to).	

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		<p>procedure codes to be created for endoscopic insertion of rectal, colonic and colorectal junction stents. In the interim could the QCC recommend how to code these procedures and also review previous coding advice on endoscopic insertion of rectal stents? QCC query 0203-03 suggests assigning the following codes for endoscopic insertion of rectal stent, 90314-00 [942] Other procedures on rectum, 32084-00 [905] Fiberoptic colonoscopy to hepatic flexure and 92066-00 [1894] Insertion of rectal tube. However as the procedure description specifically mentions stent and given that a rectal stent and tube are different devices could the QCC further evaluate if the code for rectal tube should be assigned when coding 'endoscopic insertion of rectal stent'? Could the QCC also recommend how to code endoscopic insertion of a colonic stent? Should this be coded to 90310-00 [925] Other procedures on large intestine with an appropriate colonoscopy code? Or would 32094-00 [917] Endoscopic dilation of colorectal stricture be considered more reflective of the procedure (as per the index entry, Dilation - colon - - stricture - - - and rectal stricture (endoscopic) 32094-00 [917]), although it is acknowledged that 'dilation' and stricture' may not necessarily be documented, and that the stenting component is still not captured within the code. Additionally, it is noted that the above Index entry does not provide a code number at the indent after - colon - - stricture (i.e. Dilation - colon - - stricture) so as to enable a code to be assigned when there has been dilation of a colonic stricture without dilation of a rectal stricture . Therefore, it is suggested that there be an index entry for Dilation - colonic - - stricture (endoscopic) 32094-00 [917] Endoscopic dilation of colorectal stricture as this would facilitate code assignment. What code/s should be assigned for endoscopic insertion of a colorectal stent (i.e. stent placed at the colorectal junction)? Should this be coded to 90310-00 [925] Other procedures on large intestine. Or would it be considered more reflective to assign 32094-00 [917] Endoscopic dilation of colorectal stricture as proposed above, AND to then also assign Other procedures on large intestine in an attempt to capture the stenting</p>		

QCC_ID	Query summary	Query	Decision	Response from NCCH
0806-04	Dropped lens/dropped nucleus	<p>component?</p> <p>Please see QCC query 0204-14. Advice given at that time for the specific scenario was "The committee agreed that code T88.8 is more appropriate than H59.9." This does not appear to have been sent to NCCH for ratification. Literature seems to indicate that the term 'dropped lens' may be used when describing either 1) a complication during cataract extraction surgery where fragments are dropped into the vitreous or 2) later displacement of an IOL. In light of this, I request QCC review of the decision made for query 0204-14 and general advice as how to code these conditions. I suggest that in use type 1) 'a complication during cataract extraction surgery where fragments are dropped into the vitreous' code set options include: • cataract code • H59.8 vs H59.0 (I am not sure but literature seems to suggest that a number of conditions can be considered as 'vitreous syndrome') • Y61.0 vs Y65.8 • Y92.88 I am not sure which Codefinder path should be followed. There are a number of cataract surgery complication pathway choices but none exactly say 'dropped lens' or 'dropped nucleus'. From the complication, (spell) cataract surgery pathways we can get codes H59.0 or H59.8 and H26.8 or H43.3 depending on which is chosen. I am not sure which, if any, is applicable for dropped nucleus/lens, unless the specific detail is provided in the record. I suggest that in use type 2) 'later displacement of an IOL' codes are: T85.2 Y83.1 Y92.22 Further Clinical Advice: Your question is not easy to answer. Vitreous syndromes are a slightly turbid entity. They are usually used to describe post-cataract surgery cystoid macular oedema; which includes your entire list. Not all are definitely due to vitreous traction and I would make your definition less stringent. Show me your next definition.</p>	<p>1.12.06 - this decision over-rides the decision in Sept 06 Literature seems to indicate that the term 'dropped lens' may be used when describing either 1) a complication during cataract extraction surgery where fragments are dropped into the vitreous or 2) later displacement of an IOL. The enquirer was unsure how to code "dropped lens/dropped nucleus". After clinical consultation, the QCC recommended the following code string: T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical operation Y92.22 Health service area S05.8 Other injuries of eye and orbit H43.2 Crystalline deposits in vitreous body Y60.0 Unintentional cut, puncture, perforation or haemorrhage during surgical operation Y92.22 Health service area 7.9.06:T81.2 Accidental puncture and laceration during a procedure, not elsewhere classified</p>	
0906-02	Postprocedural IDC	<p>I refer to ACS 0042 point 14, NCCH queries 1358 and 584 and QCC query 1000-17 with regards to the coding of IDCs. ACS 0042 states that 'postprocedural' urinary catheterisation should be coded if the patient is discharged with catheter in situ. NCCH query 1358 states that "In the case cited, urinary</p>	<p>Due to the disparity of advice this query is to be forwarded to the NCCH</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		retention was not postprocedural, and as the catheter was still present on discharge, you would be correct in assigning a code for the insertion of an indwelling catheter." QCC query 1000-17 states that "if the IDC is the only procedure performed during the episode of care then the procedure should be coded." Should an IDC be coded when a patient is discharged with the catheter in situ and the urinary catheterisation is not 'postprocedural'? Should an IDC be coded when a patient is discharged with a non-postprocedural urinary catheter in situ and other procedure codes have also been assigned? If the intention of ACS 0042 is to ensure routine postprocedural catheters are not coded, should the ACS be reworded?		
0906-03	AICD Generator Change	Patient admitted for AICD generator change. This particular type of AICD also has a pacing function Please clarify. According to both NCCH queries 2072 and 2155 advice recommends coding both the insertion of the pacemaker and AICD components separately. Therefore should we also code both the replacement of the AICD and the removal and insertion of a pacemaker for these types of combined devices? Care would need to be taken when interpreting the data for these particular devices, as over reporting (specifically for pacemakers) may result.	The QCC felt that the enquirer should continue to code the procedure as normal. The QCC would support the creation of a Public submission to request an update to the classification to include AICD as a device. Update 12/2/07: The QCC felt that the enquirer should code both the PPM and the ICD when a combined ICD/PPM is replaced. This replaces the previous advice to "code as normal".	
0906-04	CPOA - Pressure Ulcer	A man was admitted and while doing a pressure ulcer search it was found that he had a stage 3 pressure ulcer on his sacrum and stage 1 pressure ulcers on his heels. His wife states that the pressure ulcer on his sacrum was present on admission with the ulcers of his heels being new. The coding standards state code only the higher of the two pressure ulcers. Therefore do i code only the stage 3 pressure ulcer of his sacrum without the 'C' prefix, or in this case would i code both using the 'C' prefix with the stage 1 pressure ulcer??	Since the Condition Present on Admission indicator does not affect code allocation, the stage 3 pressure area would be coded as per the coding standard. The Stage 3 pressure ulcer would be deemed present on admission and have a prefix, in HBCIS, of "A" or an indicator of 1.	
0906-05	Cord complications during delivery	We have a query re cord complications during delivery. In the mother's record if the only mention of a cord complication is the tick box on the perinatal form, there is nothing documented in the notes about any problems caused by the cord being draped around the neck or entangled, is it	Page 4 of the ACS includes midwives under the category of "clinician" therefore the perinatal form can be used to assist with coding. AS for the second component of the question, whether you should code cord compression, the QCC refers you to NCCH	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>necessary to add the code O69.8 Labour and delivery complicated by other cord complications. We note that when there is a cord compression then extra nursing/medical care is usually undertaken and code O69.1 Labour and delivery complicated by cord around neck, with compression would be used. Also for the baby's record we note that the relevant P codes would be used as there is usually an effect from the cord problems</p>	<p>Query 255: "Assign 'O69.2 Labour and delivery complicated by other cord entanglement' whenever 'cord around infant's neck - no compression' or 'cord around infant's neck - loose' is documented by an obstetrician/ clinician/midwife." This is supported by standard 1506 that states to code cord presentation if abnormal during labour</p>	
0906-01	Principle diagnosis back pain or Adenocarcinoma	<p>Patient admitted with back pain First procedure biopsy lesion of spine - Metastatic Adenocarcinoma Procedures done on different days Second procedure biopsy lung - Primary Adenocarcinoma This was the first admission for the patient. We have asked about 6 other coders as to what they would use as the Principal Diagnosis and so far it is 50/50. Some are using the secondary as the Pdx as this caused the back pain, the others say that the lung primary is the Pdx as this caused the secondary. This example would arise often for new coders, but it is impossible to find any guidance on the NCCH website. Would it be possible for the NCCH to set up a website that gives examples of scenarios and answers just like above. The Queries database does not always give assistance to new coders.</p>	<p>In this instance, due to the symptoms exhibited by the patient, the principal diagnosis is metastatic Adenocarcinoma of the spine. ACS 0236 states "The sequencing of either primary or secondary malignancy code is dependent on the treatment at each episode. Selection of the principal diagnosis should be made in accordance with ACS 0001 Principal diagnosis</p>	
1006-04	Place of Occurrence - Motel and B&Bs	<p>Patient slipped and fell causing an injury in a motel. What would be the place of occurrence? Would you use Y92.53 - Café, hotel or restaurant or another Y92 code? Similarly, what about bed and breakfasts and holiday apartments? Holiday apartments is a bit more difficult as "apartment" is an inclusion for Y92.09.</p>	<p>Forward to NCCH. In the interim code to Y92.53 27/10/2006 forward to NCCH: Clarification is sought with regards to the correct "place of occurrence" code to use if a patient slips and falls causing an injury in a motel. Similarly, confirmation of the correct code for bed and breakfasts and holiday apartments is sought. What 'definitions' apply to 'trade and service area' and 'home'? Would Y92.53 - Café, hotel or restaurant be deemed a suitable code or another Y92 code? (If considered a trade and service area, should a place for sleeping overnight be grouped with places that seem to be mainly for eating and socializing for a short period?)</p>	<p>The NCCH advises that the correct place of occurrence code to assign for an injury occurring in a motel, bed &amp; breakfast or holiday apartment is Y92.53 Café, hotel and restaurant. However, this code should not be assigned if any of these types of accommodation is the patients usual place of residence. Assign Y92.09 Other and unspecified place in home, in these circumstances. The NCCH will consider indexing these places for a future edition of ICD-10-AM.</p>
1006-09	Head Injury for observation	<p>Please refer to ACS 1905 (Closed Head Injury) and NCCH query database response 2003. Please advise the correct</p>	<p>Committee members favoured the use of S09.9 when the head injury referred to an unspecified</p>	<p>The following advice previously issued in Q2247 stands: "We recognize that the previous response (referring to</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>code assignment for the following scenario: Patient has "head injury" as the stated diagnosis on the summary and front sheet. Scleral haematoma is also documented. The patient had a fall from furniture onto a hard surface. There was no known loss of consciousness but the patient was noted by parents to be "very sleepy for 5 minutes", have a nose bleed and vomit with flecks of blood and be "not alert". This history was taken and the examination also revealed a small scleral haematoma. The patient was admitted for neurological observations. Query 2003 advises than any specified injury of the head (eg abrasions, contusions and lacerations) be coded rather than head injury S09.9. I request that further consideration be given to this and advice be clarified in 10 commandments and a future amendment to the standard. I believe that the term 'head injury' is used variably e.g. • To describe the circumstance -act of injury to the head • A general term to describe any injury of the head (including abrasions, contusions, lacerations etc) • A general term for brain injury In many instances clinicians can describe that a patient has a head injury and e.g. cheek contusion meaning this to be 2 injuries- one being the contusion and the other being the general term for brain injury based on neurological indicators and signs such as drowsiness, vomiting, pupil reaction etc. Normally the minor obvious superficial injury would not require admission. I do not believe that just coding the minor injury is reflective of the care, tests and observations performed. Perhaps consideration should be given to using a Z code for observation as the principal and coding the minor injury as additional or creating an extra digit to S09 to differentiate unspecified head injury which is obviously severe from that which requires no further study/care after initial admission for observation?</p>	<p>neurological injury. Cross reference to NCCH query 2247 for further information. The QCC will refer this query on to the NCCH. 27/10/2006 sent to NCCH: Please refer to ACS 1905 (Closed Head Injury) and NCCH query database response 2003 and subsequently 2247. Clarification is sought with regards to the correct code assignment for the following scenario: SCENARIO Patient has "head injury" as the stated diagnosis on the summary and front sheet. Scleral haematoma is also documented. The patient had a fall from furniture onto a hard surface. There was no known loss of consciousness but the patient was noted by parents to be "very sleepy for 5 minutes", have a nose bleed and vomit with flecks of blood and be "not alert". This history was taken and the examination also revealed a small scleral haematoma. The patient was admitted for neurological observations. Query 2003 advises than any specified injury of the head (e.g. abrasions, contusions and lacerations) be coded rather than head injury S09.9. We request that further consideration be given to this advice with clarification given in 10-AM Commandments and a future amendment to the standard. The term 'head injury' is used variably e.g. •To describe the circumstance -act of injury to the head •A general term to describe any injury of the head (including abrasions, contusions, lacerations etc) •A general term for brain injury In many instances clinicians can describe that a patient has a head injury and e.g. cheek contusion meaning this to be 2 injuries- one being the contusion and the other being the general term for brain injury based on neurological indicators and signs such as drowsiness, vomiting, pupil reaction etc. Often the minor obvious superficial injury would not require admission. Coding of the minor injury alone does not reflect the care, tests and observations performed. Perhaps consideration could be given to using a Z</p>	<p>Q2003) regarding the coding of a laceration as 'a more specific diagnosis' may not be entirely appropriate. As stated previously we are undertaking to review ACS 1905 Closed Head Injury/Loss of Consciousness/Concussion regarding the use of S09.9 Unspecified injury of head and to clarify the phrase 'more specific diagnosis. In the meantime, we would strongly recommend that each site continues to apply the standard in an agreed and consistent manner (i.e. continue to code as you have done previously) until further advice is received." See also Q2003 and Q2247.</p>

QCC_ID	Query summary	Query	Decision	Response from NCCH
			code for observation as the principal diagnosis and coding the minor injury as additional or including an extra digit with the S09 code to differentiate unspecified head injury which is obviously severe from that which requires no further study/care after initial admission for observation.	
1006-03	Maltreatment Syndrome	QCC 8.9.05 item 6.3 "this form will be filed in the patient record and coders should assign the T74.x (maltreatment syndromes) as per ACS 1909". We have this form filled in on our birth admission episodes and baby is fine or usually just has other codes from the P chapter. No documentation of suspected child abuse or " child at risk". Various issues relating to the mother are given eg young mum, daily MJH use, no money and hx domestic violence, and they are then followed up after leaving the hospital. Do we need to assign a code from T74.x for our birth admissions due to this form being completed?	Forward to NCCH to clarify the advice provided on query 2069 regarding Z76.2 for newborn of perceived risk. Also clarify with the NCCH whether older children can be coded using Z76.2 and request that the standard ACS 1909 is changed to reflect this advice. DSU to investigate edits for Z76.2. In the interim use the code Z76.2 for "risk" described in the birth episode where there has been no actual maltreatment. Continue to use T74 for any others. If NCCH approve the use of Z76.2 for older children, it may be appropriate to retain a fatal edit but advice will be provided via Codefile to use Z76.2 with a message map.	In the first scenario cited it is inappropriate to assign a code from category T74 Maltreatment Syndromes. Follow the previous advice given in Q2069 and assign Z76.2 Health supervision and care of other healthy infant and child following the pathway: High -risk --infant Z76.2 Completion of the child safety form should not be the impetus for code assignment, as this is not a national practice. Similarly with reference to the second scenario cited, also assign Z76.2 Health supervision and care of other healthy infant and child following the above pathway. The NCCH will consider improvements to the ICD-10-AM Alphabetic Index for a future edition. See also Q2069.
1006-02	Excisional Debridement	When an excisional debridement is coded, the episode groups to an AR-DRG for an OR procedure regardless of whether the debridement was performed in theatre or on the ward. There are often occasions where an excisional debridement is performed on the ward and not in theatre. This has previously been identified in QCC query 0700-07. Can this situation be taken into consideration for future versions of the Grouper.	QCC will clarify the background of why excisional debridement is considered an OR procedure. Whilst it is understood that a procedure can be considered an operating room procedure regardless of where it is performed.	
1006-01	Uterine Scar	ACS 1506 states that O75.7 Vaginal delivery following previous caesarean section should be assigned for cases where a trial of caesarean scar proceeds to a vaginal delivery. Does this apply to a vaginal delivery following a previous caesarean section where the caesarean section was not the most recent delivery? Or is 'trial of scar' by definition, only when the vaginal delivery is immediately following a previous caesarean section? After researching the definition of 'trial of scar', it appears that a vaginal delivery following a previous caesarean section requires greater management/resources	Continue to code as per current hospital practice. Query to be forwarded to NCCH for clarification and rewording of the ACS to reflect the intention. ACS 1506 introduces the concept of 'trial of scar'. This is not a term in the tabular or index and so it is confusing whether: 1) 1) previous means the immediate previous vs any previous 2) points in the standard are intended to be taken literally and strictly applied e.g. can we code O34.2 only if the reason for caesarean is previous, failed 'trial of scar' or there is	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		eg presence of obstetrician, anaesthesiologist, operating room ready and staff available to provide an emergent delivery (regardless of whether the previous caesarean section was immediately preceding the vaginal delivery, or otherwise). If the purpose of the code O75.7 Vaginal delivery following previous caesarean section is to reflect this requirement for greater management/resources, can the statement in the ACS be further defined to avoid confusion?	some other specific need for care because of the scar and can we code O75.7 only where a 'trial of scar' proceeds to a vaginal delivery vs the standard is just giving examples on when to use O34.2 and O75.7.	
1006-05	Adhesions of Appendix	Adhesions appendix K38.8 generates a fatal validation edit when coded with 30393-00 [986] - laparoscopic division of adhesions abdominal. In CRDS K38.8 is not one of the companion codes for the procedure 30393-00[986]. Can K38.8 be added as an acceptable companion code for 30393-00[986]?	Request an extension to the CRDS companion code range for 30393-00 [986] to include K38.8	
1006-06	Fracture of Bone following insertion of orthopaedic implant, joint prosthesis or bone plate	Could you please confirm code M96.6 should be followed by a code in the range Y83-Y94.99, as per HQI error H564? Our case involved a fracture from drilling a plate into place to reduce another fracture. The preferred EX code was Y65.8 Other specified misadventure during surgical or medical care. Would it be possible to widen the acceptable companion code range to include Y65.8?	QCC will query NCCH to establish whether M96.6 can be used when the fracture occurs interoperatively in light of previous advice provided regarding S and T codes and clarify if M96.6 applies to post or interim codes. Clarification will also be sought with regards to whether a code such as T88.8 or other (ACS 1904) is required if the fracture is considered a misadventure. In the Interim, code to Y65.8 and request that it be mapped.	
1006-08	Neonatal AABR screening (for hearing)	QCC query 0305-03 asks advice regarding the most suitable code to reflect the AABR screening test but does not give guidance as to whether it should be routinely coded when performed. AABR screening is performed routinely for newborns, usually on day 3, in hospitals that are participants in the Healthy Hearing project. If day 3 is before discharge, the test will have been performed while an inpatient, but the baby may be discharged prior to testing so this may be done as an outpatient or in the community, and hence would not be coded. Should we be coding AABR (11300-00) when performed on inpatients?	QCC to send a selection of procedures to the NCCH for clarification. In the interim, continue to code as per current hospital policy. 27/10/2006: Sent to NCCH Is it possible for NCCH to list or flag procedures that either are or are not required for coding at a national level? Either a list or use of a symbol/shading in the tabular ACHI would be of value. When determining whether to code a particular procedure coders are guided by ACS 0016, 0042, and specialty standards such as ACS 1615 (interventions for the sick neonate). Difficulty arises when procedures are not 'specifically' covered by standards and coders have different interpretations of what constitutes 'procedural risk' and 'special	The issue of determining whether particular interventions should be coded is addressed in ACS 0016 GENERAL PROCEDURE GUIDELINES and ACS 0042 PROCEDURES NORMALLY NOT CODED and other specialty standards such as ACS 1615 SPECIFIC INTERVENTIONS FOR THE SICK NEONATE. It is not feasible to address the numerous issues you have identified as a coding query. Review of coding standards should be progressed as a public submission. ACS 0016 PROCEDURES NORMALLY NOT CODED is currently under review.

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>facilities, equipment and training'. While it is understood that procedures performed under anaesthetic (except local) are coded and that any procedure may be coded if required at a local level (e.g. research), QCC would like clarification about which procedures (not performed under anaesthetic) that coders are expected to code/ report nationally. QCC would like to pass on this guidance so that there is more standardized reporting and to promote efficiency (some coders labour over decisions about how to code procedures that do not actually require coding). Some procedures identified that are coded routinely by some coders and not by others are:</p> <ul style="list-style-type: none"> <li>Radiography involving enemas or swallowed contrast e.g. barium enema, gastrograffin swallow. (most coders seem to code radiology involving IV contrast)</li> <li>•Fluoroscopy/image intensifier used either in or out of theatre when reducing fractures (and other procedures where there is not a code encompassing the fluoroscopy). There are some NCCH database questions regarding coding of fluoroscopy. Most advise was to code fluoroscopy, but not for EPS with ablation as it is considered a component. Coders are unsure whether reducing a fracture under image intensifier under anaesthetic represents a component or should be coded because it is under anaesthetic and though common, it is not performed for all reductions.</li> <li>•Neonatal AABR screening. This is routinely performed in some hospitals (e.g. participants in the Healthy Hearing project).for newborns, usually on day 3, If day 3 is before discharge, the test will have been performed while an inpatient, but the baby may be discharged prior to testing so this may be done as an outpatient or in the community, and hence would not be coded. Should AABR (11300-00) be coded when performed on inpatients?</li> <li>•Minor suturing (including tissue glue) e.g. when performed for elderly patients who get skin</li> </ul>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>tears while in hospital or when a patient is in A&amp;E with several significant injuries but minor lacerations are also sutured. •Aged Care assessment, other assessments •Resuscitation procedures at birth e.g. intubation and ventilation (especially when this is continued until collection by a retrieval team or prolonged). In ACS 1615 there is a note that these procedures are not coded when “part of resuscitation at birth”, but it is not clear whether this relates only to parenteral fluid therapy or to oxygen therapy and enteral infusion also or all procedures that are part of resuscitation. NCCH query 1754 advises not to code a short period of IPPB because it was part of resuscitation, but it is not clear whether this reasoning/advice is applicable to other scenarios. •Removal of devices (block [1896]) •Removal of wax from ear</p>	
1006-10	<p>Suprapubic bladder aspiration Barium follow through Opaque meal Gastric lavage Counselling e.g. for diabetes Routine childhood vaccination Application of a cast</p>	<p>Please advise whether there is an expectation that any of the following procedures should be routinely coded for neonates, children or adults. Suprapubic bladder aspiration Barium follow through Opaque meal Gastric lavage Counselling procedures e.g. for diabetes Routine childhood vaccinations Application of a cast (under GA) at the end of a tendon transfer procedure</p>	<p>Suprapubic bladder aspiration - Code Counselling e.g. for diabetes - Do not Code Routine childhood vaccination – Do not Code Application of a cast (under GA) at the end of a tendon transfer procedure (after closure) – Do not Code application of cast unless it is done as a stand-alone procedure. QCC will be forwarding the following to the NCCH as consensus was not achieved regarding the coding of these: Barium follow through Opaque meal Gastric lavage</p>	
1006-11	Colonic manometry	<p>Please advise the correct code to be assigned for colonic manometry. Current options appear to be [925] 90310-00 ‘other procedures on large intestine’ or [1866] 92204-00 ‘Noninvasive diagnostic tests, measures or investigations, not elsewhere classified’. As 90310-00 drives DRG assignment and anal manometry is classified in chapter 19, should consideration be given to creating a new code in block 1859 for either ‘other digestive system diagnostic test, measure or investigation’ or colonic manometry specifically?</p>	<p>In the interim, use 92204-00 [1866] The QCC will request a new code in block [1859] addition from NCCH.</p>	
1006-12	Child was climbing from	<p>n this example is the activity ‘specified’ .8 or ‘unspecified’ .9?</p>	<p>Code to U73.9 (unspecified) as the child’s activity</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
	a chair to a lounge when they fell	We know they were climbing but do not know whether this was in play or whether they were climbing to the lounge to go to sleep.	was not clearly documented.	
1006-13	1)Inflammatory bowel disease and cryptitis in a child 2) (different patient) 'disuse colitis' or 'diversion colitis' in a child with a stoma	ACS 1120 directs that if gastroenteritis is not stated as infectious it should be coded as A09 diarrhoea and gastroenteritis of presumed infectious origin in children (15 years and under). Can non infective colitis be used in these situations and if so can the standard be revised to make this clear?	Code as non-infective/non-inflammatory colitis This query will be forwarded to the NCCH for a final decision.	
1006-14	Child with wound mouth as a result of falling when walking with a stick in their mouth.	The index directs when coding fall on a sharp, edged or pointed object to see fall by type. Information about the sharp object is not captured. Should there be an alternate code used or should there be an enhancement to fall codes to capture information about the sharp object?	The QCC recommendation is to code the fall. The QCC will discuss with HBCIS about the ability to code multiple external cause codes for the principal diagnosis	
1006-15	"Delay scalp flap" "transposition of scalp flaps to close the defect"	Using the index Flap -skin --delay ---direct 45230-00 [1653] However the tabular for 45230-00 says "delay of direct distant skin flap". The index look up for Flap -skin --direct (distant) has 'distant' as a non essential modifier. Can 45230-00 be used if the flap is not distant? Should 'distant' be removed from the code title in the tabular and used as a non essential modifier in the index?	QCC agreed that 45230-00 [1653] could be used where distant is not mentioned as it is a non-essential modifier in the index. A decision was made to send a suggestion to the NCCH that the word "distant" be removed from the code title for 45230-00 [1653] since the index entry has distant as a non-essential modifier	
1006-16	Excision brain lesion	Should excision of brain lesions be coded as 39706-01 [9] Decompression of intracranial tumour via osteoplastic craniotomy, when 'decompression' has not been documented. Clinical clarification regarding excision of brain lesions at one hospital resulted in advice that decompression was the most appropriate code to assign. In other hospitals without the benefit of this advice, most coders are likely to assign the code for removal of other intracranial lesion or excision lesion brain	Code according to the documentation provided. When in doubt seek clinical advice as to the particular procedure carried out.	
1006-17	Cystic fibrosis with lung and intestinal manifestations and pancreatic insufficiency	ACS 0402 directs to code cystic fibrosis to E84._ followed by a code for any specific manifestations and that E84.8 includes cases with combined manifestations. 1)By using E84.8 alone it would not be clear that the cystic fibrosis was affecting the lung and intestines specifically (as opposed to say liver and genital system). If the specific manifestation documented this	The QCC recommends that the standard be followed as recommended. K86.8 should be added to provide additional information where the patient has pancreatic insufficiency. It is acknowledged that there is an age edit on this code. QCC will investigate if this is a Commonwealth edit. Additionally, the QCC	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		would be coded, but if not is it appropriate to use E84.0 and E84.1? Does E84.8 sill need to be used? 2)The code for pancreatic insufficiency K86.8 excludes fibrocystic disease of the pancreas and directs to cystic fibrosis but not all people with CF are pancreatic insufficient. Should K86.8 be used additionally to cystic fibrosis to provide information that the patient has pancreatic insufficiency?	will consider a public submission regarding this issue.	
1006-07	Pancreatitis	Would it be possible to have an option for pancreatitis? In 4th Edition there was a code for "pancreatitis" whereas in 5th Edition this has been removed. Does this mean that pancreatitis needs to be specified at all times and cannot be unspecified?	The form of pancreatitis must be specified. This is a new code which is found by going through the index entry: -pancreatitis -acute Seek confirmation with the NCCH with regards to intent and whether gallstone pancreatitis should be defaulted to acute status.	The 4th character codes under K85 Acute Pancreatitis were added to ICD-10-AM Fifth Edition as a result of amendments from the WHO URC. At this time, it was decided that there should be no default code for 'pancreatitis NOS.' However, more recently, an update has been received from WHO advising that the default code for 'pancreatitis NOS' should be K85.9 Acute Pancreatitis. This will be updated in the ICD-10-AM Alphabetic Index in the September 2007 errata. With regards to your query in relation to gallstone pancreatitis, the indexing of this condition will be reviewed for a future edition of ICD-10-AM.
1106-04	Pterygium	Operation notes read as follows: L Pterygium excision and advancement flap, very large pterygium – extensive fibrotic attachment of body to sclera. Dissected off cornea and base clear to limbus. Tumour and pterygium dissected. One specimen sent to QML. QML Report as follows: L Pterygium specimen – conjunctiva, left biopsy conjunctival intraepithelial neoplasia CIN 1, pterygium probably completely excised.	The QCC advises that the procedure codes to be used are as follows: 42686-00 [172] – Excision of Pterygium 42641-01 [255] – Autoconjunctival transplant + relevant anaesthetic codes	
1106-01	Outcome of Delivery	May I have some clarification with regard to the Z37.- "Outcome of Delivery" code. Pt was admitted at 18 weeks with PROM with small bleeds prior to that; after discussion with Obstetrician the Pt opted to TOP. Therefore, induction of labour was carried out and progressed to SVD of a Live male – RIP at 18 mins of age. Is the outcome of delivery Z37.0 as the baby was born alive and lived for 18 minutes?	The QCC considers that regardless of birthweight or gestation	
1106-03	Difficult Intubation	Corrie Martin has requested that this coding decision be forwarded to the QCC: It has been the routine practice at this hospital to assign Failed or Difficult Intubation (T88.4/Y84.8/Y92.22) in the following scenarios: 1.	There has been a lot of discussion at QCC and this query has been referred to the NCCH. The QCC recommends that the hospital should continue with their current practice until a response is received	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Documented on Anaesthesia Record in the Ventilation &amp; Airway field "Diffic. Of intub. Level: Diff " and specified in the Clinical Comments field "Bougie used" or "fiberoptic awake intubation". Patient successfully intubated with no adverse outcome. No other documentation/mention of difficult intubation in progress notes. Postoperative period uneventful and patient received routine care and discharged as per normal. 2. Documented on Anaesthesia Record in the Ventilation &amp; Airway field "Diffic. Of intub. Level: Diff " and specified in the Clinical Comments field "Bougie used" or "fiberoptic awake intubation". Patient successfully intubated with no adverse outcome. Documented in progress notes/pre-anaesthetic clinic notes as Difficult Intubation (sometimes documented as difficult airway) level 3-4 required bougie or fiberoptic intubation in theatre, postoperative assessment stable, routine postoperative care given and patient discharge as per normal. The pathway look up for condition Difficult Intubation is Difficult, difficulty –intubation, in anaesthesia T88.4 To verify correct code assignment by referring to the tabular list there is an annotation at beginning of the code blocks (T80-T88) Complications of Surgical and Medical Care to refer to ACS 1904 Procedural Complications indicating that the code should be checked against the standard before it is applied. Other pathways of getting to the code T88.4 is by using the lead term Complications –anaesthesia, anaesthetic - - difficult or failed intubation T88.4 and using the lead term Failed –intubation during anaesthesia T88.4. We recently questioned the practice of assigning this code in the above circumstances as the condition 'difficult intubation' requiring assistance or different techniques (eg. Bougie, fiberoptic) did not seem to be a complication of the procedure as the patient was intubated successfully without an adverse outcome and therefore did not meet the ACS 1904 Procedural Complication. We sought clinical advice from the Director of Anaesthesiology to get a better understanding of the documentation on the Anaesthetic Record. The clinical advice received was that "Difficult intubation" is most often due to a patient's unusual anatomy. Different instruments and</p>	<p>from the NCCH. This query will be forwarded to the NCCH for consideration. The QCC will consider a public submission to the NCCH regarding clarification of difficult intubation</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>techniques are used to address the variation of the patient's respiratory anatomy in order to successfully intubate them for surgery (eg. fiberoptic intubation used for patients with broken jaws). Successful intubation of a difficult to intubate patient is a positive and expected outcome and is not a procedural complication. We were advised that difficult or failed intubation would be a procedural complication in the following circumstances -</p> <ul style="list-style-type: none"> <li>• Where intubation is not performed correctly resulting in a complication of the procedure</li> <li>• Where the patient couldn't be intubated resulting in an adverse effect on the patient (eg: aspiration)</li> <li>• Where it is expected that the patient would be able to be intubated but intubation is not successful (eg: failed intubation in a trauma patient requiring an urgent tracheostomy).</li> </ul> <p>Given that we have received clinical advice from the Director of Anaesthesiology and looking more carefully at the logic of the Australian coding standards, our conclusion is that the use of the codes T88.4/Y83.8/Y92.22 in the circumstances outlined in points 1 &amp; 2 above (ie: where difficult intubation was encountered but the patient was successfully intubated) would not be appropriate.</p>		
1106-02	Conjunctival Intraepithelial Neoplasia	<p>Kumar: Robbins and Cotran: Pathologic Basis of Disease, 7th ed., Copyright © 2005 Saunders, An Imprint of Elsevier</p> <p>NEOPLASMS Both squamous neoplasms and melanocytic neoplasms and their precursors tend to develop at the limbus. Conjunctival squamous cell carcinoma may be preceded by intraepithelial neoplastic changes analogous to those seen in the evolution of cervical squamous cell carcinoma. In the conjunctiva, the spectrum of changes from mild dysplasia through carcinoma in situ is also designated as CIN, which in this context designates conjunctival intraepithelial neoplasia. Squamous papillomas and conjunctival intraepithelial neoplasia may be associated with the presence of human papillomavirus types 16 and 18.[6] Although conjunctival squamous cell carcinoma tends to follow an indolent course, mucoepidermoid carcinoma of the conjunctiva (reflecting the ability of conjunctival stem cells to differentiate into squamous epithelium and goblet cells) follows a much more aggressive course. Yanoff: Ophthalmology, 2nd ed., Copyright © 2004</p>	The QCC advises that the code H11.8 "Other specified disorders of conjunctive" be used. This query will be forwarded to the NCCH	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Mosby, Inc. CONJUNCTIVAL INTRAEPITHELIAL NEOPLASIA In immunocompetent individuals, conjunctival intraepithelial neoplasia (CIN) is the most common neoplasm of the ocular surface. It is a known precursor of squamous cell carcinoma, the most common conjunctival malignant neoplasm. Traditional risk factors for this disease include ultraviolet light exposure, petroleum products, heavy cigarette smoking, light hair and ocular pigmentation, and family history.[11] The most significant risk factor, however, is human papillomavirus infection. Although CIN typically affects men in the sixth and seventh decades of life, this ocular tumor has been observed in young AIDS patients. Cervical intraepithelial neoplasia, increasingly common in women who have AIDS, shares some characteristics with CIN—both involve nonkeratinized epithelium, occur at transitional zones of surface epithelium, and have been associated with human papillomavirus infection.[11] Abeloff: Clinical Oncology, 3rd ed., Copyright © 2004 Churchill Livingstone, An Imprint of Elsevier Squamous Cell Carcinoma of the Conjunctiva and Its Precursors Squamous cell carcinoma and its precursor lesions are the most common conjunctival neoplasms. They typically occur in elderly patients, 75% of whom are men; however, when seen in young patients these tumors are frequently associated with human immunodeficiency virus (HIV) infection and may be more aggressive.[712][713][714][715] Preinvasive, dysplastic lesions are usually either discrete actinic keratoses when superimposed on pterygia or ill-defined lesions when arising de novo. Currently, the preferred term for partial-thickness dysplasia of the epithelium is conjunctival intraepithelial neoplasia (CIN) grade I or II, and for full-thickness dysplasia, the term is CIN grade III or carcinoma in situ. Patients with squamous cell carcinoma are a mean of 8 years older than patients with CIN at the time of diagnosis.[712][713] ..... Neoplasia - endocrine, multiple (MEN) (M8360/1) (see also Adenomatosis, endocrine) D44.8 - germ cell, intratubular (M9064/2) D07.6 - intraepithelial - - anal, grade III (AIN III) (M8077/2) D01.3 - - cervix (CIN) (uteri) N87.9 - - - with</p>		

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>invasion — see Neoplasm, cervix, malignant - - - grade I N87.0 - - - grade II N87.1 - - - grade III (severe dysplasia) (M8077/2) D06.9 - - - - endocervix D06.0 - - - - exocervix D06.1 - - - - specified NEC D06.7 - - ductal, grade 3 (DIN 3) (M8500/2) D05.1 - - glandular, grade III (M8148/2) D07.5 - - prostatic (PIN) - - - grade I N40 - - - grade II N40 - - - grade III (PIN III) (M8148/2) D07.5 - - squamous, grade III (M8077/2) — see Neoplasm, in situ There is no index entry for neoplasia conjunctiva, nor for dysplasia conjunctiva. Dysplasia eye does not seem appropriate. I would code CIN 1 conjunctiva to H11.8 'Other specified disorders of conjunctiva'. Given the above info I would look to see if there is any documentation of HPV. In this episode I would code the pterygium as the principal diagnosis and H11.8 as additional.</p>		
1206-08	Hepatitis C post transfusion	Please refer to NCCH query 1987 Please advise whether any code such as nosocomial condition or a complication external cause code should be used to indicate the source of the infection.	Where Hep C is in its acute phase ie first presentation and there is documentation that it has been caused by the blood transfusion, you may allocate the code T80.8	
1206-09	Post Cholecystectomy Pain	Please refer to ACS 1807 and 1904 Please advise the correct code assignment for "post cholecystectomy pain" ACS 1807 advises when a patient is suffering postoperative pain, to assign codes for which the surgery was performed or the conditions causing the pain. In this episode the only diagnosis given was "post cholecystectomy pain". It was not clear whether this was likely to be related or unrelated to previous cholelithiasis or cholecystectomy. In this instance an ERCP had been performed. The cholangiogram had failed but there was documentation of normal pancreatic duct. Following ACS 1807 one might assign cholelithiasis but there was no mention of residual stones and arguably the pain is abdominal pain of unknown origin that is occurring in the post operative period (or later) and ACS 1904 should be followed. Does ACS 1807 apply if documentation does not make it clear that the pain is definitely due to either the original condition or procedure? Does the standard require rewording to make this clearer?	The QCC has sent the the following query to the NCCH for their consideration: NCCH Query: ACS 1807 advises that when a patient is suffering postoperative pain, to assign codes for which the surgery was performed or the conditions causing the pain. In this episode the only diagnosis given was "post cholecystectomy pain". It is not clear whether this is likely to be related or unrelated to previous cholelithiasis or cholecystectomy. In this instance an ERCP had been performed. The cholangiogram had failed but there was documentation of normal pancreatic duct. Following ACS 1807 one might assign cholelithiasis but there was no mention of residual stones and arguably the pain is abdominal pain of unknown origin that is occurring in the post operative period (or later) and ACS 1904 should be followed. The QCC advised the enquiry hospital, that clinician clarification is required to determine whether the pain is part of the disease process, a	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>complication of the procedure or of unknown origin. The QCC would like to ask the NCCH whether ACS 1807 still applies where documentation does not make it clear that the pain is definitely due to either the original condition or procedure? The QCC requests that the standard be reworded in order to be more clear in this regard.</p>	
1206-10	Personality Trait	<p>There is no symbol accompanying Z73.1 (accentuation of personality trait) to indicate a relevant Australian Coding Standard. ACS 0512 Personality Trait/Disorder advises where a diagnosis of personality trait is made, the Clinician should be asked to confirm whether the diagnosis is actually a disorder or a trait. If it is a disorder, then it should be coded. But the standard is not clear as to whether personality traits should be coded if clearly stated and the Clinician confirms no diagnosis related personality disorder has been made. Please provide advice about when Z73.1 should be assigned.</p>	<p>The QCC has sent the following query to the NCCH for their consideration: NCCH Query: Firstly, the QCC notes that there is no symbol accompanying Z73.1 (accentuation of personality trait) to indicate a relevant ACS. ACS 0512 Personality Trait/Disorder advises where a diagnosis of personality trait is made, the Clinician should be asked to confirm whether the diagnosis is actually a disorder or a trait. If it is a disorder, then it should be coded. The standard is not clear as to whether personality traits should be coded if clearly stated and the Clinician confirms no diagnosis related disorder has been made. QCC recommends to the NCCH to further incorporate into the ACS that traits may be coded where the clinician/coder has confirmed that the patient has a trait but does not have a disorder.</p>	
1206-11	<p>"Small R groin haematoma •no bruit •distal pulses√"</p>	<p>When and how should a haematoma following coronary angiography be coded? In what circumstance would haematoma following angiography satisfy coding standard 0002 i.e. what constitutes •therapeutic treatment, •diagnostic procedures, •increased nursing care and/or monitoring? In what circumstance would haematoma following angiography satisfy coding standard 1904?</p>		
1206-06	<p>Neonatal resuscitation - especially with regard to ventilation and when this is 'extended'</p>	<p>Please refer to ACS 1615, 1006 and NCCH query 1754. I am seeking advice whether to code ventilation (bag and mask, IPPB, ETT and mechanical) when this is part of resuscitation but occurs for a prolonged period e.g. within the same hospital for a number of hours, or for a short time when the baby is transferred still requiring ventilation. Neonates sometimes have some respiratory problems at birth and</p>	<p>The QCC feels that you can code procedures that do not form part of the resuscitation at birth</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		require 'bag and mask' or other ventilation. Currently we do not code this, but it is no formal instruction as to what defines resuscitation and that resuscitation procedures at birth should not be coded. There is a 'note' at the end of the section Parental fluid therapy in ACS 1615 not to code when part of resuscitation but it is not clear whether this applies only to parental fluid therapy or relates to enteral infusion and oxygen therapy also or indeed all resuscitation procedures. ACS 1006 states that ventilation		
1206-02	Iron Infusions for Iron Deficiency Anaemia	Could you please confirm the correct procedure code for patients admitted for iron infusions for iron deficiency (anaemia). On making enquiries at 3 other hospitals we have received 3 different responses. They are as follows: 92064-00 Transfusion of other substance; 96199-09 Intravenous administration of pharmacological agent, other and unspecified pharmacological agent; and 96199-07 Intravenous administration of pharmacological agent, nutritional substance.	The QCC had strong arguments for -07 and -09, it was decide to forward this query to the NCCH for them to identify what is a nutritional substance. Interim Decision: Continue using 96199-09	
1206-07	Documentation of alcohol or drug "abuse" when the abuse does or does not appear to meet ACS 0002.	ACS 0503 is titled Drug, Alcohol and Tobacco Use Disorders. There are definitions and a classification section that appear to be relevant to drug, alcohol and tobacco and then a Further section specific for tobacco, including sections for 'personal history', 'current use' and 'harmful use' of tobacco. The classification section that covers drug and alcohol states descriptions such as heavy drinker should not be coded and "Assign the fourth character of 1 if the clinician has clearly documented a relationship between a particular condition(s) and alcohol/drug use. Such documentation includes qualifying statements such as 'alcohol-induced' or 'drug-related' indicating evidence that the substance use was responsible for (or substantially contributed to) physical or psychological harm." But also "Where clear documentation and clinical advice is unavailable and, therefore, capture of vital alcohol/drug information classifiable to specific fourth characters in F10–F19 may be lost, assign the fourth character of '1' (harmful use) as a last resort for nonspecific terminology such as 'abuse' or 'use disorder". Please confirm	If alcohol abuse/use disorder is documented code to F10.1 providing it meets ACS 0002. Heavy drinking or Alcohol ++++ should not be coded unless you seek clinical clarification to qualify the condition and the condition then meets ACS 0002. If alcohol use NEC is documented this should not be coded to F10.1 unless clinical clarification has been sought to qualify the condition and the condition then meets ACS 0002.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>that the following interpretations are correct. 1) Before coding either drug or alcohol 'abuse' or 'use disorder', these terms should meet ACS 0002 i.e. during this admission need • therapeutic treatment • diagnostic procedures • increased nursing care and/or monitoring 2) If there is documentation of a condition being due to alcohol/drug use this should be coded as harmful use (unless using another code F-.2-.9). But if no causal relationship is stated but there is documentation drug or alcohol 'abuse' or 'use disorder' and it meets ACS 0002. F10.1-F19 .1 (except F17) should be assigned. 3) Documentation of alcohol "++++" does not qualify as suitable documentation equivalent to abuse. As per NCCH ? 893 "binge drinking" is also not coded. Has there been any follow up to NCCH queries 482 and 570 i.e. when would codes Z72.1 and Z86.41 be used? (What is the differentiation between harmful and hazardous)? Some external coding education advises that documentation of "heavy drinker" or "binge drinker" should be coded to Z72.1 if ACS 0002 is met. Is this correct or incorrect?</p>		
1206-05	Ovarian Hyperstimulation Syndrome	<p>Patient admitted with Ovarian Hyperstimulation Syndrome. Coder selected the following N98.1 Hyperstimulation of ovaries Y42.8 Other and unspecified hormones and their synthetic substitutes Y92.22 However NCCH Query advises using Y84.8 Other medical procedures as the cause of abnormal reaction of the patient, or of a later complication, without mention of misadventure at the time of the procedure Can you confirm which is the better code Y42.8 or Y84.8 as the coder believes the drugs not the procedure caused the hyperstimulation.</p>	<p>The QCC recommends that the enquirer reviews the external cause code and to code the specific drug if documented eg Clomid Y42.5 and if no specific drug is documented and it is impossible to seek further clinical advice, use Y42.8 The QCC will ask the NCCH to review their query from 1999.</p>	
1206-04	Correct code to assign for the ultrasound in a TRUS biops	<p>'What is the correct code to assign for the ultrasound in a TRUS biopsy? Unsure what code to assign when taking into account firstly, NCCH Database query 2115 and secondly, an ACHI Tabular List change in the ICD-10-AM 5th Edition Education workshop booklet (Item 1163 - page 154).'</p>	<p>Assign 55600-00 [1943] - Transrectal ultrasound of prostate, bladder &amp; urethra when it is done in conjunction with transrectal prostatic biopsy. Ask the NCCH for verification whether a "code also" note has a higher hierarchical position than an "excludes" note.</p>	
1206-03	Code selection for same day pain	<p>This patient has disseminated end stage cervical cancer with intractable back pain with no specific cause for the back pain</p>	<p>The QCC advises that these codes are suitable if the pain is due to the cancer. The loading only in this</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
	management for cancer via CADD	identified other than disseminated cancer ie no bony mets identified, no nerve compression identified. Her pain has been managed by intrathecal catheter to which a CADD is attached. She attends periodically for loading of pain relief (opioid) into the CADD. The following codes have been used: C53.9 M8070/3 C77.5 C77.2 M8070/6 M54.89 96208-09 Loading of ambulatory drug delivery device Can you advise if these codes are suitable? Should 18216-03 Epidural infusion of opioid be use instead of or as well as 96208-09? Does Z45.1 need to be the PD as we do for loading of chemo?	scenario is to be coded.	
1206-01	Bronchopneumonia with reactive airways disease	Which code is used for the reactive airways disease? After consultation with our Director of Paediatrics the suggestion was to maybe use J98.8 other specified respiratory disorders. It was also suggested that if reactive airways disease was documented with asthma only code the asthma. We also get documentation of viral URTI with reactive airways disease. The treatment for the reactive airways disease is similar to asthma treatment. I have checked the NCCH database, VIC coding queries and the QCC queries.	Enquirer to continue with current practice. Bronchospasm code if there is no clinical clarification. The QCC will send an enquiry to the NCCH.	
0207-01	Smoking Dependence Form	A stamp pertaining to Smoking has appeared in our medical record (mainly long stay mental health). Example attached. On this stamp there is a section regarding 'Dependence Status'. I spoke with a couple of the clinicians in the mental health ward about this stamp and they explained that they assess the patient for tobacco dependence and withdrawal risk and treat them as tobacco dependent. We are assuming that this is sufficient for us to assign F17.2 for nicotine dependence. Does the QCC agree	The QCC supports the utilisation this particular form for collection of nicotine dependence.	
0307-05	Hypostatic oedema after surgery	Patient is documented as having labial swelling in the post-operative period. This was diagnosed as "hypostatic oedema after surgery". Should this be coded as a surgical complication?	Meeting Response: The QCC considers that the labial swelling is a transient condition. Therefore, the QCC advises the enquirer to code the condition as recommended within ACS 1904 Procedural Complications	
0307-01	Insertion of OFIP (peritoneal port to deliver chemo)	Discussion with the Registrar has confirmed that this device delivers the drug directly into the peritoneal cavity but is not connected to an intra-abdominal vessel as per the code 30400-00 [766] 'Insertion of implantable vascular infusion	Interim Response: The QCC advises that the hospital utilise the following code: 90331-00 [1004] – Other procedure on abdomen, peritoneum or omentum is to be used for insertion, revision and removal of	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		device, intra-abdominal vessel'. Currently we are using 90331-00 [1004] Other procedure on abdomen, peritoneum or omentum. Can you advise whether we should continue to use 90331-00, perhaps assign 30400-00 despite the fact that the device is not attached to a vein or perhaps suggest another code.	peritoneal port until such time as a formal response is received from the NCCH New Codes for intra Peritoneal Drug Delivery Device: The QCC considers that this query should be forwarded to NCCH and ask for a new code for: Insertion Revision & Removal of a peritoneal drug delivery device	
0307-02	Reversal of Colostomy NCCH Query 2249	Referring to NCCH Query 2249 and the advice to code the cancer as an additional diagnosis. Does this/should this advice be applied to other non-cancer conditions eg reversal of Hartmann's post resection of Diverticular Disease	The QCC considers that the query response is based upon the requirement within ACS 0236 that you can code cancer in these instances. This will not apply to other conditions.	
0307-03	Cor Pulmonale and Pulmonary Hypertension	Where cor pulmonale and pulmonary hypertension are both documented in the patient's current episode of care, do you allocate a code for both conditions?	Interim Decision: The QCC considers that until a final decision is received from the NCCH that the enquirer should code both conditions. Meeting Response: This query is to be forwarded to the NCCH	
0307-04	Depression and psychosis	Where a patient is documented as being depressed (nowhere documented as a major depression) and they are also documented as currently having a psychosis, can you code psychotic depression?	Meeting Decision The QCC recommends that the enquirer seek clinical clarification as psychotic depression cannot be assumed from the documentation. Where clinical clarification is not possible, the QCC recommends that the enquirer utilises both the depression and the psychosis code to adequately reflect the condition. The QCC will raise this issue with the NCCH to highlight the difficulty in coding this scenario.	
0307-07	Stones spilling from the gallbladder at cholecystectomy	Where stones spill from the gallbladder during cholecystectomy, should this be coded as a complication or a misadventure? Furthermore, if there is no rupture of gallbladder to allow for a spill, what causes the stone spill?	The QCC has sent the following query to the NCCH for their consideration. NCCH Query: Where stones spill from the gallbladder during cholecystectomy, should this be coded as a complication or a misadventure? Furthermore, if there is no rupture of gallbladder to allow for a spill, what causes the stone spill? QCC has advised the enquiry hospital that this scenario should be coded as a misadventure. The QCC recommends that the coder should also assign codes to additional procedures where appropriate. For example: 30396-00 - Debridement and lavage of peritoneal cavity. The QCC seeks ratification from the NCCH regarding this advice.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
0307-06	Endoscopy with hot biopsy	Where it is documented that a patient has had an endoscopy with hot biopsy of a polyp, and the entire polyp may have or have not been removed do you code a biopsy or polypectomy?	The QCC recommends that the enquirer consult with the clinician to ascertain what procedure has actually been carried out in this instance. However, where clinical clarification is impossible the QCC recommends that the enquirer code the biopsy.	
0407-06	Postprocedural Anaesthesia	Can you code Postprocedural Analgesia code for a regional nerve block that was initiated in recovery. One of our anaesthetists does TKR under iv/spinal anaesthetic 92515xx(1910) 9250 xx (1909) A femoral nerve block is then connected in recovery. Is it right to code the FNB as 92517-03 (1912) Management of regional block of nerve of lower limb, or is it not coded as there was no regional block used during the procedure and the description in block 1912 stated "continuing" and code first the regional block. (even tho is this scenario it would not be coded because the spinal would be coded using the block hierarchy) I have re-read the paragraphs relating to Postprocedural analgesia but am still unsure.	The QCC recommends that this query be forwarded to the NCCH NCCH Query: Can a Post-procedural Analgesia management code be assigned for a regional nerve block initiated in the operating suite or recovery if this was the first regional block actually given? An anaesthetist at a private hospital does a TKR under iv/spinal anaesthetic 92515xx and at the end of the procedure administers a femoral block. Is it correct to assign a code for the femoral nerve block - 92517-03 (1912) - Management of regional block of nerve of lower limb? Or is this not coded as there was no regional block used during the procedure and the description in block 1912 states "Note: Codes within this block are to be used only when the procedure described is initiated in the labour ward and/or operating suite (theatre or recovery) and there is documentation of continuing infusion/bolus injection/top up occurring postprocedurally" Code first: • regional block, nerve of lower limb (92512 [1909]) The problem is that the management code requires the original nerve block to be coded first, however the femoral nerve block administered is initiated in recovery (regardless of the concept that blocks are not coded if there is a spinal hierarchy). Further clarification/explanation is required re: associated logic	
0407-01	DIEP Flap – Deep Inferior Epigastric Perforator Flap for breast reconstruction.	Registrar confirms that this procedure is the same as a TRAM but no muscle is used ie subcutaneous tissue and fat only. Anastomosis of blood vessels still occurs. Registrar also confirms that the procedure is not the same as an omental flap reconstruction. As there is no other code we are using 45530-00 [1756] Reconstruction of breast using	The QCC has sent this query to the NCCH for their consideration: NCCH Query: The QCC has had a query pertaining to DIEP Flaps. The enquiring hospital has consulted with one of their Registrars and the Registrar confirms that this procedure is the same as a TRAM but no muscle is used i.e.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		myocutaneous flap. Does the committee agree with this?	subcutaneous tissue and fat only. Anastomosis of blood vessels still occurs. Registrar also confirms that the procedure is not the same as an omental flap reconstruction. Currently, due to the unavailability of a code, the QCC has recommended that 45530-00 [1756] Reconstruction of breast using myocutaneous flap be utilised when DIEP flap is carried out. However, there are issues with the code title. The QCC requests that: 1. The NCCH ratifies this code allocation. 2. The NCCH considers removing the "myocutaneous" from the code title for 45530-00 [1756] Reconstruction of breast using myocutaneous flap If request 2 isn't possible, is there an alternative way to make it clear to Clinical Coders that this is the correct code. Please refer to NCCH query database ID 1355 regarding the use of non-essential/essential modifier.	
0407-02	Acute Blood Loss in Neoplastic Disease	This case was discussed at a monthly coding meeting: A patient had "acute blood loss" documented on the discharge summary and in the notes. The patient also had a neoplastic disease. Do we have to just code D63.0* Anaemia in neoplastic disease? Or are we able to add/ or only code D62 to specify the acute blood loss.	The QCC considers that there were 2 components to this query. The QCC considers that acute blood loss does not necessarily equate with anaemia per se and recommends that the enquirer clarifies further with the clinician The QCC considers that if the anaemia is related to the neoplasm that D63.0 is coded. The QCC will query the NCCH whether it is possible to add another code in addition to D63.0* Anaemia in neoplastic disease to further specify the anaemia Additionally, we will query the NCCH whether there is required to be a documented link between the anaemia and the neoplasm in order to utilise D63.0* Anaemia in neoplastic disease. NCCH Query: A patient had sustained "acute blood loss" and this was documented on the discharge summary and in the clinical notes. The patient also has a neoplastic disease. Is D63.0* Anaemia in neoplastic disease the only code assigned? Or are we able to add D62 acute post haemorrhagic anaemia to specify the acute blood loss. Or should we only code D62? Also, please advise whether there is required to be a	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			documented link between the anaemia and the neoplasm.	
0407-03	Multiday admission for insertion of Tenckhoff catheter for dialysis	If a patient has a multiday admission and is admitted electively for insertion of a peritoneal dialysis catheter, what code should be assigned as the principal diagnosis? There is an index pathway for Admission, creation of AV Fistula that goes to Z49.0 but there is no index pathway for insertion of peritoneal dialysis catheter. Index pathway for fitting/removal of peritoneal catheter goes to Z45.8. We note NCCH #2043 which advises to use Z49.0 but this specifically applies for "same day admission for i/o peritoneal dialysis catheter". If we use PD Z49.0, OD N18.0 and PR 13109-00 [1062] we get DRG Z01B OR Procedure W Diagnoses Other Contacts W Health Services W/O CC. If we use PD Z45.8, OD N18.0 we get DRG Z01A OR Procedure ..W Cat/Sev CC. If we use N18.0 ESRF as the PD we get DRG L02B Operative Insertion of Peritoneal Catheter for Dialysis.	QCC Interim Response: Z49.0 as PDx – multi-day and same day The QCC will query the NCCH to clarify whether this code should be allocated regardless of multi-day or same day. NCCH Query: Where a patient has a multi-day admission and is admitted electively for insertion of a peritoneal dialysis catheter, what code should be assigned as the principal diagnosis? There is an index pathway for Admission, creation of AV Fistula that goes to Z49.0 but there is no index pathway for insertion of peritoneal dialysis catheter. The index pathway for fitting/removal of peritoneal catheter goes to Z45.8. We note NCCH #2043 advises to use Z49.0 but this specifically applies for "same day admission for i/o peritoneal dialysis catheter". If we use PD Z49.0, OD N18.0 and PR 13109-00 [1062] we get DRG Z01B OR Procedure W Diagnoses Other Contacts W Health Services W/O CC. If we use PD Z45.8, OD N18.0 we get DRG Z01A OR Procedure..W Cat/Sev CC. If we use N18.0 ESRF as the PD we get DRG L02B Operative Insertion of Peritoneal Catheter for Dialysis. QCC has provided an interim response indicating that Z49.0 be used as the Principal Diagnosis for both multi-day and same day episodes. Please clarify as to whether this code may be assigned regardless of multi-day or same day.	
0407-09	Procedural Components	The enquirer would like to know what constitutes a procedural component in the two following scenarios: A) A patient comes in for a Total Hip Replacement. An IDC is inserted in theatre post-op (under GA anaesthesia). Do you code the insertion of the IDC. B) A patient is about to undergo a CABG. A CVL and a Radial Arterial line are inserted under GA. Do you assign a procedure code for the CVL and Radial Arterial line?	Meeting Response: 1. The QCC members considered that the IDC can be used for hip replacement and would not be coded by most of the members of the committee. 2. The QCC members considered that CVLs and art lines done in conjunction with a CABG would commonly occur and would not be coded. However, where the procedure is done as a stand alone procedure, the insertion, alone would be coded once. This advice is to go to	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>the NCCH for final ratification. NCCH Query: Thank you for considering our query. An enquiry hospital approached the QCC with the following queries: What constitutes a procedural component in the two following scenarios: a) A patient comes in for a Total Hip Replacement. An IDC is inserted in theatre post-op (under GA anaesthesia). Do you code the insertion of the IDC? b) A patient is about to undergo a CABG. A CVL and a Radial Arterial line are inserted under GA. Do you assign a procedure code for the CVL and Radial Arterial line? The QCC proffered the following advice to the enquiry hospital: QCC considers that the IDC was an expected procedure accompanying a Total Hip Replacement and would not be coded by the majority of the Committee. QCC considers that CVLs and arterial lines done in conjunction with a CABG would routinely occur and therefore not be coded. However where the procedure is done as a stand alone procedure, the insertion alone would be coded once. However, since there was not complete consensus within the QCC in regards to the above advice; the QCC requests ratification from the NCCH.</p>	
0407-07	Seprafilm	<p>Principal Diagnosis: Adhesions – omentum to anterior abdominal wall, sigmoid adherent to left pelvic side wall, caecum to right pelvic side wall. Procedure: Extensive Adhesiolysis (90 minutes). Seprafilm x 3 inserted to Pouch of Douglas, right paracolic gutter, abdominal wall. Seprafilm – Genzyme Australasia internet site states that this is “an adhesion barrier to separate tissues and organs while the body heals. Seprafilm is composed of chemically modified sugars, some of which occur naturally in the human body. It is a clear film that sticks to the tissues to which it is applied, and is slowly absorbed into the body over a period of 7 days. Seprafilm is intended to be placed at sites of tissue injury during surgery to help prevent the formation of adhesions between tissues and organs.” If we choose to assign a procedure code to capture the use of Seprafilm, does the</p>	<p>Interim Response: Hospital to continue with current practice. The QCC has sent the following query to the NCCH for their consideration: NCCH Query: Principal Diagnosis: Adhesions – omentum to anterior abdominal wall, sigmoid adherent to left pelvic side wall, caecum to right pelvic side wall. Procedure: Extensive Adhesiolysis (90 minutes). Seprafilm x 3 inserted to Pouch of Douglas, right paracolic gutter, abdominal wall. Seprafilm – Genzyme Australasia internet site states that this is “an adhesion barrier to separate tissues and organs while the body heals. Seprafilm is composed of chemically modified sugars, some of which occur naturally in the human body. It is a clear film that sticks to the tissues to which it is applied, and is</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>QCC agree with the use of 96201-09 (1920) Intracavitary administration of other and unspecified pharmacological agent.</p>	<p>slowly absorbed into the body over a period of 7 days. Seprafilm is intended to be placed at sites of tissue injury during surgery to help prevent the formation of adhesions between tissues and organs.” The enquiry hospital asked the QCC whether the use of 96201-09 (1920) Intracavitary administration of other and unspecified pharmacological agent is appropriate in this instance. The interim response by QCC to hospital is to continue with current practice. The QCC would like to ascertain whether a code is required for this procedure? If so, what would be the most appropriate code to assign? Please refer to the following links for your reference:  <a href="http://www.seprafilm.com/medprof/efficacy.asp">http://www.seprafilm.com/medprof/efficacy.asp</a>  <a href="http://www.seprafilm.com/patients/adhesions.asp">http://www.seprafilm.com/patients/adhesions.asp</a>  <a href="http://www.adhesions.org/images/icd9fordoc.pdf">http://www.adhesions.org/images/icd9fordoc.pdf</a></p>	
0407-10	PICQ indicator 101979	<p>PICQ indicator 101979 (Degree B Indicator): This indicator identifies records containing a pneumonia code as principal diagnosis and a chronic obstructive pulmonary disease (COPD) code. ACS 1008 ‘Chronic obstructive pulmonary disease’ states that, when the infective exacerbation of COPD is pneumonia, the COPD is sequenced before the pneumonia code. These records may be correct if the pneumonia and COPD are not linked in the documentation. According to the standard: Clinically, pneumonia may not always exacerbate COPD. It is often the case that clinical documentation is unclear whether pneumonia exacerbates COPD. From a classification point of view, the presence of COPD with pneumonia is sufficient to assign J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection. This is similar to diabetes mellitus coding where the ‘with’ rule applies and it is not necessary for clinical coders to ascertain a cause and effect relationship between the conditions. When there is unclear documentation of the principal diagnosis, such as COAD/Pneumonia or pneumonia + COPD coders should find documentation in the clinical record or seek clinical advice on which condition meets the criteria in ACS 0001 Principal diagnosis. If not available, the section on Two</p>	<p>The QCC has sent the following query regarding PICQ Indicator 101979 for their consideration. NCCH Query: PICQ indicator 101979 (Degree B Indicator): This indicator identifies records in error that contain a pneumonia code as principal diagnosis and a chronic obstructive pulmonary disease (COPD) code as an additional diagnosis. ACS 1008 ‘Chronic obstructive pulmonary disease’ now states that “When there is unclear documentation of the principal diagnosis, such as COAD/Pneumonia or pneumonia + COPD coders should find documentation in the clinical record or seek clinical advice on which condition meets the criteria in ACS 0001 Principal diagnosis. If not available, the section on Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis of ACS 0001 Principal diagnosis, should be applied.” [Extracted from NCCH eBook, July 2006, Respiratory System.] Whilst the QCC recognises that this is a degree B indicator, we would like to ask the NCCH whether they consider that this indicator should be adjusted or removed?</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>or more interrelated conditions, each potentially meeting the definition for principal diagnosis of ACS 0001 Principal diagnosis, should be applied. [Extracted from NCCH eBook, July 2006, Respiratory System.] Taking into this consideration, this component of the standard; is this indicator no longer correct?</p>		
0407-05	123Z- Local Excision and Removal of Fixation Device excl hip & femur	<p>This would appear to be a grouping anomaly When the following is coded: D48.1 - Soft Tissue of tumour of connective tissue thorax Additional Diagnosis: Adhesions lung Morph: M8825/1 - Myofibroblastic timour Procedure: Excision of soft tissue - 31350-00 Division of thoracic adhesions - 38647-00 This groups to 123Z- Local Excision and Removal of Fixation Device excl hip &amp; femur. Can you please confirm if this grouping anomaly needs any further action/query.</p>	Refer to DoHA as a grouping anomaly.	
0407-04	Post Poliomyelitis Syndrome	<p>Is this syndrome worthy of its own ICD code? The condition has been featured in the media and support groups exist for people with this syndrome. The diagnostic criteria set by the PostPolio Task Force in 1997 is: • A confirmed episode of acute poliomyelitis infection with residual motor neuron loss documented by a typical history, neurologic examination, or electromyographic studies • Neurologic and functional stability after recovery from the acute episode for several decades (median 25yr) • Insidious onset (can be acute) of new muscle weakness, atrophy, or fatigue (focal muscle fatigability or generalised) • Exclusion of other conditions that can present like PPS The condition is currently coded as per ACS 0008 Sequelae - with residual condition codes sequenced first followed by B91 Sequelae of poliomyelitis. The residual condition however is 'PostPoliomyelitis Syndrome'. Since there is no specific code for this syndrome coders are required to code a combination of symptom codes followed by B91 Sequelae of poliomyelitis. Is there a better way of classifying this condition? Please also amend the Codefinder pathway to include a prompt for assigning codes for the residual condition as per ACS0008. The Codefinder currently provides B91 only.</p>	The QCC will discuss with enquirer the potential for a public submission for the creation of a new code for this condition.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
0507-03	Benign Carcinoid tumour	Patient underwent wedge resection of upper lobe of left lung. Histology report is "Typical Carcinoid Tumour" SNOMED M8240/3. Doctor has documented "Benign Carcinoid". How do I code a "benign Carcinoid" when there is no morphology code to capture this? QLD cancer reg states that they would code off the histology report as "malignant". Please advise on the correct morphology to use.	The QCC advises to please consult with the clinician for further clarification. If this is not possible, the QCC advises to code the tumour as described by the histology result.	
0507-01	T cell lymphoproliferative disorder	When looking up T-cell lymphoproliferative disease in the alphabetical index (pg 117) it directs the coder to see:neoplasm,skin, benign (D23.9) but the M code provided is a malignant M code (M9718/3).	The QCC has sent the following query to the NCCH for their consideration. NCCH Query: When looking up T-cell lymphoproliferative disease in the alphabetical index (pg 117) it directs the coder to see:neoplasm,skin, benign (D23.9) but the M code provided is a malignant M code (M9718/3). This does not seem appropriate. Our clinical representative upon the QCC informed us that T cell lymphoproliferative disorder describes a range of disorders that are neither benign, nor confined to the skin. For your reference, the enquirer researched at: <a href="http://gena.ontology.ims.u-tokyo.ac.jp:8081/mov/cgi-bin/movOntologyView.php?type=UMLS&amp;target=C1371159&amp;mode=search">http://gena.ontology.ims.u-tokyo.ac.jp:8081/mov/cgi-bin/movOntologyView.php?type=UMLS&amp;target=C1371159&amp;mode=search</a> Information within the site says that T-cell lymphoproliferative disease "represents a spectrum of lymphoproliferative disorders characterized by CD30 (Ki-1)-positive cutaneous T-cell infiltrates. The two ends of the spectrum include lymphomatoid papulosis (benign end) and primary cutaneous anaplastic large cell lymphoma (malignant end). Borderline lesions are also included in this spectrum. (WHO, 2001) – 2003". The enquirer then looked in the classification for lymphomatoid papulosis and it gives an L code with the same morphology. The QCC requests that the NCCH review the coding of T-cell lymphoproliferative disorder as it does not seem appropriate that a benign lesion should have a morphology of malignant behaviour.	
0507-02	Enhancement request	It has been noted that there is no reference link to ACS 1109	The QCC has sent an Enhancement request for ACS	

QCC_ID	Query summary	Query	Decision	Response from NCCH
	for ACS 1109	in the Tabular book against code Q43.8 for redundant colon. Can this please be added. Please also include a link to the ACS reference in the Codefinder against code Q43.8.	1109 to NCCH for their consideration. NCCH Query: It has been noted that there is no reference link to ACS 1109 in the Tabular book against code Q43.8 for redundant colon. Can this please be added? Please also include a link to the ACS reference in the Codefinder against code Q43.8. Thank you	
0607-04	Suicidal ideation.	My query was in relation to the use of R45.81 suicidal ideation. It was picked up in my audit that I should be using this for patients who were suffering suicidal ideation when admitted with major / severe depression. However there is an excludes note attached to R45.81 that excludes suicidal ideation constituting part of a mental disorder F00-F99. So when coding F32.20 severe / major depression the suicidal ideation / thoughts is included in this code, no need to use R45.81. I have been coding Z91.5 for all patients who have a history of suicide attempt. It has been suggested that I could use Z91.5 and R45.81 together for patients who have a history of suicide attempt and who are currently suicidal precipitating admission. But I would only use R45.81 if the suicidal ideation did not constitute part of a mental disorder. For example a patient who comes in with PDX major / severe depression with a history of suicide attempt and current suicidal thoughts - I would code F32.20 and Z91.5. I would leave out the R45.81 as this is included in F32.20. However if the patient was diagnosed with only mild depression, I would code PDX F32.00, R45.81 and Z91.5 because suicidal ideation would not constitute part of mild depression. Can the QCC please confirm if the above is correct	The QCC has sent the following query to the NCCH for their consideration. NCCH Query: It was picked up in the enquiry hospital's audit that they should be using the above code for patients who were suffering suicidal ideation when admitted with major / severe depression. The enquiring hospital responded with the following: There is an "excludes note" attached to R45.81 - suicidal ideation that excludes suicidal ideation constituting part of a mental disorder F00-F99. So when coding F32.20 severe / major depression the suicidal ideation / thoughts is included in this code, no need to use R45.81. They have been coding Z91.5- personal history of self harm, for all patients who have a history of suicide attempt. It has been suggested that they could use Z91.5 and R45.81 together for patients who have a history of suicide attempt and who are currently suicidal precipitating admission. But they would only use R45.81 if the suicidal ideation did not constitute part of a mental disorder. For example a patient who comes in with PDX major / severe depression with a history of suicide attempt and current suicidal thoughts - they would code F32.20 and Z91.5. They would leave out the R45.81 as this is included in F32.20. However if the patient was diagnosed with only mild depression, they would code PDX F32.00, R45.81 and Z91.5 because suicidal ideation would not constitute part of mild depression. The QCC responded with the following: According to NCCH query 2023, R45.81 can be used as an additional diagnosis where it fulfils ACS 0002. Therefore, for multiple condition coding, the addition of R45.81 to	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>the code string (following the code for the mental disorder) provides a fuller description of the condition. Z91.5 should be allocated when history of self harm fulfils ACS 0002. The QCC would like: 1. Ratification of code allocation 2. Examples of when Z91.5 would fulfil ACS 0002.</p>	
0607-03	High Output Ileostomy	<p>A patient at our facility is admitted for a same day episode on a weekly basis. Documentation states "Needs 3-5 litres of normal saline weekly due to dehydration from a high output ileostomy, secondary to a proctocolectomy performed for ulcerative colitis." Clinical advice indicates that the patient is dehydrated at each admission and the saline is treatment rather than prophylaxis. What is the correct coding for this patient?</p>	<p>The QCC has sent the following query to the NCCH for their consideration: NCCH Query: A patient at our facility is admitted for a same day episode on a weekly basis. Documentation states "Needs 3-5 litres of normal saline weekly due to dehydration from a high output ileostomy, secondary to a proctocolectomy performed for ulcerative colitis." Clinical advice indicates that the patient is dehydrated at each admission and the saline is treatment rather than prophylaxis. The QCC has recommended the following code allocation: E86 – Dehydration Z93.2 – Presence of ileostomy However, taking into consideration the information below, we are curious as to whether this could be considered a post-procedural complication? Complications of Construction and Closure of Temporary Loop Ileostomy Journal of the American College of Surgeons - Volume 201, Issue 5 (November 2005) Complications can appear at any time after the surgical procedure. Arumugam and coworkers<sup>13</sup> conducted a prospective study of stoma complications. Different types of stoma were evaluated; the early complications included retraction, early skin excoriation, stoma increase, ischemic necrosis, and detachment. Late complications included parastomal hernia, late skin excoriation, prolapse, and high-output stomas. Patients with ileostomy usually have a relative fluid depletion because the efflux of the ileum is liquid or semiliquid, and once the peristalsis returns after operation, the patient often enters a high-volume output adaptation phase. The output during this</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>phase usually exceeds 1,000mL/day and may frequently reach up to 1,800mL/day. The physiologic explanation for the high-output phase is the loss of the colonic absorptive capacity combined with the loss of the anatomic barrier of the ileocecal valve. The fluid depletion is mostly subclinical and improves with the adaptation of the small bowel over a period of days to weeks after operation. After the adaptation phase, the average output decreases to 500 to 800mL/day. Nowadays, most surgeons do not rotate the bowel clockwise to caudate place the afferent limb when constructing the ileostomy. This is especially true when constructing an ileoanal pouch, because this maneuver requires the use of more proximal bowel loop, is believed to be related to increased output, and may be associated with a higher risk of bowel obstruction. A high-output stoma puts the patient at risk of dehydration and electrolyte disturbances. Hallbook and coworkers<sup>19</sup> recorded the maximum output of ileostomies per 24hours during the early postoperative period in patients who underwent either total proctocolectomy and ileo-pouch anal anastomosis (IPAA) or low anterior resection with a protecting loop ileostomy. They defined the normal estimated efflux of an ileostomy as approximately 1,000mL per 24hours. The ileostomy was created 50 to 60 cm proximal to the pouch in the IPAA group and 20 cm proximal to the ileocecal valve in the low anterior resection group. Maximal ileostomy output exceeded 2,000mL per 24hours in 36% of the patients in the IPAA group compared with 28% in the low anterior resection group, and it exceeded 3,000mL in 15% of patients in the IPAA group compared with 8% in the low anterior resection group. These differences were statistically insignificant even though in the IPAA group, the loop ileostomy was placed more proximally than it was in the anterior resection group. Three patients with</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>IPAA were readmitted to the hospital because of secondary dehydration from a high-output ileostomy. In one patient this complication required early closure. In this study, there was no difference in maximal ileostomy flux between patients who were or were not treated with steroids at the time of the primary procedure. Some of the studies do not systematically address this complication; in most studies there is no definition of high output, and others address only the consequences of high-output electrolyte disturbances or dehydration. These reports vary from no documentation of this complication at all to documentation of it in more than 70% of patients. To avoid dehydration, it is important to instruct the patients to maintain adequate intake of fluids and electrolytes. Hot weather, strenuous physical activity, advanced age, malnutrition, dietary indiscretion, infectious diseases, short bowel syndrome, and recurrence of inflammatory bowel disease are all predisposing factors to dehydration and electrolyte complications. Antidiarrheal agents and dietary regulation can also reduce high output.</p>	
0607-02	Follow up for TCC	<p>Could you please assist with code selection and sequencing for this case given that the patient still has metastatic disease. Patient admitted for 'check cystoscopy' for previous TCC of the bladder. No residuals were found but the patient has known pelvic and para-aortic LN mets from the previously treated bladder TCC.</p>	<p>The QCC has sent the following query to the NCCH for their consideration. NCCH Query: Could you please assist with code selection and sequencing for this case given that the patient still has metastatic disease? Patient admitted for 'check cystoscopy' for previous TCC of the bladder. No residuals were found but the patient has known pelvic and para-aortic LN metastases from the previously treated bladder TCC. The QCC recommended that the following be coded: PDx Z08.* LN mets morph code/6 C67 for bladder primary Morph code /3 Cystoscopy Could the NCCH please confirm whether the code allocation recommended is correct?</p>	
0607-01	Recurrent Shoulder Dislocation	<p>We have received clinical advice that a shoulder dislocation occurring more than once can be considered 'recurrent'.</p>	<p>The QCC has sent the following query to the NCCH for their consideration: NCCH Query: We have</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Sometimes Medical Officers will document 'recurrent shoulder dislocation' and note the number of times dislocated previously. Other times documentation is 'shoulder dislocation' and noted that a previous dislocation occurred in 2006 for example, but no mention of 'recurrent'. If a patient has had a previous dislocation of shoulder and is presenting for treatment of a present dislocation of the same shoulder, can this be coded to 'recurrent' or does it need to be documented as 'recurrent'?</p>	<p>received clinical advice that a shoulder dislocation occurring more than once can be considered 'recurrent'. Sometimes Medical Officers will document 'recurrent shoulder dislocation' and note the number of times dislocated previously. Other times documentation is 'shoulder dislocation' and noted that a previous dislocation occurred in 2006 for example, but no mention of 'recurrent'. If a patient has had a previous dislocation of shoulder and is presenting for treatment of a present dislocation of the same shoulder, can this be coded to 'recurrent' or does it need to be documented as 'recurrent'? The QCC would like to confirm with the NCCH whether "recurrent" must be "so-stated" or can it mean "more than once"?</p>	
0707-01	<p>Z03 - Medical observation and evaluation for suspected diseases and conditions - ACS 1617.</p>	<p>Scenario 1. Mother has PROM, baby is born premature and given antibiotics. No documentation of 'risk of sepsis'. Scenario 2. Mother goes into normal premature labour and baby is born premature and given antibiotics. No documentation of 'risk of sepsis'. In both scenarios, is it appropriate to assign a code from Z03 Medical observation and evaluation for suspected diseases and conditions, as per ACS 1617, or is it necessary to have 'risk of sepsis' documented.</p>	<p>The QCC has sent the following query to the NCCH for their consideration. NCCH Query: The QCC wishes the NCCH to review the following scenarios: Scenario 1 - Mother has PPRM, baby is born prematurely and antibiotics are administered. However 'risk of sepsis' is not documented. Scenario 2. Mother goes into spontaneous premature labour without PPRM, and baby is born prematurely and antibiotics are administered. Again, 'risk of sepsis' is not documented. In both scenarios, is it appropriate to assign a code from Z03 Medical observation and evaluation for suspected diseases and conditions according to ACS 1617, or is it necessary to have 'risk of sepsis' documented. The QCC has provided an interim response and advised that Clinical Coders continue to assign the Z03.* code until formal advice is received from NCCH. The QCC requests the NCCH to investigate amending the wording of the standard to reflect context.</p>	
0707-02	<p>Anaemia secondary to angiodysplasia</p>	<p>1. What codes should be used if a patient is admitted for "anaemia secondary to angiodysplasia"? Suggested options include: D64.9 anaemia unspecified and K55.21</p>	<p>The QCC has sent the following query to the NCCH for their consideration. NCCH Query: The QCC wishes the NCCH to review the following questions:</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		<p>Angiodysplasia of colon without mention of haemorrhage Or D50.0 anaemia due to loss of blood (chronic) and K55.22 Angiodysplasia of colon with haemorrhage. 2. Can Angiodysplasia of colon without haemorrhage still result in anaemia? 3. In K55.22 what defines 'haemorrhage'? Does it have to be an overt haemorrhage or can it just be very slow and slight as might be expected from a vascular lesion? 4. Does the 'haemorrhage' have to be present in this episode? Does the logic used in ACS 1103 "even if haemorrhage is not noted during the examination or does not occur during the hospital admission." apply only to upper GI bleeding or can this particular component also apply to lower GI bleeding? This part of the statement appears to just add advice to the emphasised direction about when to assume the site of bleeding. It is not clear whether the logic can be applied elsewhere also. When a patient is admitted to hospital for treatment/ management because of a condition does that condition actually have to be present at the time? e.g. We code chronic tonsillitis when a patient is admitted for tonsillectomy, even though they do not actually have tonsillitis at the time. A patient may have a dental abscess and be given antibiotics and then be admitted for removal of the tooth with the reason being given as the 'dental abscess', yet the patient may not actually have the abscess at the time of admission 5. In order to assign K55.22 does the 'haemorrhage' actually have to be documented?</p>	<p>(1) What codes should be used if a patient is admitted for "anaemia secondary to angiodysplasia"? Suggested options include: D64.9 anaemia unspecified and K55.21 Angiodysplasia of colon without mention of haemorrhage Or D50.0 anaemia due to loss of blood (chronic) and K55.22 Angiodysplasia of colon with haemorrhage. (2) Can Angiodysplasia of colon without haemorrhage still result in anaemia? (3) In K55.22 what defines 'haemorrhage'? Does it have to be an overt haemorrhage or can it just be very slow and slight as might be expected from a vascular lesion? (4) Does the 'haemorrhage' have to be present in this episode? The logic used in ACS1103 states "if a patient is admitted for investigation of upper GI bleeding, and ulcer, erosions or varices are found at endoscopy, coders should code the condition found 'with haemorrhage' and assume that the bleeding can be attributed to the lesion noted on the endoscopy report, even if haemorrhage even if haemorrhage is not noted during the examination or does not occur during the hospital admission." Is this standard only applicable to Upper GI bleeding or may this standard also be applicable to Lower GI bleeding. The standard does not clearly indicate whether this assumption may be made. For example, when a patient is admitted to hospital for treatment/ management of a condition, does that condition actually have to be present at the time of admission? Chronic tonsillitis is coded where a patient is admitted for tonsillectomy, even though the patient may not actually have tonsillitis at the time. A patient may have a dental abscess and be treated by antibiotics and subsequently admitted for removal of the tooth; at the time of admission the patient may not actually have the abscess. The QCC has provided an Interim Response to the following questions (please refer to questions above): (1)</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>Where there is anaemia with angiodysplasia, a causal link should not be assumed. There clearly needs to be a documented link. (2) Where there is angiodysplasia without haemorrhage, the anaemia may still be causative. Clinical coders cannot establish a link between the anaemia and angiodysplasia unless clearly documented by a clinician. Please seek further clarification from clinician. (3) A haemorrhage is a haemorrhage regardless of the type of loss; however it does need to be documented or is current. (4) Yes the haemorrhage does need to be present or alternatively, documented as the reason for investigation. There exists a directive in ACS 1103 which states that where haemorrhage is found at endoscopy in the Upper GI tract "with haemorrhage", then this condition may be assumed. However where haemorrhage is found in the Lower GI tract, this may not be assumed. The QCC seeks further clarification from the NCCH regarding ACS 1103.</p>	
0707-03	<p>Primary breast cancer plus lymphoma found at internal mammary biopsy</p>	<p>Patient admitted for a wide excision of known Invasive Lobular Carcinoma Breast. Procedures consented for and performed were Breast wide excision, axillary dissection, blue dye and internal mammary biopsy. Patient has known B Cell Small Lymphocytic Lymphoma. Histology of internal mammary biopsy reveals B Cell Small Lymphocytic Lymphoma Should the lymphoma diagnosis be coded as an additional diagnosis? The admission was for surgical treatment of the breast cancer only, no treatment of the lymphoma.</p>	<p>The QCC has sent the following query to the NCCH for their consideration: NCCH Query: Thank you for considering our query. Patient admitted for a wide excision of known Invasive Lobular Carcinoma Breast. Procedures consented for and performed were Breast wide excision, axillary dissection, blue dye and internal mammary biopsy. Patient has known B Cell Small Lymphocytic Lymphoma. Histology of internal mammary biopsy reveals B Cell Small Lymphocytic Lymphoma. Should the lymphoma diagnosis be coded as an additional diagnosis? The admission was for surgical treatment of the breast cancer only, no treatment of the lymphoma. Does the condition found in histopathology require an associated diagnostic procedure to be coded - reference made to ACS 0002. The QCC provided an interim response advising Clinical Coders to assign the code for</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			lymphoma as an additional diagnosis. The QCC seeks further clarification from the NCCH regarding the abovementioned.	
0707-09	Operation heading: Insertion Steinmann's pin and traction fractured right femur	<p>Operation heading: Insertion Steinmann's pin and traction fractured right femur Please see attached documentation. The patient had a spiral fracture shaft of femur. Operation notes document the procedure as Thomas splint taken down Fracture manipulated. Length attained. Lower limb prep and drape Steinmann pin inserted percutaneously to proximal tibia Thomas splint reapplied with sliding traction through tibial pin Query (in detail) The patient has been processed with an acute care type-length of stay 50 days. The Steinmann's pin was inserted into the tibial bone for Thomas splint sliding traction. The Thomas splint was insitu prior to theatre. Steinmann pin removed 10 days post reduction. Which codes are appropriate ? At first glance, the normal pathway to follow is: Reduction -fracture (bone) (with cast) (with splint) - - femur (closed) 47516-01 [1486] - - - with internal fixation (cross) (intramedullary) 47531-00 [1486] which gives the tabular: 47531-00 Closed reduction of fracture of femur with internal fixation DRG I08B However it appears that the pin is s being used as an attachment for the traction rather than for Fixation of the fracture. ACS 0041 States that The prepositions 'as', 'by', 'for', 'with' and 'without' immediately follow the main term or subterm to which they refer. When a procedure description includes terms listed under a prepositional subterm and an alphabetic subterm, the prepositional subterm takes precedence. There is no guidance as to what to do when the subterm is a distinct separate procedure to the main term ie that there was a reduction of fracture and then application of traction using a steinmanns pin. Suggested alternate coding options for the above episode are: 1. 47516-01 and 50309-00 DRG I23Z Reduction -fracture (bone) (with cast) (with splint) -- femur (closed) 47516-01 [1486] and Insertion -pin or wire -- orthopaedic 47921-00 [1554] ---with ----adjustment of ring fixator (or similar device) 50309-00 [1554] OR 2. 47516-01 and 47516-00 DRG I60Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and</p>	<p>QCC Interim Response: Please code the procedures separately where a pin is being utilised as a traction device instead of a fixation device. The assumption should not be made that it is a closed reduction and internal fixation. The QCC seeks further clarification from the NCCH that the insertion of PIN does not automatically equal fixation device. Is the intent that when a reduction is coded and with an internal fixation device regardless of the reason, is that code still used? This query has been sent to the NCCH for their consideration: Operation heading: Insertion Steinmann's pin and traction fractured right femur The patient had a spiral fracture shaft of femur. Operation notes document the procedure as follows: Thomas splint taken down Fracture manipulated. Length attained. Lower limb prep and drape Steinmann pin inserted percutaneously to proximal tibia Thomas splint reapplied with sliding traction through tibial pin Query (in detail) The patient has been processed with an acute care type-length of stay 50 days. The Steinmann's pin was inserted into the tibial bone for Thomas splint sliding traction. The Thomas splint was insitu prior to theatre. Steinmann pin removed 10 days post reduction. Which codes are appropriate ? At first glance, the normal pathway to follow is: Reduction -fracture (bone) (with cast) (with splint) - - femur (closed) 47516-01 [1486] - - - with internal fixation (cross) (intramedullary) 47531-00 [1486] which gives the tabular: 47531-00 Closed reduction of fracture of femur with internal fixation DRG I08B However it appears that the pin is s being used as an attachment for the traction rather than for Fixation of the fracture. ACS 0041 States that The prepositions 'as', 'by', 'for', 'with' and 'without' immediately follow the main term or subterm to which</p>	

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		<p>Traction NEC 90531-00 [1870] -femoral --with fracture (dislocation) 47516-00 [1476] Operation heading: Insertion Steinmann's pin and traction fractured right femur Please see attached documentation. The patient had a spiral fracture shaft of femur. Operation notes document the procedure as Thomas splint taken down Fracture manipulated. Length attained. Lower limb prep and drape Steinmann pin inserted percutaneously to proximal tibia Thomas splint reapplied with sliding traction through tibial pin Query (in detail) The patient has been processed with an acute care type-length of stay 50 days. The Steinmann's pin was inserted into the tibial bone for Thomas splint sliding traction. The Thomas splint was insitu prior to theatre. Steinmann pin removed 10 days post reduction. Which codes are appropriate ? At first glance, the normal pathway to follow is: Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] ---with internal fixation (cross) (intramedullary) 47531-00 [1486] which gives the tabular: 47531-00 Closed reduction of fracture of femur with internal fixation DRG I08B However it appears that the pin is s being used as an attachment for the traction rather than for Fixation of the fracture. ACS 0041 States that The prepositions 'as', 'by', 'for', 'with' and 'without' immediately follow the main term or subterm to which they refer. When a procedure description includes terms listed under a prepositional subterm and an alphabetic subterm, the prepositional subterm takes precedence. There is no guidance as to what to do when the subterm is a distinct separate procedure to the main term ie that there was a reduction of fracture and then application of traction using a steinmanns pin. Suggested alternate coding options for the above episode are: 1. 47516-01 and 50309-00 DRG I23Z Reduction -fracture (bone) (with cast) (with splint) -- femur (closed) 47516-01 [1486] and Insertion -pin or wire -- orthopaedic 47921-00 [1554] ---with ----adjustment of ring fixator (or similar device) 50309-00 [1554] OR 2. 47516-01 and 47516-00 DRG I60Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Traction NEC 90531-00 [1870] -femoral --with fracture</p>	<p>they refer. When a procedure description includes terms listed under a prepositional subterm and an alphabetic subterm, the prepositional subterm takes precedence. There is no guidance as to what to do when the subterm is a distinct separate procedure to the main term ie that there was a reduction of fracture and then application of traction using a steinmanns pin. Suggested alternate coding options for the above episode are: 1. 47516-01 and 50309-00 DRG I23Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Insertion -pin or wire --orthopaedic 47921-00 [1554] - --with ----adjustment of ring fixator (or similar device) 50309-00 [1554] OR 2. 47516-01 and 47516-00 DRG I60Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Traction NEC 90531-00 [1870] -femoral --with fracture (dislocation) 47516-00 [1476] The QCC wishes to confer with the NCCH and acknowledge that insertion of a pin does not automatically equal fixation device. Is the intent that when a reduction is coded with an internal fixation device regardless of the reason is that code still used.</p>	

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		<p>(dislocation) 47516-00 [1476] Operation heading: Insertion Steinmann's pin and traction fractured right femur Please see attached documentation. The patient had a spiral fracture shaft of femur. Operation notes document the procedure as Thomas splint taken down Fracture manipulated. Length attained. Lower limb prep and drape Steinmann pin inserted percutaneously to proximal tibia Thomas splint reapplied with sliding traction through tibial pin Query (in detail) The patient has been processed with an acute care type-length of stay 50 days. The Steinmann's pin was inserted into the tibial bone for Thomas splint sliding traction. The Thomas splint was insitu prior to theatre. Steinmann pin removed 10 days post reduction. Which codes are appropriate ? At first glance, the normal pathway to follow is: Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] ---with internal fixation (cross) (intramedullary) 47531-00 [1486] which gives the tabular: 47531-00 Closed reduction of fracture of femur with internal fixation DRG I08B However it appears that the pin is s being used as an attachment for the traction rather than for Fixation of the fracture. ACS 0041 States that The prepositions 'as', 'by', 'for', 'with' and 'without' immediately follow the main term or subterm to which they refer. When a procedure description includes terms listed under a prepositional subterm and an alphabetic subterm, the prepositional subterm takes precedence. There is no guidance as to what to do when the subterm is a distinct separate procedure to the main term ie that there was a reduction of fracture and then application of traction using a steinmanns pin. Suggested alternate coding options for the above episode are: 1. 47516-01 and 50309-00 DRG I23Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Insertion -pin or wire --orthopaedic 47921-00 [1554] ---with ----adjustment of ring fixator (or similar device) 50309-00 [1554] OR 2. 47516-01 and 47516-00 DRG I60Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Traction NEC 90531-00 [1870] -femoral --with fracture (dislocation) 47516-00 [1476] Operation heading: Insertion</p>		

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		<p>Steinmann's pin and traction fractured right femur Please see attached documentation. The patient had a spiral fracture shaft of femur. Operation notes document the procedure as Thomas splint taken down Fracture manipulated. Length attained. Lower limb prep and drape Steinmann pin inserted percutaneously to proximal tibia Thomas splint reapplied with sliding traction through tibial pin Query (in detail) The patient has been processed with an acute care type-length of stay 50 days. The Steinmann's pin was inserted into the tibial bone for Thomas splint sliding traction. The Thomas splint was insitu prior to theatre. Steinmann pin removed 10 days post reduction. Which codes are appropriate ? At first glance, the normal pathway to follow is: Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] ---with internal fixation (cross) (intramedullary) 47531-00 [1486] which gives the tabular: 47531-00 Closed reduction of fracture of femur with internal fixation DRG I08B However it appears that the pin is s being used as an attachment for the traction rather than for Fixation of the fracture. ACS 0041 States that The prepositions 'as', 'by', 'for', 'with' and 'without' immediately follow the main term or subterm to which they refer. When a procedure description includes terms listed under a prepositional subterm and an alphabetic subterm, the prepositional subterm takes precedence. There is no guidance as to what to do when the subterm is a distinct separate procedure to the main term ie that there was a reduction of fracture and then application of traction using a steinmanns pin. Suggested alternate coding options for the above episode are: 1. 47516-01 and 50309-00 DRG I23Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Insertion -pin or wire --orthopaedic 47921-00 [1554] ---with ---adjustment of ring fixator (or similar device) 50309-00 [1554] OR 2. 47516-01 and 47516-00 DRG I60Z Reduction -fracture (bone) (with cast) (with splint) --femur (closed) 47516-01 [1486] and Traction NEC 90531-00 [1870] -femoral --with fracture (dislocation) 47516-00 [1476] The patient had a spiral fracture shaft of femur. Operation notes document the procedure as</p>		

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0707-04	Retained Lens Fragments	May I please seek your help once again? I am looking at Retained Lens Fragments. This occurs when one surgeon at removal of cataract and intra ocular lens implant operation hasn't been able to remove the entire cataract. If the surgeon	Interim response: Delegated to QCC member to obtain further material and code range to make a well-informed decision.	

QCC_ID	Query summary	Query	Decision	Response from NCCH
		is not a retinal surgeon the case is passed on and corrected by performing a posterior vitrectomy. In this instance could codes would you use? Your expertise is greatly appreciated.		
0707-05	Central chest pain, atypical chest pain, musculoskeletal chest pain	There are no index entries for central chest pain, atypical chest pain, musculoskeletal chest pain. How should each of these terms be coded?	QCC interim response: Agree with QCC member's interpretation provided. The QCC advises not to amend current coding practice. Advice is being sought further via the cardiac network for clinical clarification. Once clinical opinion is ascertained, a formal query will be submitted to the NCCH for ratification.	
0707-06	Depression and anxiety	There was documentation of a history of "depression and anxiety" Is it acceptable to assign F41.2 mixed anxiety and depressive disorder? There is a description accompanying this code that explains it is used for when symptoms and anxiety and depression are both present but neither is clearly predominant and neither type of symptom is present to the extent that justifies a diagnosis if considered separately. When both anxiety and depressive symptoms are present and severe enough to justify individual diagnoses both diagnoses should be recorded and this category should not be used. How should coders apply this note?	QCC response: Where documentation states that a patient has anxiety and a depressive disorder, these conditions should be coded separately with the exception of documentation of mixed anxiety and depressive disorder or "when symptoms of anxiety and depression are both present, but neither is clearly predominant, and neither type of symptom is present to the extent that justifies a diagnosis if considered separately."	
0707-07	Localisation of a breast lump at another facility prior to admission and excision biopsy at this hospital.	The patient had an excisional biopsy of the breast. There is an instructional note to also assign a code for localisation of the breast lesion when performed. The patient did have a localisation of the lesion but this was performed at a private hospital before arrival. There was no indication whether the localisation was performed as an admitted procedure under contract. Is there is value in creating code extensions for excisional biopsy of breast to capture the concept of localisation (even though the localisation was performed elsewhere)?	QCC response: The QCC considers it is unnecessary to create code extensions for excisional biopsy of breast to capture the concept of localisation, where this procedure was performed elsewhere.	
0707-08	Failure to progress	When there is only documentation of "failure to progress" in labour but the perinatal data sheets give a time for both first and second stage, should O62.2 be coded (particularly when there is documentation such as pushing for 2 hours)? If there is no second stage time recorded (and the patient has a LSCS) should O62.1 be assigned?	QCC Interim Response: Where failure to progress is documented, where known, the reason for the failure the progress should be coded. Where the condition for failure to progress is known, the QCC advocates the utilisation of a code reflecting failure to progress in both instances, because you may have a condition	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>which causes the failure to progress and the patient may also have that condition and progress to a normal delivery. The episode of care should be appropriately reflected in the code assignment. This query has been sent to the NCCH for their consideration: NCCH Query: When there is only documentation of "failure to progress" in labour but the perinatal data form provides times for both first and second stage, should O62.2 be assigned (particularly when there is documentation such as pushing for 2 hours)? Conversely, If there is no second stage time recorded (and the patient has a LSCS) should O62.1 be assigned?</p>	
0907-08	Angina and IHD (or history of)	<p>Please see NCCH ? 917 Please advise whether in any episode where angina is coded (ie criteria for coding met), if IHD (or CAD) has been listed as a condition under the heading of medical history in the admission systems review by the Clinician, the code for IHD (or CAD) is always assigned additionally.</p>	<p>QCC Response: The QCC members indicated the majority would code both angina and coronary artery disease/IHD. The QCC has advised Clinical Coder to determine code assignment on a case by case basis.</p>	
0907-02	Specialist assessment/educational programmes	<p>Ipswich Hospital have several specialist assessment and educational programmes for our patients. Should we be capturing these important resources within our coding. For example: Cardiac Rehabilitation: Assessment and Education. Currently this codes is assigned to 96076-00 (1867) - is this correct? Lung Health: Counselling and health management, exercise, diet etc for patients with chronic lung diseases. Charm/Community Health: Community assessment and planning for patient's prior to discharge. Stomatherapist: Patient education and information in the care of stomas and equipment. Please note: The QCC Secretarist advises QCC members to refer to NCCH Query ID 311 for further information.</p>	<p>QCC Response: Currently this data is not routinely collected at a state level. Where the collection of such data is utilised to inform hospital processes, the data may be collected at a local level.</p>	
0907-03	Closed Reduction of Acetabulum	<p>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>QCC response: Refer to NCCH re: index suggestion. 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. NCCH Query: The only code for reduction of fracture of acetabulum</p>	

QCC_ID	Query summary	Query	Decision	Response from NCCH
			<p>leads to an Open reduction with internal fixation. Block 1486. Are there any other acceptable codes for this procedure? This reduction was definitely closed. 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. 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". There appears to be a typographical error also at this code, 47489.</p>	
0907-04	Diastolic Dysfunction - Acute Pulmonary Oedema	<p>Dr David Henshaw (Noosa Hospital) emailed the following in relation to a recent VLAD review at Noosa Hospital. "I am writing to you in regards to issues we have found following recent review of heart failure deaths as requested by Queensland Health following a VLAD review. The chief concern is that a considerable number of cardiac diagnoses including pulmonary oedema, diastolic dysfunction and other non-specific cardiac causes are all coded as ventricular failure. This DRG coding is then picked up by the VLAD reviewers as left ventricular failure presumably implying poor left ventricular function i.e. ejection fraction of less than 50%. This would clearly not be the case if acute pulmonary oedema was caused by fluid overload or diastolic dysfunction. Indeed diastolic dysfunction cannot be coded. We therefore found in our review that most of the cases did not indeed have poor left ventricular function but have pulmonary oedema from other causes, i.e. diastolic dysfunction, fluid overload due to chronic renal impairment of other causes." On further discussion with Dr Henshaw his problem is the fact there is no code for Diastolic Dysfunction and he believes a lot of APO is due to this rather than LVF. He does not believe we should be using I50.1 and would like to see a code for Diastolic Dysfunction. He has been shown the Standards and the codes and while he accepts the way we have to code APO, he does not agree. From a Coder's perspective the main</p>	<p>QCC Response: A suggestion will be made to NCCH to consider a code specifically for diastolic dysfunction. 3M will be notified of pathway anomalies that may have increased the perceived frequency of left ventricular failure. The QCC has reviewed this issue and will be further progressing the highlighted concern. Furthermore DSU will formulate an article for Codefile highlighting this issue and the potential for pathway problems. Coders can only use documentation/information provided by clinicians. The coding of this information is then constrained by the availability of ICD 10 AM codes and by the wording of the standards. The clinical relevance of the codes can be improved within limits by communication between clinical coders and clinicians. The QCC would welcome a collaborative effort between interested clinicians and the QCC to formulate a public submission for the creation of a code for diastolic dysfunction.</p>	

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		<p>issue is in the majority of cases there is rarely documentation of the cause of APO. Therefore following AC 0920 you code I50.1. However if you follow the pathway in the Index, Oedema - Lung you get J81. It will not take you to I50.1 unless you follo the pathway 'with heart condition of failure' which is not stated in the Standards. We do realise that in the Tabular under J81 does direct you to ACS 0920 however the index is misleading and the Standard is vague. How do we explain this to Dr Henshaw? Are we overusing I50.1? Does the Pathway need changing? Does the Standard need reviewing?</p>		
0907-05	Cervical dysplasia and Koilocytotic atypia	<p>What codes should be assigned for cervical dysplasia and koilocytotic atypia?-Should the code for papillomavirus be used additionally to the code for cervical dysplasia?</p>	<p>QCC Response: The relationship between CIN, dysplasia &amp; HPV needs to be further clarified to alleviate ambiguity. The QCC recommends that NCCH undertake a review of the CIN standard. NCCH Query: A query was receiving 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? The QCC provided an interim response recommending that the relationship between CIN, dysplasia &amp; HPV needs to be further clarified in the standard to alleviate ambiguity. The QCC recommends to NCCH that a review of the CIN standard be undertaken.</p>	
0907-06	Low birth weight in preterm babies	<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</p>	
0907-07	Transfer back to hospital close to home following orthopaedic surgery. Transfer to another hospital following breast reduction surgery.	<p>Please see NCCH ? 2004. 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). Without</p>	<p>QCC Response: QCC to 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. NCCH Query: Regarding scenario 1, the NCCH has advised that the appropriate code to use for the scenario is Z47.9</p>	

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		<p>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. 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). A similar situation is 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. 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>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). 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. 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). Scenario 2 is 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. 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? The QCC seeks further clarification from the NCCH. Referral is made to ACS 2103 - Admission for Convalescence/Aftercare.</p>	
0907-09	High grade CIN or CIN 2-3	<p>Would NCCH consider review the classification of CIN or clarification by way of a standard? Currently some coders are having trouble dealing with varying documentation of CIN levels for a given patient (same doctor reports different levels on different dates but about the same episode eg lead-into, episode and post episode documentation / different doctors report different levels and coders can't tell which way to go/ the doctor reports one thing and histo another). There are</p>	<p>QCC Response: Where the documentation is conflicting, check with the clinician and assign the highest degree of CIN documented, alternatively this consideration will be added to the review of the standard.</p>	

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		<p>questions and issues such as: • Have the abnormal cells been removed by a pap smear? • Is the same area sampled? • Has there been change over the period? • Is Bx more definitive than pap • Cytology screeners can have some variance in their call as to whether something would be CIN 2 or 3. These all probably explain some of the different documentation that one sees between the pap smear result and the cx biopsy taken while an inpatient. Our books deal with CIN in terms of grade 1-3 with CIN1=mild N87.0, CIN2=moderate N87.1 and CIN 3=carcinoma in situ D06._ The most common difficulty is when CIN 2-3 is documented or there is CIN 2 in one place and CIN 3 elsewhere. Cytology/histo reports usually now report changes as 'low grade' or 'high grade' (I believe using Bethesda which I think is becoming the preferred classification.) The issue is that 'high grade' encompasses both CIN 2 and CIN 3. And so the existing classification is not in line with changing clinical reporting. CIN 2 and 3 are classified in different chapters of ICD-10-AM and CIN 3 requires cancer registry but CIN 2 does not.</p>		