

Queensland Coding Committee February to June 2011 queries

QCC_ID	Query summary	De-identified Query	QCC Response
0211-01	Acute cauda equina syndrome – G83.4	<p>Can QCC please recommend the correct sequencing of cauda equina syndrome?</p> <p>Codefinder pathway: Enter Key Word: -- SYND - SYND -- Syndrome - - Syndrome -- SPELL other syndrome - - - Enter Key Word: -- CAU - - - - CAU -- Cauda equina - - - - - Syndrome, cauda equina due to -- Lumbar disc prolapse - - - - - Syndrome, cauda equina due to lumbar disc prolapse -- Unspecified - - - - - Interventions commonly occurring with disc disorders -- No procedure performed or already coded</p> <p>Codes assigned are: 1. M51.2 <i>Other specified intervertebral disc displacement</i> 2. G83.4 <i>Cauda equina syndrome</i></p> <p>Why does Codefinder sequence the codes in this order?</p> <p>We cannot find any current conventions in the index or tabular specifying to code first the underlying disorder, or any previous coding advice regarding sequencing.</p> <p>In ICD-10-AM 1st Edition, at rubric G83 there was a Note: <i>"For primary coding, this category is to be used only when the listed conditions are reported without further specification, or are stated to be old or longstanding but of unspecified cause. The category is also for use in multiple coding to identify these conditions resulting from any cause."</i></p> <p>This instruction has been removed from ICD-10-AM 2nd Edition onwards.</p> <p>Can QCC please advise if the Codefinder sequencing is to be followed particularly if the Acute Cauda Equina Syndrome has been identified as the principal diagnosis (PD) by the treating clinician, where the Acute Cauda Equina Syndrome is documented as precipitating admission and requiring urgent decompressive laminectomy?</p> <p>Or should the PD be selected based on the documentation on a case by case basis?</p>	<p>QCC Response: When considering this query the QCC noted the following standards:</p> <p>ACS 0001 <i>Principal Diagnosis</i> Problems and underlying conditions: <i>"1. Coding the underlying condition as the principal diagnosis. When a patient presents with a problem, and during the episode of care the underlying condition is identified, then the underlying condition is assigned as the principal diagnosis code and the problem should not be coded.</i> <i>2. Coding the problem as the principal diagnosis. If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code."</i></p> <p>ACS 0625 <i>Quadriplegia and Paraplegia Nontraumatic</i> Subsequent [chronic] phase of paraplegia/ quadriplegia: <i>"Sequencing of these diagnoses should be guided by the principal diagnosis definition."</i></p> <p>As neither code is subject to the dagger and asterisk convention sequencing would be determined by applying ACS 0001.</p> <p>The QCC will provide this advice to the 3M Clinical Support Specialist.</p>
0211-02	Grouping Anomaly – DRG J12C	<p>L89.2 <i>Stage 111 decubitus ulcer and pressure area</i> 90665-00 [1628] <i>Excisional debridement of skin and subcutaneous tissue</i></p> <p>Groups to: DRG J12C <i>Lower Limb Procs W Ulcer/Cellulitis</i></p> <p>Is this a grouper anomaly or is acceptable for the above to group to this DRG?</p>	<p>QCC Response: The QCC agrees that the grouping of this scenario to J12C <i>Lower Limb Procedures W Ulcer/Cellulitis</i> is counterintuitive.</p> <p>Whilst one of the significant drivers for the DRG classification is clinical meaningfulness, grouping of like resourced patients is another.</p> <p>The QCC considers that resource homogeneity would be the reason for this scenario grouping in this manner.</p> <p>QCC Update In version AR-DRG 6.0 the codes group to: J08B <i>Other Skin Graft and/or Debridement Procedures W/O cc</i></p>

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0211-03	Cessation of oral hypoglycaemic drugs in a diabetic patient	<p>Does the cessation of oral hypoglycaemic drugs in a long term diabetic patient meet the criteria for coding diabetes in ACS 0002 <i>Additional Diagnosis</i> - commencement, alteration or adjustment of therapeutic treatment when it's:</p> <ol style="list-style-type: none"> 1. Not related to the drug being replaced by another drug to control the same condition and; 2. Related to a condition that the patient still has e.g. the patient still has diabetes, but will now control the condition through lifestyle modification only instead of medication. 	<p>QCC Response: The QCC considers that for this particular scenario, the cessation of oral hypoglycaemic medication included assessment and adjustment of therapeutic treatment.</p> <p>Therefore in this case, the QCC recommends the coding of appropriate codes for diabetes.</p> <p>The QCC notes, however, that cessation of medication/treatment regimes is not always sufficient to fulfil the criteria for coding under ACS 0002.</p> <p>Every decision regarding the allocation of additional diagnoses codes should be made on a case-by-case basis.</p>
0211-04	Congenital mixed venous and lymphatic malformation	Can the QCC please suggest codes for the diagnosis Congenital mixed venous and lymphatic malformation?	<p>QCC Interim Response: The QCC notes that congenital mixed venous and lymphatic malformations can be part of a syndrome such as Klippel Trenaunay (-Weber) Syndrome.</p> <p>Therefore, the QCC recommends that the enquirer consult with the clinician whether the described conditions are components of a syndrome. If they are part of a syndrome, then the clinical coder should code accordingly.</p> <p>If the condition(s) is not part of a syndrome, then the QCC recommends coding Q27.9 <i>Congenital malformation of peripheral vascular system, unspecified</i> following the coding pathway</p> <p>Anomaly -vessel (s) Q27.9</p> <p>NCCC Query: The QCC has submitted a query to the NCCC asking whether there is a better code allocation for congenital mixed venous and lymphatic malformation.</p>
0211-06	Layered suturing techniques	<p>Are the terms "deep" or "soft" (tissue) required to be documented to code repair of soft/deep tissue?</p> <p>ACS 1217 <i>Repair of wound of skin and subcutaneous tissue</i> states: "A repair involving deeper tissue relates to more complex lacerations where layered suturing techniques are required. The Surgeon may suture tissue layers under the skin with dissolvable sutures before suturing the skin..."</p> <p>However ACS 1331 <i>Soft Tissue Injuries</i>, Soft tissue (deep tissue) states: "... Soft tissue includes muscles, nerves, tendons, fat, blood or lymph vessels, fasciae and tissue around joints (synovial tissue) (that is, all tissue excluding skin, subcutaneous tissue, cartilage and bone)."</p> <p>Subcutaneous tissue is the third of the three layers of skin and contains fat and connective tissue that houses larger blood vessels and nerves.</p> <p>Should assignment of codes with 'deep' or 'soft tissue' should be assigned based on documentation of layered suturing techniques or whether these terms must be specified to support code assignment.</p>	<p>QCC Response: The QCC acknowledge that ACS 1217 <i>Repair of wound of skin and subcutaneous tissue</i> definition of superficial wound "involves a simple repair of one layer of epidermis, dermis, or subcutaneous tissue. Deeper wounds "where layered suturing techniques are required".</p> <p>Whilst we acknowledge that some soft tissue contains fat. Please refer to ACS 1331 <i>Soft Tissue Injuries</i>.</p> <p>Clinical coders should not assume the level of injury or depth of wound by the method of suturing.</p> <p>The QCC advise to seek clarification from the clinician as to the depth of the wound.</p>

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0211-07	Oromotor weakness	<p>ACS 0604 <i>Stroke</i> states: "169. - <i>Sequelae of cerebrovascular disease codes should only be used when the treatment period is complete but residual deficits are still manifest and meet the criteria for an additional diagnosis.</i>"</p> <p>Can the QCC please advise whether oromotor weakness should be coded as hemiparesis? Guidance to whether mild longstanding deficits meet criteria for coding additionally when assessments are made during short admissions for unrelated conditions.</p>	<p>QCC Response: The QCC recommends that the enquirer consult with the clinician regarding the appropriate allocation of the code.</p> <p>If the clinical coder wishes to allocate the code for hemiplegia to represent oromotor weakness please confirm with the clinician that this code is representative.</p>
0211-08	Thrombosis of splenic vein, mesenteric proximal portal	<p>Can the QCC please clarify as to what code/s should be assigned for the following?</p> <p>Thrombosis of splenic vein, superior/inferior mesenteric vein and proximal portal vein. CT scan showed a splenic infarct.</p> <p>Depending on what lead term is used to look up the index, different codes are provided.</p>	<p>QCC Response: QCC agreed that there is an index issue and the clinical coder should get thrombosis of spleen, vein(s) and then code the infarction. The QCC recommend that the clinical coder code out all thrombotic sites noted.</p> <p>NCCC Query: The QCC has submitted a query to the NCCC with regards to the index.</p>
0211-09	Hypogammaglobulinaemia & recurrent infection secondary Non Hodgkin lymphoma & NHL/recurrent lower RTI	<p>Documentation states Non-Hodgkin's Lymphoma, recurrent infection secondary to Non Hodgkin's lymphoma, recurrent lower respiratory tract infection, and hypogammaglobulinaemia.</p> <p>Can the QCC please clarify the principal diagnosis in this instance: Non Hodgkin's lymphoma, lower respiratory tract infection or hypogammaglobulinaemia?</p>	<p>QCC Response: QCC advises that there needs to be further consultation with the clinician on principal diagnosis at current admission.</p> <p>Where this is not possible, the QCC recommends that the clinical coder allocate the principal diagnosis as D80.1 <i>Hypogammaglobulinaemia</i>.</p>
0211-10	Ventilation under one hour	<p>Could the QCC please clarify the advice provided in Coding Matters Volume 15, number 3 (since included in ACS 1006 <i>Ventilatory Support</i>) and whether this advice should be applied to all cases where the ventilation /intubation is for less than one hour? Coding the intubation and/or ventilation procedures reflect the level of care associated with the episode.</p> <p>Coding Matters Vol 15, no3 FAQ's Ventilation "Q: If a patient is intubated and ventilated for <1 hour and then transferred to another hospital what codes are assigned? A: As per ACS 1006 <i>Ventilatory support hours of mechanical ventilation should be interpreted as completed cumulative hours (point 1c.) and any method of intubation for ventilatory support is not coded (point 2b.). For classification purposes if a patient is intubated and ventilated for less than one hour the intubation and ventilation are not coded. Amendments will be made to ACS 1006 to reflect this advice.</i>"</p> <p>7th edition ACS 1006 <i>Ventilatory Support</i> Transferred intubated and ventilated patients "When a ventilated (by ETT or tracheostomy) patient is transferred, both the transferring and receiving hospitals assign the code for the appropriate hours of CVS. If the patient has a tracheostomy then this should be coded at the hospital where it was performed. Do not code the ventilation/intubation if it is for < 1 hour prior to transfer."</p> <p>Transferred intubated (without ventilation) patients When an intubated (by ETT or tracheostomy) patient is transferred, the following guidelines apply: "1. The transferring hospital assigns the appropriate code for intubation (block [568]) or tracheostomy (block [536]), if these procedures were performed at the transferring facility. 2. The receiving hospital assigns the appropriate code for management of intubation (block [568])."</p>	<p>QCC Response: QCC will suggest to NCCC that all ventilation should be coded regardless of the length of time provided.</p> <p>In the interim clinical coders are to follow the current standard ACS 1006 <i>Ventilatory Support</i> regarding transferred patients ventilated for under 1 hour.</p> <p>QCC will recommend that a new code for ventilation <1 hr be created.</p> <p>NCCC Query: QCC to submit a request to NCCC that all ventilation should be coded. Also recommending a new code for ventilation <1 hr is created.</p>

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0211-11	MAS Code and Standard clarification	<p>ACS 1613 <i>Massive Aspiration Syndrome</i> states: <i>"Category P24 Neonatal aspiration syndromes should only be used in cases of 'massive aspiration syndrome' (P24.9 Neonatal aspiration syndrome, unspecified), 'meconium aspiration syndrome' (P24.0 Neonatal aspiration of meconium), etc and cases who have a significant respiratory illness indicated by the requirement for supplemental oxygen for a period of at least 24 hours."</i></p> <p>Should clinical coders still code P24 for cases where MAS is clearly documented and ventilation/oxygen could not be given for greater than 24 hours because the neonate died within 24 hours of birth?</p>	<p>QCC Interim Response: The QCC considers that the intent of the ACS 1613 <i>Massive Aspiration Syndrome</i> recommendation is to ensure that only "true" cases of Massive Aspiration Syndrome (MAS) are coded.</p> <p>The QCC recommends that the diagnosis of MAS should be coded for neonates who die within 24 hours of birth. This advice would also apply to newborns who are transferred out from the birth hospital with a diagnosis of MAS < 24 hrs from transfer.</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p> <p>NCCC Query: The QCC will submit a query to the NCCC recommending that ACS 1613 is updated to allow for the coding of MAS when the neonate dies or transfers within 24 hours of birth.</p> <p>For additional information relating to coding advice given referring to MAS, please review QCC Query 1010-08.</p>
0311-01	Complex congenitally corrected transposition of the great arteries (ccTGA)	<p>Complex congenitally corrected transposition of the great arteries (ccTGA) as the PD for a neonatal admission.</p> <p>Can QCC please advise us of the correct index entry to follow for application of the following which were introduced in ICD-10-AM 7th Edition?</p> <p>Q20.51 <i>Corrected transposition</i> Laevotransposition L-type transposition of great arteries</p> <p>Q20.31 <i>Transposition of great vessels, complete</i> Dextrotransposition of aorta D-type transposition of great vessels</p> <p>To code ccTGA, which of these 3 index entries should be followed?</p> <p>Transposition - corrected Q20.51</p> <p>Transposition - great vessels (complete) Q20.31</p> <p>Transposition - great vessels (complete) Q20.31 - - L-type Q20.51</p> <p>Transposition (congenital) - see also Malposition, congenital - aorta (dextra) Q20.31 - corrected Q20.51 - D-type Q20.31 - great vessels (complete) Q20.31 - - L-type Q20.51 - - partial Q20.1 - heart Q24.0 - - with complete transposition of viscera Q89.31 - laevotransposition Q20.51 - L-type Q20.51 - vessels, great (complete) (see also Transposition, great vessels) Q20.31</p>	<p>QCC Response: The QCC agree that the index pathway that sufficiently describes ccTGA is:</p> <p>Transposition -corrected Q20.51</p> <p>The QCC agree that the index is confusing and an additional entry as per the example below would reduce confusion:</p> <p>Transposition -great vessels (arteries) (complete) Q20.31 --corrected Q20.51 --L-type Q20.51</p> <p>In addition this query and QCC response has been forwarded to the Perinatal Data Collection for their information.</p> <p>NCCC Query: The QCC will propose the index entries be reviewed for ccTGA.</p>

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0311-02	Diagnosis for Bilateral Inguinal Hernia, one recurrent, one not recurrent	<p>Bilateral Inguinal Hernia with repair. One side is recurrent, the other side not recurrent.</p> <p>Would you code the hernia disease code twice to show this: PD K40.91 <i>Unilateral Inguinal Hernia without gangrene or obstruction, recurrent.</i> AD K40.90 <i>Unilateral Inguinal Hernia without gangrene or obstruction not specified as recurrent.</i></p> <p>Or would the code for recurrent over-ride the 'not recurrent' code in bilateral coding therefore only coding one code as K40.21 <i>Bilateral Inguinal Hernia without gangrene or obstruction, recurrent?</i></p> <p>And similarly, if is possible to have a scenario with Bilateral Hernia Repair with one side obstructed would this also be captured with two diagnosis codes along with two procedure codes 30615-00 [997] for the obstructed hernia repair along with a code from block [990]?</p>	<p>QCC Response: The QCC note that K40 has a 5th character level subdivision identifying whether the hernia is specified as recurrent yet list recurrent as a non-essential modifier at the lead term Hernia. Also there is no option for recurrent/non-recurrent under bilateral.</p> <p>A query will be submitted to the NCCC to obtain clarification on the discrepancy between the (recurrent) nonessential modifier direction and then the addition of a 5th character subdivision to identify recurrent.</p> <p>In the interim continue current practice.</p> <p>NCCC Query: Clarification on the discrepancy between the (recurrent) nonessential modifier direction and then the addition of a 5th character subdivision to identify recurrent.</p>
0311-03	Atrophied undescended testis	<p>Principal diagnosis is documented and confirmed as superficial mass consistent with atrophied undescended and confirmed as non-descended testis with degenerative changes. A previous orchidectomy had been performed for undescended testis.</p> <p>1. Is this a Post Procedural Complication of the genitourinary system N99.8 <i>Other postprocedural disorders of genitourinary system</i> Or T81.8 <i>Other complications of procedures, not elsewhere classified?</i></p> <p>2. Would you code the undescended testis at all?</p> <p>3. What Procedure code do we use? Exploration of groin mass – 90952-00 [987] <i>Incision of abdominal wall</i> or 30641-00 [118] <i>Orchidectomy, unilateral</i></p> <p>When I code this the codes I get are: N99.8 <i>Other postprocedural disorders of genitourinary system,</i> Q53.12 <i>Undescended testicle, unilateral, inguinal,</i> Y83.6 <i>Removal of other organ (partial)(total),</i> Y92.22 <i>Health service area</i></p> <p>The procedure code I want to use is 90952-00 [987] <i>Incision of abdominal wall</i> not 30641-00 [118] <i>Orchidectomy, unilateral</i> as the testes in just under the skin of the groin and all they do is incision into the groin. This gives a 901Z Error DRG.</p> <p>Do you think the codes are correct?</p>	<p>QCC Response: The QCC agreed not to code this as a complication of surgery following the logic that the condition of undescended testis had not been successfully treated in the first instance. There is also insufficient evidence to support that a complication occurred at the original surgery. Therefore the committee members agreed to code undescended testis as the PD.</p> <p>As the testis was removed use procedure code 30641-00 [118] <i>Orchidectomy, unilateral.</i></p> <p>It is not necessary to also assign 90952-00 <i>Exploration of groin.</i></p>
0311-04	Post Procedural Complications	<p>Scenario 1. A patient admitted for a tonsillectomy, on extubation had a Laryngospasm and had to be re-intubated to keep the airway open.</p> <p>Scenario 2. A patient developed Stridor in Recovery and was admitted to HDU for observation and kept overnight.</p> <p>Scenario 3. A patient in recovery developed Hypoxia and Oxygen and Naloxone were administered.</p> <p>Are these complications or misadventures and if they are how would they be coded?</p>	<p>QCC Response: The QCC agreed to follow ACS 1904 <i>Procedural complications</i> : <i>" If it cannot be determined whether a condition meets the definition of a procedural complication, it should not be coded as such. In these cases, assign a code(s) for the condition..."</i></p> <p>Therefore in all 3 scenarios, without further clarification from the treating clinician(s), the conditions would not be coded as complications.</p> <p>The QCC, however, encourages clarification with the treating clinician(s) on all 3 scenarios before making final code selection.</p>

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0311-05	Laparoscopic to open ULAR and loop ileostomy	<p>Laparoscopic to an open ultralow anterior resection (ULAR).</p> <p>ACS 0023 advises: <i>"If a procedure is performed laparoscopically and there is no code provided which encompasses both the endoscopy and the procedure, then both procedures should be coded."</i></p> <p>In light of this advice the option is to code only the open ULAR because to assign a code for laparoscopy would appear to flag it as a laparoscopic procedure.</p> <p>However in doing so information is lost that this was planned or attempted as a laparoscopic procedure.</p> <p>Can the QCC please advise the appropriate codes in these cases and also consider how to accurately capture a laparoscopic to open appendectomy?</p>	<p>QCC Response: The QCC agreed to code both 32026-00 <i>Ultra Low Anterior Resection</i> and 30390-00 <i>Laparoscopy</i> as per ACS 0019 <i>Procedures not completed or interrupted</i>: <i>"If a surgical procedure was interrupted or not completed for any reason, code to the extent of the procedure performed."</i></p> <p>There is currently no way to differentiate between a laparoscopic ULAR and a laparoscopic ULAR converted to open with current codes and still comply with Australian Coding Standards.</p> <p>In the case of a planned laparoscopic appendectomy converted to open potentially two codes would be assigned. What these codes are would depend on the extent to which the procedure was performed before converting to open.</p>
0311-06	Fractional Flow Reserve (FFR) procedure	<p>Fractional Flow Reserve (FFR) is basically an angioplasty without the balloon. It is diagnostic like an angiography but resembles more an angioplasty in that it navigates the coronaries and crosses lesions.</p> <p>Reference: http://www.ptca.org/ivus/FFR.html</p> <p>Clinical advice is the most appropriate code is from block [670] Transluminal coronary angioplasty.</p> <p>Can the QCC advise on the best code to capture this new procedure.</p>	<p>QCC Interim Response: The QCC members agreed to assign 92056-00 [1857] <i>Monitoring of cardiac output or blood flow NEC</i> by following the index pathway:</p> <p>Monitoring -blood flow, 92056-00 [1857]</p> <p>NCCC Query: As clinical advice has strongly indicated to also use codes from block [670], the QCC will submit this query to the NCCC for a final response.</p>
0411-02	Procedure - EBUS with biopsy	<p>1. Endobronchial ultrasound (EBUS) with biopsy preformed under intravenous (IV) sedation. Reference: http://sydneypulmonology.com.au/procedures/endobronchial-ultrasound Coded as 41898-01 <i>Fibreoptic bronchoscopy with biopsy</i></p> <p>Is a code for the Endoscopic ultrasound also assigned to cover the EBUS? ultrasound -with bronchoscopy 30668-00 [1949] <i>Endoscopic ultrasound</i></p> <p>Ultrasound in conjunction with endoscopy Would this be an exception to ACS 0042 <i>Procedure Normally Not Coded</i> point 13: <i>"Imaging services – all codes in ACHI Chapter 20 Imaging services and block [451] Dental radiological examination and interpretation except transoesophageal echocardiogram (TOE) (55118-00 [1942])?"</i></p> <p>EBUS provides real time imaging of the surface of the airways, vessels, lungs and nodes as opposed to bronchoscopy visualisation of bronchus & lungs. EBUS allows physicians to perform transbronchial needle aspiration to obtain tissue, fluid etc for lungs and surrounds without conventional surgery.</p> <p>2. Radial endoscopic ultrasound (EUS) Coding Matters vol 16 no 4 Radial endoscopic ultrasound (EUS) states: <i>"What is the correct code to assign for radial endoscopic ultrasound (EUS)? In ACHI Sixth Edition, radial endoscopic ultrasound (EUS) should be assigned a code from block [1949] Intraoperative ultrasound, as appropriate. In ACHI Seventh Edition, radial endoscopic ultrasound should be assigned to the new code - 30668-00 [1949] Endoscopic ultrasound. However, EUS should only be coded if it meets the criteria for code assignment as per the guidelines in ACS 0042 Procedures normally not coded."</i></p> <p>Please help clarify the last paragraph? If an EUS is performed with an endoscopy with biopsy or without under IV sedation, does the code 30668-00 [1949] <i>Endoscopic ultrasound</i> need to be added?</p>	<p>QCC Response: QCC recommends that both components of the procedure are coded i.e. the ultrasound and bronchoscopy with biopsy. This procedure is usually performed under cerebral anaesthetic and would therefore be coded under the current ACS 0042 <i>Procedure Normally Not Coded</i> : <i>"The listed procedures should be coded if cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 Anaesthesia)."</i></p>

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0411-03	Post eye vitrectomy for removal of oil	<p>Patient admitted post Eye Vitrectomy for removal of oil.</p> <p>Should the original diagnosis be used followed by Z09.0 <i>Follow-up examination after surgery for other conditions</i>.</p> <p>Other options - PD H33.2 <i>Retinal Detachment</i> followed by Z48.8 <i>Other specified surgical follow-up care</i> or PD Z46.2 <i>Fitting and adjustment of other devices related to nervous system and special senses</i>.</p>	<p>QCC Response: The QCC agreed to code H33.2 <i>Retinal Detachment</i> as the principal diagnosis as clinical advice indicated the removal of the oil is a stage in the process of treating the retinal detachment.</p>
0411-04	Ilioinguinal Neuralgia and Exploration	<p>Ilioinguinal Neuralgia and Exploration Inguinal Canal.</p> <p>PD M79.28 <i>Neuralgia and neuritis, unspecified</i>, other and PP 90952-00 <i>Incision of abdominal wall</i> = DRG 901Z</p>	<p>QCC Response: The QCC considers the correct code for ilioinguinal neuralgia is G58.8 <i>Other specified mononeuropathies</i> following the ICD index pathway below:</p> <p>Neuralgia - specified nerve NEC G58.8</p> <p>The QCC notes that the DRG for this episode remains as 901Z after updating the principal diagnosis with G58.8. Testing the scenario using AR DRG version 6.0 also results in an "error" DRG.</p> <p>NCCC Query: The QCC will raise this issue with the NCCC.</p>
0411-05	Arthroscopic hip procedures - CAM Lesion	<p>With regard to arthroscopic hip procedures could the QCC please advise of the correct code for CAM Lesion of the Hip - M89.95 <i>Disorder of bone, unspecified</i>?</p> <p>(Cam = "type of impingement describes a 'bump' on the surface of the femoral head which jams on the rim of the acetabulum")</p>	<p>QCC Response: The QCC considers the correct code allocation is M89.95 <i>Disorder of bone, unspecified</i> Follow the index look up: Lesion - bone M89.95</p>
0411-06	AC Joint Repair with LARS	<p>Which one of the following procedure codes is the correct code for AC Joint Repair with Ligament Advanced Reinforcement System (LARS)?</p> <p>48930-00 [1404] <i>Stabilisation of Shoulder</i> 90533 -00 [1404] <i>Other Repair of Shoulder</i> 47966-00 [1572] <i>Transfer of Tendon of ligament NEC</i></p>	<p>QCC Response: According to research a LARS procedure utilises synthetic ligament.</p> <p>The QCC considered that this procedure can be a reconstruction, repair or stabilisation procedure.</p> <p>The QCC recommends that the enquirer consult with the clinician confirming the type of procedure performed.</p>

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0411-07	Metalosis of Hip Replacement	<p>What is the correct code for Metalosis?</p> <p>The Victorian Coding Committee Database (2004/05) recommend to code <i>" T84.8 Other complications of internal orthopaedic prosthetic devices, implants and grafts</i> <i>Y83.1 Surgical operation with implant of artificial internal device</i> <i>Y92.22 Place of occurrence, health service area</i></p> <p><i>Only code T84.5 Infection and inflammatory reaction due to internal joint prosthesis if inflammation is documented in the clinical notes."</i></p> <p>However this advice is several years old. Is it still relevant? Google search has several articles on Metalosis. Some say it is a complication of the prosthesis, others say it is an inflammatory reaction to the metal prosthesis.</p> <p>T84.0 <i>Mechanical Complication of internal joint prosthesis</i> might be more suitable than T84.8 <i>Other complications of internal orthopaedic prosthetic devices, implants and grafts</i>.</p> <p>However if Histology shows inflammation could T84.5 <i>Infection and Inflammatory reaction due to internal joint prosthesis</i> be coded as well?</p>	<p>QCC Response: The QCC recommends that in this particular scenario the Metalosis is caused by a mechanical problem with the prosthesis.</p> <p>The QCC considers the correct code allocation is T84.0 <i>Mechanical complication of internal joint prosthesis</i>.</p> <p>If additional pathology is identified e.g. synovitis these conditions should also be coded as per ACS 0002 <i>Additional Diagnoses</i> and ACS 0027 <i>Multiple coding</i>.</p>
0411-08	ACS 1911 Burns & ACS 1906 Current and Old Injuries	<p>First admission - patient admitted with full thickness (FT) burns. Second admission - patient admitted with partial thickness (PT) burns with the FT burns still being actively treated.</p> <p>Can it be confirmed if it is appropriate to code the PT burns as the principal diagnosis for the second admission and code the FT burns as additional diagnoses?</p> <p>ACS 1911 <i>Burns</i> Sequencing states <i>"Code first the most severe site."</i></p> <p>There are also instructions to code the original burns injury for admission for change of burn dressing & readmission for burn treatment. The external cause, place of occurrence & activity codes are the same for both burn injuries so that will not capture that the burns occurred at different times.</p> <p>The original FT burns seems to meet the definition of a current injury in ACS 1906 <i>Current and old injuries</i> and ACS 1911 <i>Burns</i>, readmission for burn treatment or for complications is referenced in ACS 1906.</p>	<p>QCC Response: The QCC advises that for this scenario the Partial thickness burns would be the principal diagnosis as per ACS 0001 <i>Principal Diagnosis</i>.</p>

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0411-09	Coding procedures Trachelectomy	<p>Please advise how the following procedures should be coded: Radical Vaginal Trachelectomy Laparoscopic Trachelectomy Open Trachelectomy Laparoscopic Trachelectomy converted to Open Trachelectomy</p> <p>The following procedures exist in ACHI but there is uncertainty if these equate to any of the above.</p> <p>35618-04 [1276] <i>Amputation of cervix</i> 35613-00 [1276] <i>Removal of stump of cervix, vaginal approach</i></p>	<p>QCC Interim Response: The QCC suggests that the following codes could be used:</p> <p>Radical Vaginal Trachelectomy – 35618-04 <i>Amputation of Cervix</i> plus procedure codes for any lymph node removal.</p> <p>Laparoscopic Trachelectomy – 35618-04 <i>Amputation of Cervix</i> plus 30390-00 <i>Laparoscopy</i></p> <p>Open Trachelectomy – 35618-04 <i>Amputation of Cervix</i></p> <p>Laparoscopic Trachelectomy converted to Open Trachelectomy - 35618-04 <i>Amputation of Cervix</i> and 30390-00 <i>Laparoscopy</i></p> <p>The QCC recognises that there are no specific codes for trachelectomy and clinical advice indicates that these procedures are likely to become more prevalent.</p> <p>NCCC Query: A public submission will be sent to the NCCC to create new codes for future editions of ICD.</p>
0511-01	Iron Infusion	<p>A patient with a neoplasm (who has regular anti-neoplastic drugs) was admitted for iron infusion.</p> <p>Following the Codefinder pathway, admission for chemotherapy neoplasm leads you to 96199-00 [1920] <i>Intravenous administration of pharmacological agent, Antineoplastic agent.</i></p> <p>However there is a Codefinder pathway for administration of iron which takes you to 96199-09 [1920] <i>Intravenous administration of pharmacological agent, Other and unspecified pharmacological agent</i></p> <p>It is assumed the correct code is -00 as treatment of the neoplasm is a complete treatment of pharmacotherapy as in ACS 0044 <i>Chemotherapy</i>. <i>"For coding purposes, chemotherapy is defined as: "The administration of any therapeutic substance (usually a drug), excluding blood and blood products."</i></p>	<p>QCC Response: The QCC agree to assign iron infusion to 96199-09 [1920].</p> <p>Please note that extension -00 is used for the administration of anti neoplastic agents. Also note Coding Matters Vol 14 No3: <i>"When a patient is admitted specifically for administration of iron, for a day only episode of care, assign 96199-09 [1920] Intravenous administration of pharmacological agent, other and unspecified pharmacological agent, following the pathway: Administration - agent (to) - - pharmacological - - - intravenous 96199 [1920]</i> <i>For multi-day episodes of care, an intervention code for the administration of iron is not required, as per point 5 Drug treatment in ACS 0042 Procedures normally not coded."</i></p>
0511-02	Glasgow coma score	<p>Can loss of consciousness be coded based on documentation of decreasing Glasgow coma score (GCS) or a low GCS value or is a statement of "loss of consciousness" necessary for code assignment?</p> <p>ACS 1905 <i>Closed head injury/loss of consciousness/concussion</i> states: <i>"loss of consciousness (both due to trauma and when no head injury is documented) should be coded."</i></p> <p>Reference: http://www.unc.edu/~rowlett/units/scales/glasgow.htm</p>	<p>QCC Response: The QCC agree that loss of consciousness should not be coded based on documentation of decreasing GCS or a low GCS value alone. A statement such as 'loss of consciousness' would be required.</p> <p>However the GCS score could be used as an indicator that the diagnosis of unconsciousness should be queried with the treating clinician.</p>

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0511-03	IV FEIBA	<p>What is the correct code for Administration of anti-inhibitor coagulant complex (FEIBA VH)?</p> <p>92062-00 <i>Administration of other serum?</i></p> <p>Reference: http://www.baxter.com/healthcare_professionals/products/feiba_vh.html</p>	<p>QCC Response: The QCC agree to code to 92061-00 <i>Administration of Coagulation Factors</i> by following the index look up: Administration -coagulation factors.</p> <p>Note: If Transfusion is used as the lead term, there is no indent for coagulation factors and are directed to 'see also Administration'.</p>
0511-04	Piriformis muscle syndrome	<p>What is the correct code for Piriformis muscle syndrome?</p> <p>Index pathway: Enthesopathy - hip M76.8 <i>Other enthesopathies of lower limb, excluding foot</i></p> <p>and Enthesopathy - spinal - - sacral M46.08 <i>Spinal enthesopathy, sacral and sacrococcygeal region?</i></p> <p>Reference: http://orthopedics.about.com/cs/sprainsstrains/a/piriformis.htm</p>	<p>QCC Response: The QCC note that as there is no code for this syndrome apply ACS 0005 <i>Syndromes</i> (with particular reference to steps 1, 2, and 3) and code the documented causes, i.e. trochanteric and sacral insertion enthesopathy (M76.8 <i>Other enthesopathies of lower limb, excluding foot</i> and M46.0 <i>Spinal enthesopathy</i>).</p> <p>The QCC emphasise the importance of seeking clinical clarification about the underlying cause and structures involved before making final code selection.</p>
0511-06	STARR procedure code	<p>Can the QCC please provide an interim response to the following NCCC query?</p> <p>What code should be assigned for Stapled Transanal Rectal Resection (STARR) Procedure commonly performed for rectal prolapse? STARR = Stapled transanal Rectal Resection. Is 32111-00 <i>Reduction of rectal mucosa for rectal prolapse</i> appropriate?</p>	<p>QCC Response: The QCC advise the following interim codes pending NCCC response. The code for STARR procedure would be determined by the condition that it is treating.</p> <p>STARR for Rectal Prolapse – Follow the index pathway: Repair -rectum --prolapse ---by rectal reduction of rectal mucous (by excision) 32111-00 <i>Reduction of rectal mucosa for rectal prolapse</i>.</p> <p>STARR for other conditions - Follow the index pathway: Excision -lesion --rectum ----submucosa (per anal) 32099-00 <i>Per anal submucosal excision of lesion or tissue of rectum</i></p>

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0511-07	<p>Coding consistency and funding - smoking/Tobacco use</p>	<p>It appears that coding relating to tobacco use (<i>Z72.0 Tobacco Use, current</i>) is not routinely coded.</p> <p>This has resulted in and potentially results in</p> <ul style="list-style-type: none"> - inaccurate statistical data - reduction in funding <p>Via inquiries with clinicians and clinical coders, it has been advised that clinical coders do not code from nursing or allied health information as the term "clinician" is limited to "doctor" under Australian Coding Standards.</p> <p>Queensland Health changed terminology from "RMO" notes to "Progress notes" to reflect that clinicians include an interdisciplinary pool of nurses, doctors and allied health that provide care.</p> <p>The State wide Respiratory Clinical Network would like to work in partnership with QCC to ensure that coding standard "A joint effort between the clinician and clinical coder is essential to achieve complete and accurate documentation, code assignment and reporting of diagnoses and procedures" is accurately met.</p>	<p>QCC Response:</p> <p>Queensland clinical coders have been coding the smoking status as:</p> <p><i>Z72.0 Tobacco use, current,</i> <i>Z86.43 Personal history of tobacco use disorder,</i> <i>F17.1 Mental and behavioural disorders due to use of tobacco, harmful use</i> and <i>F17.2 Mental and behavioural disorders due to use of tobacco, dependence syndrome</i>) since 1998.</p> <p>Codes for smoking/tobacco are generally abstracted from the record documentation regardless of author including:</p> <ul style="list-style-type: none"> Patient history forms Emergency department forms Patient questionnaires Anaesthetic forms Progress notes Smoking sticker and stamps <p>The QCC wish to assure the enquirer that strict compliance with the Australian Coding Standards (ACS) including ACS 0503 <i>Drug, Alcohol and Tobacco Use Disorders</i> is promoted. The QCC also direct clinical coders to the follow under extract from the Introduction in the Australian Coding Standards under HOW TO USE THIS DOCUMENT:</p> <p><i>"The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline."</i></p> <p>When coding history of smoking the greatest challenge is determining whether it is current, history, harmful use, or dependence. The following is an extract of the ICD codes available and attached are the latest ACS 0503 that provide guidance in the application of these codes.</p> <p><i>Z72.0 Tobacco use, current</i> Use within the last month Excludes: harmful use of tobacco (F17.1) and tobacco dependence (F17.2)</p> <p><i>Z86.43 Personal history of tobacco use disorder</i> Excludes: harmful use of tobacco (F17.1) and tobacco dependence (F17.2)</p> <p><i>F17.1 Mental and behavioural disorders due to use of tobacco - harmful use</i> A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (eg episodes of depressive disorder secondary to heavy consumption of alcohol).</p> <p><i>F17.2 Mental and behavioural disorders due to use of tobacco - dependence syndrome</i> A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong</p>

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			<p>desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state.</p> <p>Documentation in the record is often very poor to support the assignment of codes F17.1 or F17.2.</p> <p>For coding purposes it is desirable for clinical forms that collect smoking behaviour to provide wording that correctly captures status of smoking e.g. Smoking Yes/No does not specify if current or past and therefore is insufficient documentation for code assignment (unless we can find further information in the body of the health record).</p> <p>It is also desirable for the clinician to link any chronic disease with smoking if it is a contributing factor e.g. 'smoking related Chronic obstructive airway disease (COAD)', as this allows clinical coders to assign F17.1.</p> <p>Many clinical coders find the use of smoking stickers and stamps in the progress notes very helpful provided they are worded correctly.</p>
0611-01	Rehabilitation Standards ACS2104 Explanation	<p>ACS2104 <i>Rehabilitation</i> states: "Should assign an appropriate Z50.-" to reflect the rehabilitation admitted for.</p> <p>When coding split episodes of Rehab to Acute and back to Rehab during long stay episodes (where the patient has been transferred for day only chemotherapy or dialysis sessions); should clinical coders continue to code the original condition for rehabilitation along with previous additional conditions in each split rehabilitation episode?</p> <p>If not, what do clinical coders assign when no allied health intervention has occurred during their current rehabilitation episode due to the shortened LOS. Should Z50.9 <i>Care involving use of rehabilitation procedure, unspecified</i> be assigned as default?</p> <p>Do we use Z50.8 <i>Care involving use of other rehabilitation procedures</i> for when one of the following is only seen for the rehabilitation episode - Diabetes Education, Audiology, Dietician, Orthotics/Prosthetics, Pastoral, Pharmacy, Podiatry, Social Work?</p>	<p>QCC Response: When a rehabilitation patient has an episode of care change to acute to undergo day only chemotherapy or renal dialysis (i.e. acute routine re-admission), the QCC believe ACS 2104 <i>Rehabilitation</i> should be applied in accordance with the clinical intent of the rehabilitation program regardless of episode of care changes. If the rehabilitation program/intent remains the same on return to rehabilitation then the diagnosis coding should reflect this regardless of what actual allied health interventions occur. Additional Diagnosis would only include those that meet ACS 0002 <i>Additional diagnoses</i> for the particular episode of care.</p> <p>If at the start of the rehabilitation program Z50.9 <i>Care involving use of rehabilitation procedure, unspecified</i> was assigned as the PD then this will remain as the PD for each rehabilitation episode of care that is interspersed with renal dialysis or chemotherapy provided the clinical intent of the rehabilitation program has not changed.</p>
0611-02	Sepsis Diagnosis	<p>Candidaemia postpartum.</p> <p>ACS 0110 <i>Sepsis, severe sepsis and septic shock</i> Sepsis states: "When a patient has sepsis coded to... O85 <i>Puerperal Sepsis ... assign an additional code from A40.- Streptococcal sepsis to A41.- Other sepsis to indicate sepsis or B95–B97 Bacterial, viral and other infectious agents to indicate an identified causative organism in a localised infection.</i>"</p> <p>Can we code B37.7 <i>Candidal sepsis</i> (out of the code range) with O85 <i>Puerperal Sepsis</i> to identify the causative organism?</p>	<p>QCC Response: The QCC advise to follow ACS 0027 <i>Multiple Coding</i> (as found at block O85) and assign B37.7 <i>Candidal sepsis</i> to complete the medical statement.</p> <p>NCCC Query: The QCC agreed to send a query to the NCCC to question why B37.7 is not included in the 'Use additional' range of infectious agents.</p>
0611-03	Diagnosis postpartum condition	<p>If coding a postpartum admission with a condition classifiable to the obstetrics chapter but the condition is not stated as a postpartum condition or complication should we use a code from the obstetrics chapter or a code from other chapters?</p> <p>If the patient had no obstetric care in their admission would you still code the conditions to the obstetrics chapter?</p>	<p>QCC Response: The QCC agreed that this is primarily a documentation issue. In this instance seek clarification from the treating clinician to establish if the conditions listed were related to or aggravated by the puerperium.</p>

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0611-04	Intrathecal chemotherapy and lumbar puncture	<p>Intrathecal chemotherapy administered via lumbar puncture and under sedation.</p> <p>Is it necessary to code the lumbar puncture given that the intrathecal administration 96198-00 [1920] <i>Intrathecal administration of pharmacological agent, Antineoplastic agent</i> already captures the administrative route?</p> <p>If the lumbar puncture should be coded, is it only coded if performed under sedation?</p>	<p>QCC Response: The QCC agreed that the lumbar puncture would not be coded additionally in the delivery of intrathecal chemotherapy.</p>
0611-05	Brachytherapy of Prostate	<p>Brachytherapy of Prostate at low dose rate – insertion of radioactive seeds Brachytherapy of Prostate at High dose rate- insertion of seeds</p> <p>1. What is a correct procedure code for the above procedures?</p> <p>By choosing below option of Radioactive seed I am not able to choose Low dose or High dose therapy. My only option is choosing removable planes, which will not be the correct code because seeds are not removable, they are permanent</p> <p>Seed option</p> <ul style="list-style-type: none"> - BRA -- Brachytherapy - - Brachytherapy -- Interstitial [coded as brachytherapy, with implantation of] - - - Brachytherapy, with implantation of -- Radioactive seed - - - - Brachytherapy, with implantation of, radioactive seed -- Interstitial - - - - - Brachytherapy, other - code also -- No other procedure performed or already coded <p>Removable plane option Enter Key Word: -- BRA</p> <ul style="list-style-type: none"> - BRA -- Brachytherapy - - Brachytherapy -- Interstitial [coded as brachytherapy, with implantation of] - - - Brachytherapy, with implantation of -- Removable plane, planes - - - - Brachytherapy, with implantation of, removable plane, planes -- Multiple - - - - - Brachytherapy, with implantation of, removable plane, planes, multiple -- Low dose rate <p>Looking at above options we cannot get seed brachytherapy with low dose or high dose rate, we can only get option of removable planes to get high dose or low dose.</p> <p>Or should we code Brachytherapy intravascular for seed brachytherapy?</p>	<p>QCC Response: The QCC note that documentation in the query has provided specific information regarding low dose and high dose but the index does not include these options for prostate. Therefore following the index and following the excludes notes in the tabular the correct code to assign is 15338-00 [1792] <i>Brachytherapy, prostate</i>.</p>