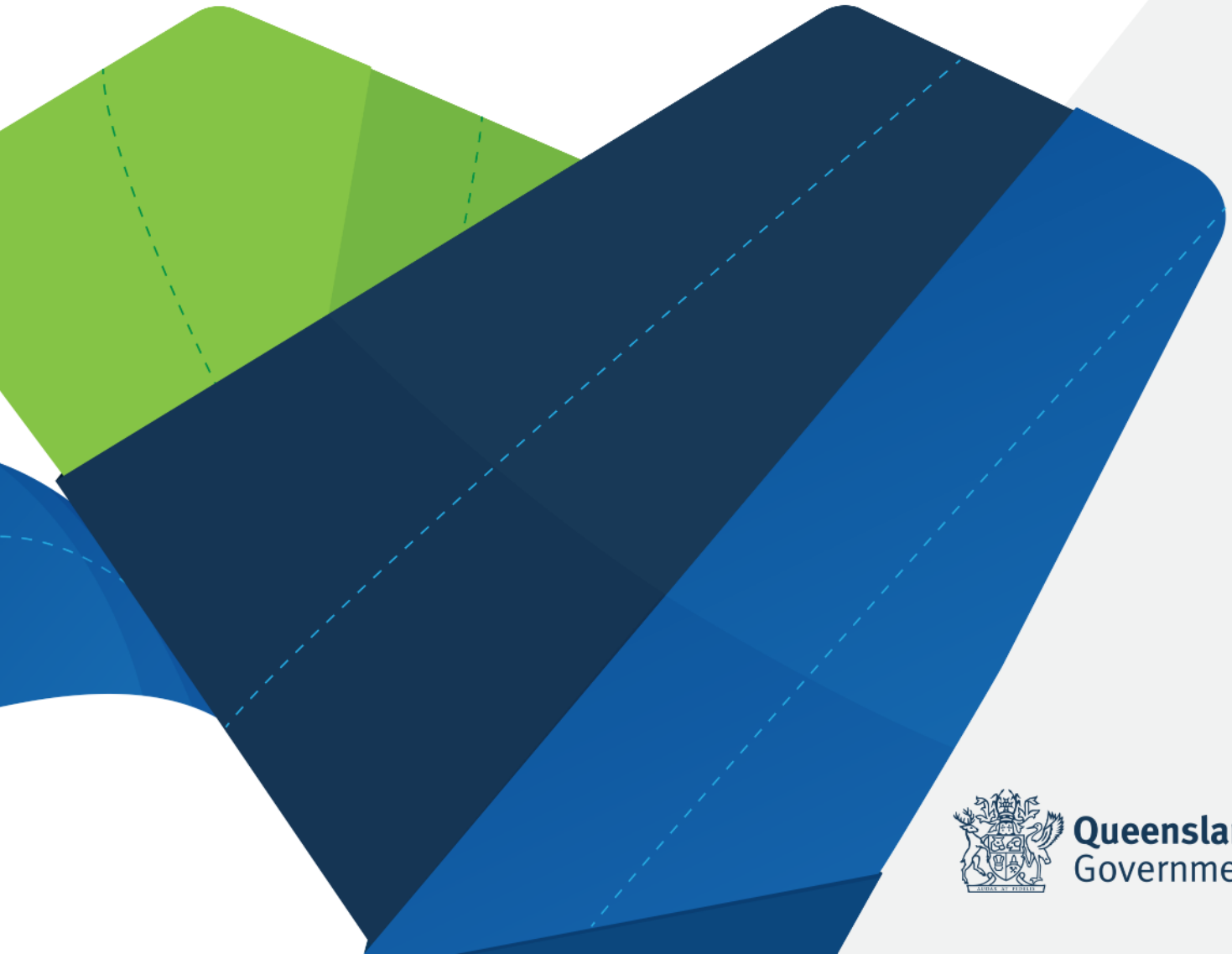
Clinical Coding Queries and Responses - RETIRED

Clinical Coding Authority of Queensland

July 2023



Queensland Government

IMPORTANT NOTE

The coding queries and responses in this document have been reviewed by the CCAQ and are considered no longer current or have been superseded by national coding advice.

Advice contained herein is for historical reference purposes only.

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An electronic version of this document is available at
https://www.health.qld.gov.au/hsu/pdf/clinical-coding-resource-material

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Query ID 06-1222: Hypotension due to anaesthesia

Reviewed 07/2023 – ADVICE RETIRED (Superseded by Coding Rule Q3616 Hypotension due to anaesthesia)

Query: Can we please confirm the correct code set for hypotension due to anaesthesia? E.g., hypotension documented as due to general anaesthesia.

Code options are:

1. T88.59 *Complications of anaesthesia, NEC* + I95.9 *Hypotension, unspecified* (+ external cause codes)
2. T88.59 *Complications of anaesthesia, NEC* + I95.2 *Hypotension due to drugs* (+ external cause codes)

Coding Rule Ref: Q3531 Hypotension due to anaesthesia from June 2020 (retired 1 July 2022) advised us to code as T88.59 *Complications of anaesthesia, NEC* with an additional code I95.9 *Hypotension, unspecified* to add specificity.

This advice has been retired for 12th Edition and there is now an option in the pathway for hypotension, drug induced, due to anaesthesia:

Hypotension

- drug induced I95.2

-- due to anaesthesia T88.59

There has also been an excludes note added at I95.2 *Hypotension due to drugs* to exclude that due to anaesthesia:

I95.2 Hypotension due to drugs

Use additional external cause code (Chapter 20) to identify drug.

Excludes: drug-induced orthostatic (postural) hypotension (I95.19)
that due to anaesthesia (T88.59)

With the recent Codefinder update (16/11/22) the pathways for hypotension due to anaesthesia have changed. Previously the pathways led to T88.59 *Complications of anaesthesia, NEC* with an additional code I95.9 *Hypotension, unspecified*.

Now the Codefinder pathway leads to the codes T88.59 *Complication of anaesthesia, NEC* with I95.2 *Hypotension due to drugs*.

Response: CCAQ acknowledges the retirement of Coding Rule Ref: Q3531 *Hypotension due to anaesthesia*, the ICD-10-AM index updates to the hypotension pathway and the recent Codefinder update may have caused some confusion for coders.

CCAQ will seek clarification on correct code assignment for hypotension due to anaesthesia from IHACPA.

In the interim, CCAQ advise that for documentation of hypotension due to anaesthesia, assign T88.59 *Complication of anaesthesia, NEC* following the index Hypotension/drug induced/due to anaesthesia. Assign an additional code from I95.- *Hypotension* to add specificity to the anaesthetic complication according to your facility's current practice, as per ACS 1904

Procedural complications: "Assign an additional diagnosis code from Chapters 1 to 18 where it provides further specificity regarding the condition/complication".

Query ID 01-0519: Cerebral Palsy as Principal Diagnosis

Reviewed 06/2023 – ADVICE RETIRED (Note: query submitted to ACE seeking further clarification of PD)

Query: The query seeks clarification of the Principal Diagnosis (PD) to be applied when a cerebral palsy patient with muscular contractures is admitted for surgery to release the contractures. Are the muscular contractures part of the disease therefore Cerebral Palsy is coded? If the contractures are coded as the Principal Diagnosis, do you code the Cerebral Palsy as an additional diagnosis?

Response: CCAQ agreed the Australian Consortium for Classification Development (ACCD) coding rule (Ref No: Q2969) – *Injection of botulinum toxin (Botox) for manifestations of cerebral palsy* – should be applied in this scenario, therefore codes within the G80 *Cerebral Palsy* range would be the PD. It was also noted that coding in the G80 range would ensure the episode of care groups appropriately to the Cerebral Palsy Diagnosis Related Group (DRG). The muscle contractures are a symptom of the Cerebral Palsy so should not be coded as the PD.

Query ID 02-0519: Post-Operative Atrial Fibrillation (AF)

Reviewed 06/2023 – ADVICE RETIRED

Query: The query seeks clarification as to whether post-op Atrial Fibrillation, documented following cardiac surgery, should be coded as (a) due to surgery, with an additional postprocedural complication code; (b) not coded as a complication of cardiac surgery given there are many factors in the post-op period that contribute to AF; or (c) queried with the clinician on a case-by-case basis to determine if the clinician can document AF due to surgery?

Response: CCAQ agreed that the documentation must clearly state that the condition arose as a complication of the procedure, in line with Australian Coding Standard (ACS) 1904 *Procedural Complications*. If the documentation is deficient, a clinical documentation query must be submitted.

Query ID 03-0519: Post-Operative Atrial Fibrillation (AF) – clarification of Australian Classification Standard (ACS) 1904

Reviewed 06/2023 – ADVICE RETIRED

Query: The query seeks clarification of ACS 1904 Procedural Complications, particularly given the differing clinical interpretations of the Standard. The ACS 1904 overview mentions that the word 'postprocedural' may be documented only to refer to the timing of an event that occurred. This is a common documentation issue across hospitals. Clinical documentation education often addresses the need for clinicians to use terms such as 'Secondary to' or 'due to' rather than 'Postoperative'. After numerous discussions with our peers, it was identified there were differing views on the interpretation of the standard and coding of Post-op AF. Clinical advice is that "Post-op AF is multifactorial – fluid shifts, anaesthetic, inotropes, the actual surgery and underlying disease process all contribute. AF has many contributors, the actual surgery i.e., handling of the heart, being on bypass, cardioplegia and stopping the heart, electrolyte shifts during surgery – all related to the surgery and a contribution from the underlying disease process as well".

In consideration of the clinical advice, three questions arise:

1. Can Post-Op AF be coded as post procedural complication?
2. If a clinical documentation query returns the response "Post-Op AF is considered multifactorial and one of those factors is 'due to surgery'", according to the standard what codes are assigned, and why?
3. For Cardiac-Thoracic surgery related to Intra-Operative Ventricular Fibrillation/Ventricular Tachycardia (VF/VT), there is old (2003) QCC coding advice that states, '*if VF occurs intra-operatively, while coming off bypass, or before the patient has left the OT then it should not be coded*'. Does this coding advice still apply?

Response:

1. CCAQ agreed that there cannot be a blanket rule and the documentation must clearly state the condition arose as a complication of the procedure, in line with Australian Coding Standard (ACS) 1904 Procedural Complications. If in doubt, a clinical documentation query must be submitted.
2. CCAQ agreed there cannot be a blanket rule and coding will be dependent on the documentation establishing a causal relationship between AF and the surgery. If documented, the coding assignment is:
   - I97.89 *Postprocedural disorder of circulatory system*
   - I48.9 *Atrial Fibrillation*

   If AF is <u>not</u> confirmed as a complication of the surgery, the coding assignment is I48.9 *Atrial Fibrillation*.

   It was noted that some clinicians are reluctant to document AF as a complication of surgery, so the coding assignment will be dependent on the clinician's documentation.
3. CCAQ agreed that the 2003 QCC advice is too old and should not be applied. The condition must meet ACS 0002 and coded accordingly.

Query ID 03-0419: Coding of lymph node metastasis from histology report

Reviewed 06/2023 – ADVICE RETIRED (Resubmitted as Query ID 06-0723)

Query: The query seeks to understand if a coder can code lymph node metastasis from histology report by sampling or excising lymph nodes during a procedure such as a hysterectomy or colectomy (per ACS 0010)? Can C77.5 *Intrapelvic lymph nodes* be assigned to add specificity, if not documented by the clinician?

Response: CCAQ agreed that in this scenario ACS 0010 should be followed and the histology report be coded to add specificity. If in doubt, a Clinical Documentation Query should be submitted to the clinician.

Query ID 04-0419: Colonoscopy with removal of skin tags

Reviewed 06/2023 – ADVICE RETIRED

Query: The query seeks clarification of the coding assignment where anal skin tags are excised with the withdrawal of the scope when a colonoscopy is performed and whether the terms "with" and "by" are synonymous in the classification?

Response: CCAQ agreed that coders should follow the Tabular pathway for *Colonoscopy (fibreoptic) -- with excision of skin tag, anal (multiple)* 32093-00 [911]. Note that the index pathway uses the 'with' convention.

Query ID 05-0419: Failed but working devices

Reviewed 06/2023 – ADVICE RETIRED (Refer to Coding Rule Q3444 published 16 Dec 2019)

Query: The query relates to the Principal Diagnosis assignment for 'failed procedure' where a working device has been implanted but it fails to have the expected impact on the patient condition.

Indication for lap band removal surgery was documented as "failed Lap Band" – doctor was queried on what 'failed' meant. Doctor replied no device failure (nothing wrong with the device) but considered failed because the patient did not experience any significant weight loss post procedure and remained morbidly obese >2 years post band placement. Band removed. Patient seen by dietician and to make appointment with surgeon to discuss future bariatric surgery.

Question: what is the PD in this instance? E66.90 because the original diagnosis is an ongoing condition or Z45.89 because the episode is essentially for management of a device?

Response: CCAQ agreed that the correct Principal Diagnosis is dependent on the documentation - if the intent of the admission is removal of the band, Z45.89 *Adjustment and management of other implanted devices* should be assigned (refer to National Coding Advice Q3444 published 16 December 2019 *Removal or replacement of a failed (meaning ineffective) implanted device*.

If the focus of the admission is obesity, then Obesity is the Principal Diagnosis.

Query ID 02-0219: Tabular Glossary descriptions

Reviewed 06/2023 – ADVICE RETIRED – refer to ICD-10-AM and ACHI tabular conventions

Query: The query seeks to clarify the intention and application of the ICD-10-AM/ACHI Glossary descriptions by clinical coders. Specifically, the query seeks to ascertain if the Glossary descriptions are intended to be used for code assignment.

Response: CCAQ noted that glossary descriptions are not to be used for coding assignment. In all instances, coders are to reference the Alphabetical Index and the Tabular List in combination to determine the appropriate coding for the episode of care. Members agreed the CONVENTIONS USED IN THE ICD-10-AM TABULAR LIST Inclusion Terms and Glossary descriptions/Definitions should be used as a guide to the inclusion and exclusions pertaining to specific codes. Coders should be guided by the clinical documentation not the glossary terms.

Query ID 04-0219: Iron infusion

Reviewed 06/2023 – ADVICE RETIRED – refer to ACS 0042

Query: The query seeks clarification of the coding assignment of 96199-19 [1920] Intravenous administration of pharmacological agent, other and unspecified pharmacological agent for iron infusions when performed in multi-day episodes of care (including obstetric).

Response: CCAQ agreed that iron infusion does not fall under the blood products block. It falls under [1920] therefore ACS 0042 is applied. It is also only coded if the intent is for admission in same-day episodes of care.

Query ID 03-0718: Neoplasm and morphology coding

Reviewed 05/2023 – ADVICE RETIRED

Query: This query relates to the coding and reporting required for invasive breast cancer (non-specific) and DCIS in the same breast.
Members were provided with two scenarios to capture the appropriate coding.

Scenario 1: If the invasive cancer is in one breast and the DCIS in the other, two separate notifications are required.
Scenario 2: If the invasive cancer and the DCIS are in the same location, only one notification for the invasive cancer is required, as the invasive cancer has the higher morphology score of 3 (DCIS is always 2).
The coding rule confirms that the non-specific cancer type is to be coded as infiltrating duct carcinoma M8500/3, unless DCIS or a different location.

Response: CCAQ agreed that in the instance provided there are two separate tumours in the one breast, requiring two notifications. The invasive tumour to be coded M8500/3 *Infiltrating duct carcinoma NOS*.

Query ID 04-0918: Sinus node dysfunction

Reviewed 05/2023 – ADVICE RETIRED (superseded by 12th Edition updates)

Query: This query relates to coding Sinus Node Dysfunction or Sinus Node Disease in the absence of documentation of Sick Sinus Syndrome (I49.5).

Response: CCAQ agreed that a Clinical Documentation Query is to be submitted in the first instance to ascertain if it is Sick Sinus Syndrome.

Query ID 01-0918: Z75.6 *Transfer for suspected condition* Sequencing

Reviewed 05/2023 – ADVICE RETIRED (refer to ACS 0012 Suspected conditions)

Query: This query relates to when this code should be sequenced. Should it be directly after the condition that the patient is being transferred for?

Response: CCAQ agreed the correct approach was to follow ACS 0012 which states Z75.6 must be sequenced directly after the diagnosis code to which it relates.

Query ID 04-1018: Intra-abdominal sepsis

Reviewed 05/2023 – ADVICE RETIRED (due to classification updates)

Query: This query relates to three scenarios involving pelvic sepsis:

Scenario 1 relates to coding for pelvic/intra-abdominal sepsis that is not related to surgery. How is it coded, and should it be coded to peritonitis?

Scenario 2 relates to coding for intra-abdominal infected collection that grows bacteria. If documentation query confirms pelvic/intra-abdominal sepsis not related to surgery, how is it coded? What is the code for the infected collection? Can it be coded to peritonitis?

Scenario 3 relates to differences in coding between male and female patients with pelvic abscess. Male patients code to acute peritonitis whereas female patients with same condition code to pelvic inflammatory disease. Same diagnosis, different DRG.

Response: CCAQ agreed a Clinical Documentation Query to clarify the condition for each scenario should be submitted.

Query ID 03-1218: Streptococcal pneumoniae meningitis

Reviewed 05/2023 – ADVICE RETIRED (superseded by a classification update)

Query: This query seeks the correct coding assignment for streptococcal pneumoniae meningitis.

Response: CCAQ agreed that G00.1 *Pneumococcal meningitis* is the correct coding for Streptococcal pneumoniae meningitis.

Query ID 02-0518: Arthroscopic ankle procedures

Reviewed 04/2023 – ADVICE RETIRED – superseded by a classification update

Query: This query relates to code assignment of the following arthroscopic ankle procedure and whether 49700-00 [1529] Arthroscopy of ankle should be assigned in addition to 49709-00 [1542] Stabilisation of ankle to capture that the procedure was performed arthroscopically. Scenario: Arthroscopic stabilisation of ankle.

Response: CCAQ agreed that for documentation of 'Arthroscopic stabilisation of ankle', both 49709-00 [1542] Stabilisation of ankle and 49700-00 [1529] Arthroscopy of ankle are to be assigned as per ACS 0023 Laparoscopic/Arthroscopic/Endoscopic Surgery. A Public Submission can be submitted to ACCD to request for an expansion of 49709-00 [1542] Stabilisation of ankle to include 'arthroscopic'.

Query ID 04-0218: Sleep Disorder Breathing

Reviewed 03/2023 – ADVICE RETIRED

Query: This query relates to December Coding Rule – Sleep Disorder Breathing where it has instructed to code R06.8 *Abnormal Breathing*. What would be the rationale for not including the additional code to capture the sleep disorder element of the term?

Response: CCAQ agreed that coders are required for the ACCD December Coding Rule – Sleep Disorder Breathing to be followed.

Query ID 03-1217: ThinPrep Test and Pap Smear

Reviewed 03/2023 – ADVICE RETIRED – superseded by ICD-10-AM 12th Edition updates

Query: This query relates to the correct code assignment for the new test Thinprep® Pap Test which utilises HPV genotyping technology to detect cervical cell changes and will be replacing the Papanicolaou (Pap) smear from 1st December 2017.

Response: CCAQ agreed that the ThinPrep® Pap test is a form of pap smear and procedure code 92130-00 [1862] *Papanicolaou smear study* is to be assigned per National Coding Advice.

Query ID 08-0617: Therapeutic Plasmapheresis

Reviewed 02/2023 – ADVICE RETIRED – replaced by new query – Query ID 09-0223 Therapeutic plasmapheresis

Query: This query askes how many times should an ACHI code be assigned for therapeutic plasmapheresis if plasmapheresis is performed several times in a single episode?

Response: CCAQ agreed that plasma is considered a blood procedure in the classification so apply ACS 0302 *Blood Transfusions* and code only once per episode.

Query ID 09-0617: AMI and subsequent PCI

Reviewed 02/2023 – ADVICE RETIRED – Coding Rule Q2878 covers the same concept for PDX selection

Query: This query relates to applying ACS 0001 to assign a PDx when a patient presents via emergency with chest pain. Patient is then admitted to the hospital and subsequently diagnosed with AMI where either the below scenarios occurred:

Scenario 1: Urgent coronary angiogram is performed, showing CAD. This was treated immediately with PCI. Patient discharged home 2 days later.
Scenario 2: Medical management of AMI for few days prior to coronary angiogram and stent insertion.

Response: CCAQ agreed in the scenarios given, AMI is to be coded as the principal diagnosis for the same reasons as stated in the query.

Query ID 07-0421: Faecal loading

Reviewed 06/2022 – ADVICE RETIRED – superseded by Coding Rule Ref: Q3656 Faecal loading

Query:

Can the Clinical Coding Authority of Queensland (CCAQ) committee please advise what diagnosis code they would assign for faecal loading?

Western Australian Coding Rule 0920/01 Faecal Loading states:

"Faecal loading is the term commonly used to refer to retained faeces evidenced on abdominal Xray, and clinical advice confirms it is synonymous with faecal retention. Faecal loading, not otherwise specified, which meets criteria in ACS 0002 Additional diagnoses, should be assigned K59.0 Constipation by following Alphabetic Index pathway: Retention, retained - faecal (see also Constipation) K59.0"

Does the CCAQ agree with Western Australian Clinical Coding Authority (WACCA), that where faecal loading meets ACS 0002 it should be coded to K59.0?

Response:

CCAQ members agreed that in this instance a clinical documentation query should be sent to the clinician seeking further specificity. Faecal loading is not indexed and could indicate constipation, faecal impaction, ileus, obstruction etc.

Query ID 01-0920: COVID-19 scenario

Reviewed 06/2022 – ADVICE RETIRED – superseded by ICD-10-AM 12th Edition updates

Query: The query sought confirmation of the coding for a patient admitted with Pneumonia cause flu? COVID-19? bacterial? patient was isolated due to suspected COVID-19 and tested for viruses including COVID-19. Test results showed positive for Flu A and negative for COVID-19. Discharge summary Principal diagnosis was Flu A pneumonia, Additional diagnosis was COVID-19 negative.

From the *Supplementary guidelines for classifying COVID-19 scenarios in admitted patient care* document for Ruled out cases, Test negative

Principal diagnosis:

Symptom(s) or condition(s)

Additional diagnoses:

Z03.8 *Observation for other suspected diseases and conditions*

U06.0 *Emergency use of U06.0 [COVID-19, ruled out*]

In IHPA *COVID-19 Frequently asked questions -admitted care (Part 1)* page 3 and page 4 Transfer for suspected COVID-19 example 1 & 2, Hospital B receives the patient with suspected COVID-19, tested patient with result negative COVID-19. The answer was Z03.8 was not assigned as an additional diagnosis. The reason for example 1 was Z03.8 is not assigned as the symptoms were confirmed to be due to influenza and COVID-19 was ruled out. In example 2 - After study, viral pneumonia was determined to be the Pdx and COVID-19 was ruled out following lab testing therefore U06.0 is assigned.

Should we apply the Supplementary guidelines and assign Z03.8 as additional diagnosis or do we apply the Rationale in FAQ part 1 the after-study concept that COVID-19 was ruled out

as not the cause of the condition and code to Condition with U06.0 as additional diagnosis only?

Response:

CCAQ members agreed that as there was no mention of 'transfer' in the scenario provided, the appropriate coding assignment is Z03.8 *Observation for other suspected diseases and conditions* and U06.0 *Emergency use of U06.0 [COVID-19, ruled out].*

Query ID 03-0820: Laryngopharyngeal reflux

Reviewed 06/2022 – ADVICE RETIRED – Superseded by Coding Rule Ref: Q3636 Laryngopharyngeal reflux (LPR)

Query: The query sought advice on which code can be assigned for Laryngopharyngeal Reflux (LPR). LPR is a condition in which acid that is made in the stomach travels up the oesophagus and gets to the throat, sometimes also referred to as silent reflux. We see cases of LPR under ENT and the condition is often treated with antacids (same as GORD).

Response:

CCAQ members agreed that as there is no index listing for Laryngopharyngeal Reflux the appropriate coding assignment in this scenario is K21.9 *Gastro-oesophageal reflux disease without oesophagitis.*

Query ID 05-0520: Obesity on EMR Waterlow Assessment

Reviewed 05/2022 – ADVICE RETIRED

Coding advice: Supplementary BMI from calculated EMR fields (ACCD) Published: 15 March 2019 and U code for obesity (ACE) Published: 20 March 2020

Query: The query sought clarification of recently published advice (Published 20 March 2020 – ACE ref ID3589) regarding the assignment of a U supplementary code for obesity based on BMI documentation on a malnutrition screening tool, and subsequent clarification of documentation on Waterlow assessment forms.

BMI is documented routinely on the Waterlow assessment forms and concern was raised that, based on the advice given, a BMI value alone cannot be considered a clinical diagnosis.

1. Is BMI value on Waterlow considered in the same light as BMI on malnutrition screening tool and advise that we should not be using it? We expect there would be a considerable drop in assignment of U78.1 *Obesity*.
2. There is another field within this Waterlow assessment form – not routinely filled out – that provides the qualifying terms "obese" and "obesity" - could these be considered a diagnosis when appearing on the Waterlow along with a BMI supporting this documentation? Likewise, in understanding that we could not code U78.1 *Obesity*

based on a "BMI value alone" from a nutritional screening tool, could we assign it based on documentation of "obese" or "obesity" somewhere on that same tool?

3. If the BMI value on an assessment tool seems to have led to an assessment of obesity on the same tool, would you consider this a diagnosis by someone apparently qualified to assess such things, such as a dietician? We are trying to ascertain if "BMI value alone" is the issue or are we to extrapolate that we aren't to code conditions from these assessments until they have been "documented by a clinician" meaning elsewhere within the EMR.

And to be clear – we are asking about supplementary code assignment here, as clearly if this is all the documentation under scrutiny ACS 0002 is not being met for chapter code assignment.

Response:

CCAQ Committee members advised as follows:

Question 1: Clinical coders cannot assign the chronic condition of Obesity from the Waterlow form.

Question 2: There must be additional documentation in the episode of care specifying obesity in order to assign the chronic condition U78.1 *Obesity* and coders must not rely on the Waterlow assessment form alone. Scenarios should be assessed on a case-by-case basis.

Question 3: There needs to be further documentation. If a dietician had input into the patient's care, the obesity condition may meet ACS 0002 and therefore could be coded as an acute condition.

Query ID 01-0719: Clarification of ACS 1904 Procedural Complications

Reviewed 11/2021 – ADVICE RETIRED – there is extensive published coding advice on this topic

Query: The query seeks clarification of two examples provided in ACCD's response to queries on ACS 1904 Procedural Complications. Example 9 (Q3348) related to development of an ulcer at the site of a coronary artery bypass graft and Example 12 (Q3398) related to pain following arthroscopic meniscal debridement.

Example 9 question: Please confirm that an ulcer at a procedural wound site can be assumed to be an infection and coded as such? ie. there does not need to be the term infection?

Example 12 question: Please confirm why the pain is not coded in this example however is coded in another example (16) in ACS?

Response:

Example 9: CCAQ members agreed it cannot be assumed that an ulcer and an infection are the same and noted that the ACCD had subsequently published an amendment to ACS 1904 on 28 June 2019, with ulcer being reworded to infection.

Example 12: CCAQ members agreed that if the pain is not at the operative site and meets ACS 0002, then an additional code may be added to provide further specificity. Members noted that the ACCD had subsequently published an amendment to ACS 1904 on 28 June 2019.

Query ID 01-1218: BOO and BPH – admission for TURP

Reviewed 08/2021 – ADVICE RETIRED – as per ICD-10-AM 11th Edition changes, coding should be in accordance with ACS 0001

Query: This query seeks to clarify the Principal Diagnosis when the patient is admitted for a TURP (Transurethral Resection of the Prostate) and has both BOO (Bladder Outlet Obstruction and BPH (Benign Prostatic Hyperplasia).

Response:

The coder must be led by the documentation and should code the first mentioned diagnosis as the Principal Diagnosis. If documentation is deficient, a Clinical Documentation Query is to be submitted.

Query ID 04-1218: Superficial injuries of the head with closed head injury

Reviewed 08/2021 – ADVICE RETIRED – refer to National Coding Advice Q3426 published March 2020

Query: The query seeks clarification of the coding assignment for superficial injuries of the head such as abrasion, contusion with documented closed head injury S09.9 *Unspecified injury of the head*. Two questions raised:

a. Using the S09.9 pathway, are only open wound or lacerations of the head coded (ACS 1905) and not superficial injuries?

b. If superficial injuries are not coded, is this rule limited to the scalp only or extended to all injuries categorised under S00 *Superficial injury of the head*?

Response: CCAQ members agreed that when a closed head injury is documented, all injuries at different sites on the head should be coded, including open wounds, lacerations, abrasions and contusions. If there are two injuries to the same site on the head documented, only the most severe injury is coded, as per ACS 1905 and 1907. *Refer to article published in Issue 19 of NetNews (March 2019) for a comprehensive explanation and examples.*

Query ID 06-1118: Soft tissue injury

Reviewed 08/2021 – ADVICE RETIRED – the National Coding Advice from September 2016 is now retired. Code in accordance with ACS 1916 and index pathway.

Query: This query relates to coding soft tissue injury of ankle. ACS 1916 states "where soft tissue is the only description documented for an injury, follow the index pathway injury/site" therefore S99.9 Unspecified injury of ankle and foot. Further ACCD advice from September 2016 advises that musculoskeletal injuries should be coded S99.8 Other specified injuries of ankle and foot. Which is correct?

Response: CCAQ members agreed that if documented as a soft tissue injury then it is specified and is to be coded to S99.8 based on the index pathway.

Query ID 03-1018: Application of ACS 1103 Gastrointestinal Haemorrhage and ACS 0051 Same-Day Endoscopy – Diagnostic

Reviewed 08/2021 – ADVICE RETIRED – 'see also' notes against ACS 0051 point to ACS 1103

Query: This query relates to admission for a same day procedure for investigation of an upper gastrointestinal bleed.

Response: The CCAQ members agreed that the link is assumed, finding the Haemorrhage as the Principal Diagnosis, and code to the GI Haemorrhage standard, K92.2 *Gastrointestinal haemorrhage, unspecified*. As per the standard, the haemorrhagic link cannot be assumed with lower endoscopy.

Query ID 07-0518: COF Hyperglycaemia diabetes

Reviewed 06/2021 – ADVICE RETIRED

Query: This query relates to the COF assignment of hyperglycaemia due to adverse reaction in a patient with uncomplicated diabetes mellitus Coding Rule April 2018.

Response: The CCAQ members agreed that ACCD Coding Rules need to be followed. A Public Submission can be submitted to ACCD if further clarification on their advice is required.

Query ID 08-0518: Ligament pain in pregnancy

Reviewed 06/2021 – ADVICE RETIRED

Query: This query relates to the Ligament Pain in Pregnancy Coding Rule April 2018.

Response: The CCAQ members agreed that ACCD Coding Rules need to be followed. A Public Submission can be submitted to ACCD if further clarification on their advice is required.

Query ID 09-0318: Stablisation of Elbow

Reviewed 05/2021 – ADVICE RETIRED

Query: This query relates to the code assignment for repair of ligament of elbow.

Response: The CCAQ members agreed that the code assignment depends on the lead term given (stabilisation vs. repair) in the clinical documentation. The index is to be followed with what is documented and if in doubt, a clinical documentation query needs to be submitted for confirmation.

Query ID 06-0218: Adherent Placenta

Reviewed 04/2021 – ADVICE RETIRED

Query: This query relates to the correct code assignment if only adherent placenta has been documented and has not been specified as 'Morbidly'. Patients having removal of placenta in theatre sometimes have documentation of adherent placenta and sometimes that placenta has to be removed 'piecemeal'. When you look up 'Adherent Placenta' there is a non-essential modifier for 'Morbidly', which sends you to code O43.2 *Morbidly Adherent Placenta*.

Response: The CCAQ members agreed that for documentation of adherent placenta, it is correct to assign O43.2 *Morbidly Adherent Placenta* as per the index as Morbidly is a non-essential modifier.

Query ID 01-1117: Systemic thrombolysis in conjunction with clot retrieval

Reviewed 03/2021 – ADVICE RETIRED

Query: This query relates to whether a code for systemic thrombolysis should be assigned when performed prior to an endovascular intervention such as clot retrieval.

Two documentation examples were provided in the query:
Patient 1 – Systemic thrombolysis with Alteplase (tPA) commenced at 0845 followed by clot retrieval
Patient 2 – Systemic thrombolysis with Alteplase (tPA) commenced at 1705 followed by clot retrieval

The query noted that ACS 0943 Thrombolytic therapy addresses transcatheter thrombolysis as an adjuvant therapy with another endovascular intervention but does not provide advice on whether systemic thrombolysis should be coded with another procedure such as clot retrieval.

Response: The CCAQ members agreed that ACS 0943 is to be referred to as this provides the required advice.

Query ID 06-0817: Sleep Study Titration

Reviewed 08/2022 – ADVICE RETIRED – included at Block [1828]

Query: This query relates to the procedure code that should be assigned for sleep study titration where the patient comes back in after the initial sleep study monitoring to see how the CPAP is working.
The query included VICC advice (# 2364) 5th Edition ACS 1006 that states:

'*VICC considers that for documentation of CPAP titration or monitoring of CPAP = 6 hours, it is appropriate to assign 11503-16 [1849] Continuous monitoring of pulmonary function for = 6 hours duration.*

VICC followed Index entry Monitoring, pulmonary, function, continuous for >= 6 hours duration to arrive at the code as our research indicates that CPAP titration involves the monitoring of CPAP levels to find the right amount of air pressure.'

Response: CCAQ agreed that CPAP 92209-00 *Management of noninvasive ventilation support ≤ 24 hours* is to be assigned along with a code for the type of sleep study performed.

Query ID 04-0817: Lymph Node Met Terminology

Reviewed 12/2020 – ADVICE RETIRED – refer to ICD-10-AM 11th Edition

Query: This query relates to the variety of terms that are being used to suggest lymph node metastases that the clinicians are using in documentation. It was requested for the CCAQ to confirm whether metastatic needs to be the only word used or can the following be use to allocate a metastatic lymph node to:

- Node positive
- Lymph node involvement
- Lymphadenopathy
- T1N1M0

Response: The CCAQ members agreed that coding should be done as per ACS 0239 *Metastases*. Members agreed that if the documentation is unclear, a Clinical Documentation

Query is required however the following **can** be considered synonymous with metastasis to lymph nodes:
• Node positive
• Lymph node involvement

The following **cannot** be considered synonymous with metastasis to lymph nodes:
• Lymphadenopathy

The following **can** be considered synonymous with metastasis to lymph nodes however supporting documentation of the site is required.
• T1N1M0

Query ID 05-0717: Drainage Endometrioma

Reviewed 11/2020 – ADVICE RETIRED

Query: This query relates to the correct code assignment of 'drainage of endometrioma'. There is no code for endometrioma and it codes to endometriosis.

Response: The CCAQ members agreed as the Operation Report states "endometrioma drained' the correct procedure code is 35637-07 [1241] *Laparoscopic rupture of ovarian cyst or abscess*.

Query ID 03-0617: Procedures cancelled but subsequently performed

Reviewed 11/2020 – ADVICE RETIRED

Query: This query relates to the PD selection when a contraindication delays procedure and the management of contraindication changes the same day episode into overnight stay.

Scenario: Elective patient admission for same day colonoscopy to investigate cause of PR bleeding. Pre-op patient was in AF so colonoscopy was cancelled and patient admitted to the cardiac care unit for medication and monitoring overnight. Cardiologist reviewed the patient the following morning and noted that the cardiac condition had stabilised and was now well enough for procedure. The gastroenterologist was informed, the patient remained in hospital and had the colonoscopy performed late afternoon day 2 (no cause identified for PR bleeding).

Question 1: Can example 5 in ACS 0011 be applied in this scenario and AF to be coded as PD because the procedure was cancelled, and the management of the AF became the primary reason for episode? I48.9 K92.2 32090-00
Or because by time of discharge the planned procedure was performed & not cancelled (just delayed) ACS 0011 does not apply and therefore PR bleeding remains PD and AF is an AD? K92.2 I48.9 32090-00

Question 2: A similar scenario is patient admitted for day chemo – cancelled due to AF – admitted for cardiac med stabilisation. Had chemo prior to discharge on day 2.
Would you code:
C18.7, M8140/3, I48.9, 96199-00
Or
I48.9, C18.7, M8140/3, 96199-00

Response: The CCAQ members agreed on the following response to each question.

Question 1: ACS 0011 does not apply as the procedure was not cancelled, it was postponed therefore the original intent of the admission was carried out and PR bleeding remains as the PD. K92.2, I48.9, 32090-00 is to be assigned.

Question 2: As per Question 1, the intent of the admission was carried out and chemo was performed therefore C18.7 is to be assigned as the PD. C18.7, M8140/3, I48.9, 96199-00 is to be assigned.

Query ID 06-0617: O08 Code assignment

Reviewed 11/2020 – ADVICE RETIRED – Refer to ICD-10-AM 11th Edition

Query: This query relates to the code assigned of O08 *Complications following abortion and ectopic and molar pregnancy* diagnosis code with a code in the range of O07 *Failed attempted abortion*. There is a note included for diagnosis codes O00 – O02 that states: *Use additional code from category O08. - to identify any associated complications*. O08 *Complications following abortion and ectopic and molar pregnancy* has the following exclude note: ***Excludes***: retained products of conception (O03-O06). But it is unclear if an O08 diagnosis code can be assigned with and O07 code. O07 does not include any direction in regard to O08.

Response: The CCAQ members agreed that O08 and O07 cannot be coded together as per Coding Rules December 2014 which clarifies ACS 1544 and assignment of O08 and O07.

"*The modification to the standard indicated that codes from O08 should not be assigned in addition to codes in the range O03–O07. Categories O03–O06 (Spontaneous abortion, Medical abortion, Other abortion, Unspecified abortion) are intended to classify complications from an abortion occurring* ***during the same episode of care*** *and codes from O08 Complications following abortion and ectopic and molar pregnancy are intended to classify complications arising from an abortion* ***occasioning a subsequent episode of care***."

Query ID 01-0417: Use of Chapter Codes with Post Procedure Complication Codes

Reviewed 05/2020 – ADVICE RETIRED

New advice has been published in ICD-10-AM 11th Edition

Query: This query relates assigning additional codes from Ch1-19 to give further specificity to a post procedural disorder code. There seems to be different practices between new and experienced coders so requesting some external advice.

As per ACS1904 instructions "An additional code from Chapters 1 to 19 should be assigned where it provides further specificity". When a coder is coding a post op abscess T81.4 – could a code be assigned from Ch1-19 to describe the site of the abscess? Or because abscess is an inclusion term, not necessary?

A similar example is pain due to joint replacement – as directed by the tabular at T84.8 pain is an inclusion term under T82.8. In the post operative pain example in coding Q&A October 2010 M25.56 joint pain, lower leg is coded.

Response: The CCAQ members agreed as per ACS 1904 Procedural Complications, follow the Instructional Notes for procedure complications – Chapter codes 1 – 19 may be assigned to provide further specificity, see examples 15 & 16 in 10th ED.

Query ID 02-0417: Prostaglandin and Suction Curette

Reviewed 09/2020 – ADVICE RETIRED

Query: Can CCAQ please advise in regard to the coding of Misoprostol for the below scenario?

Female patient is admitted for medical termination (suspected chromosomal abnormalities) at 13 weeks gestation. Misoprostol tablets (NSAID + prostaglandin) are inserted vaginally to soften the cervix prior to suction curettage. This is done so that it is easier to pass the surgical instruments. The patient then proceeds on to have a suction curette under general anaesthesia.

Response: The CCAQ members agreed, in the scenario given, a procedure code for the insertion of Misoprostol to soften/dilate the cervix is not to be coded as it is considered part of the suction curette procedure.

Query ID 19-0417: Basilar artery coiling

Reviewed 10/2020 – ADVICE RETIRED

Query: This query relates to the QCAEC Coding Quiz that was distributed early in the year. Is 35321-03[768] *Transcatheter embolization of blood vessels, face and neck* the correct code as directed by ACCD or can 35321-02[768] *Transcatheter embolization of intracranial arteries, NEC* be considered.

Response: The CCAQ members agreed that ACCD advice needs to be followed and for 35321-03[768] *Transcatheter embolization of blood vessels, face and neck* to be coded.

Query ID 05-0217: Hydro-Surgical Debridement

Reviewed 08/2020 – ADVICE RETIRED

Noting changes have been made to the Debridement Index in ICD-10-AM 11th Edition

Query: Hydro-surgical debridement is a new procedure that uses razor-thin fluid jet to remove damaged tissue or foreign objects from a wound to stimulate healing. The procedure is performed in an operating room. An example of product information can be viewed here: http://www.smith-nephew.com/key-products/advanced-wound-management/versajet/. The product information includes the term "excise".

Can CCAQ please provide advice as to the correct procedure code that should be assigned?

Response: The CCAQ members agreed hydro-surgical debridement should be coded as Excisional Debridement. Refer to Coding Rules - Wound Debridement (March 2016) re coding of Debridement Soft Tissue and Debridement Skin.

Query ID 08-1016: Mucosal pressure injury

Reviewed 06/2020 – ADVICE RETIRED

Query: Could the CCAQ please provide guidance in coding mucosal pressure injuries staged or unstaged when due to a device (insitu) e.g.; nasogastric tube, CPAP prongs, IDC
The would care nurse at our facility has concerns regarding the application of pressure injury codes as per our current coding standard [ACS 1221 pressure injury] when applied to staged/unstaged mucosal pressure injuries as they are not considered the same as pressure injuries of the skin, There is clinical (not coding) reference to the Pan pacific guidelines on staging pressure injuries in ACS 1221 which states mucosal pressure injuries are not staged as per PI of the skin and refer to the NPUAP (see below transcript and link)

Question 1) what code would be used for Unstageable mucosal pressure injury..L89.4- (unstageable PI), L89.9- (PI unspec),
Would an S..injury code or would J34.0 as in ulcer, nose skin be other options
Ulcer
- nose, nasal (infective) (passage) (septum) J34.0

Question 2) Confirm coding of mucosal pressure injury nose due to NGT (insitu)
T85.88 [mucosal PI code], Y65.8 (Misadventure as know at the time), Y92.22

Response: The CCAQ members agreed to code Mucosal Pressure Injury as per the proposed changes for Tenth Edition. Mucosal Pressure Injuries are to be classified as per the classification of ulcer by site (e.g. tongue, gastrointestinal, nasal, urethra, vaginal canal). As these types of pressure injuries are due to complications of a medical device, classification will be subject to the guidelines in ACS 1904 *Post procedural Complications*. Therefore where

a mucosal pressure injury is a complication of a medical device a relevant code from T82 - T85 should be assigned with an additional diagnosis chapter code (Ulcer/by site).

Query ID 04-0916: Ozurdex Injection

Reviewed 06/2020 – ADVICE RETIRED

Query: Does Ozurdex Injection of implant into Vitreous for Central Retinal Vein Occlusion/Macular Oedema require an additional procedure code to reflect the insertion of an implant (Although it is a biodegrable implant that slowly dissolves) in addition to 42740-03 Administration of therapeutic agent into posterior chamber?

Response: The CCAQ members agreed that Ozurdex Injection of implant into Vitreous for Central Retinal Vein Occlusion/ Macular Oedema does not require an additional procedure code to reflect the insertion of an implant as 42740-03 *Administration of therapeutic agent into posterior chamber* is sufficient.

Query ID 05-0616: Newborn cephalohaematoma

Reviewed 05/2020 – ADVICE RETIRED – Birth Trauma is no longer a non-essential modifier in code selection

Query: We have had more than one newborn delivered via uncomplicated spontaneous vaginal delivery where the newborn has a cephalhaematoma. There is no documentation that identifies that this is related to birth trauma, and when a clinical query has been raised with the paediatrician, they confirm that the cephalhaematoma was not due to birth trauma.

The Index for cephalohaematoma is:

Cephalematoma, cephalhaematoma (calcified)
- fetus or newborn (birth trauma) P12.0
- traumatic S09.8

There is no index entry/code for non-birth trauma cephalhaematoma.

Could CCAQ please provide advice in regard to the correct diagnosis code that should be assigned?

Response: The CCAQ members agreed that P12.0 Cephalhaematoma due to birth trauma is the correct code as per the index as 'birth trauma' is a non-essential modifier.

Cephalematoma, cephalhaematoma (calcified)
- fetus or newborn (birth trauma) P12.0

Query ID 01-0716: Thickened endometrium

Reviewed 09/2018 – ADVICE RETIRED - Query resolved in ICD-10-AM 9th Edition

Query: When thickened endometrium has been documented, usually as the reason for admission for a D&C, and it has not been linked to a condition, the code assigned is R93.5. When this code is assigned with the operation code for D&C, hysteroscopy etc, the DRG is 801C OR Procedures Unrelated to Principal Diagnosis, Minor Complexity.

I have looked up both endometrial thickening and endometrial hyperplasia, in medical reference dictionaries and on the internet, and it looks like they are the same, but the index does not send you to endometrial hyperplasia. Is thickened endometrium the same as endometrial hyperplasia and can we code it as such?

Response: R93.5 Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum is correct code to be used. Amendments to this code will be in the ICD-10-AM Tenth Edition.

Query ID 05-0216: Bacteraemia

Reviewed 02/2020 – ADVICE RETIRED – refer to the Coding Rule Q3332 published on 15-March-2019

Query: Can you please check the following code assignment is correct for a patient admitted with E. Coli UTI and E. Coli Bacteraemia?

Codes assigned:
N39.0 Urinary tract infection, site not specified
B96.2 Escherichia coli [E. coli] as the cause of disease classified to other chapters
A49.8 other bacterial infections of unspecified site

ICD-10-AM 9th edition Disease Index:

Bacteraemia *(see also Infection/by type)* A49.9
- with sepsis — *see Sepsis*
- meningococcal *(see also Meningococcaemia)* A39.4
- Staphylococcus, staphylococcal A49.00
- - aureus A49.01

Infection, infected (opportunistic) *(see also Infestation)* B99
- Escherichia (E.) coli NEC A49.8
- - as cause of disease classified elsewhere B96.2
- - congenital P39.8
- - - sepsis P36.4
- - generalised A41.51

Additionally, in Codefinder, on the Bacteraemia pathway (see below), I think the wording "SPELL infection site or type" is inconsistent with the index where the instructional note is just "see also Infection/by type". This causes some coders to inadvertently omit a

Bacteraemia code if they then proceed to go down the pathway of coding by the site of the infection

Response: The CCAQ members agree with the codes selected for the scenario provided utilising the following index pathway for Bacteraemia.

Bacteraemia (see also Infection/by type) A49.9

Infection, infected (opportunistic) (see also infestation) B99
- Escherichia (E.) coli NEC A49.8.

The Codefinder pathway requires the selection of 'Unspecified site' once E coli has been selected from the SPELL infection site or type.

Query ID 06-0216: Urosepsis

Reviewed 09/2018 – ADVICE RETIRED – refer to the Coding Rule published on 15-Jun-2017

Query: Can the committee please clarify the correct coding for documentation of Urosepsis? The 9th edition Disease index for Urosepsis is as follows:
Urosepsis — *see Sepsis AND Infection, infected (opportunistic)/urinary (tract) NEC*

Is the intention now that all cases of documented Urosepsis be classified to codes for both the urinary tract infection (N39.0) and an appropriate sepsis code (sequencing determined by following ACS 0001 Principal Diagnosis)?

In 8th edition, Urosepsis was classified via the Disease index to N39.0 Urinary tract infection and ACS 0110 Sepsis, Severe Sepsis and Septic Shock included advice (p51);

> "The use of the term urosepsis may need further clarification in order to determine if it refers to:
> 1. Generalised infection
> OR
> 2. Urine contamination by bacteria, bacterial by-products or other toxic material but without other finding
> Where clarification is not available, code urosepsis to N39.0 Urinary tract infection, site not specified."

Response: The CCAQ members confirm that Urosepsis is classified to codes representing the urinary tract infection and sepsis as per the instruction in the index.
Urospesis - see Sepsis AND Infection, infected (opportunistic)/urinary (tract) NEC

Query ID 01-0416: Degree of haemorrhoids

Reviewed 07/2018 – ADVICE RETIRED – refer to national coding advice

Query: If clinical documentation includes multiple haemorrhoid degrees, is each degree that is treated coded or only the highest.

Response: Please refer to the 8th edition workshop Q & A 2013:
What code(s) should be assigned when multiple grades of haemorrhoids are documented or terminology such as grade II-III haemorrhoids is used?
A:
While there is currently nothing in the classification to preclude the assignment of multiple codes to reflect different stages of haemorrhoids, clinical advice indicates that it is only necessary to assign one code for the most severe haemorrhoid grade.
Improvements to the classification will be considered in the future to reflect this advice.

Query ID 01-1115: Using radiology results to add specificity

Reviewed 12/2019 – ADVICE RETIRED

Query: Could you please provide some direction on how to code the following?

A patient was admitted with epigastric pain. CT images were discussed with the SMO. The final impression on transfer of the patient was acute cholecystitis. There is no documentation of suspected biliary colic or gallstones. The CT report states 'Cholelithiasis. No CT evidence of cholecystitis.'

In the past I would have coded K8000 Calculus of gallbladder with acute cholecystitis, without mention of obstruction to add further specificity. As per below ACCD comments on ACS 0010 (below) I am no longer sure if this is appropriate.

This dilemma also arises when clinical documentation states biliary or renal colic with no documentation of calculus/ stones and the CT report shows calculus/stones.

ACS 0010 General abstraction guidelines/Test results

> Findings that provide more specificity about a diagnosis
> Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions that meet the criteria for a principal diagnosis (see ACS 0001 Principal diagnosis) or an additional diagnosis (see ACS 0002 Additional diagnoses).

ACCD 15 September 2015 comments on ACS 0010 General abstraction guidelines/ Test results

> ...although the classification links ureteric calculus and hydronephrosis, both conditions must be documented or confirmed by the clinician to inform code assignment

Response: As per September Coding Rules the acute cholecystitis is the documented diagnosis confirmed by the clinician. Cholelithiasis, whilst documented in the radiology report, has not been confirmed and therefore can't be coded. However, the CCAQ strongly believe this is a documentation issue and there is an obligation to query this documentation with the treating clinician.

Query ID 05-1115: Pressure injury highest severity

Reviewed 08/2022 – ADVICE RETIRED – refer ACS 1221 12th Edition

Query: Which pressure injury severity is the highest? Stage IV or unstageable?

Scenario: Patient develops a stage IV pressure injury (lower back) during the episode of care which is documented in the chart. Two days later documentation relating to the lower back pressure injury notes that the pressure injury is unstageable. The injury is not debrided during the episode of care.

Can CCAQ please provide advice in regard to which diagnosis code should be assigned?
L89.34 Pressure injury, stage IV, lower back or L89.44 Pressure injury, unstageable, so stated, lower back.

Response: CCAQ consider stage 4 to be the highest stage documented and recommend coding L89.34 *Pressure injury stage IV*, as per Standard point 4 in ACS 1221:
Pressure injuries may improve or deteriorate during hospitalisation. If different stages are documented for a pressure injury of the same site, assign a code that reflects the highest stage for that site (see Examples 7 & 8).

Query ID 05-0815: Block [1888] Hyperbaric oxygen therapy

Reviewed 12/2019 – ADVICE RETIRED (refer to Coding Rule Ref No: Q2982 Published 15-Mar-2016

Query: Block [1888] *Hyperbaric oxygen therapy* is situated in Chapter 19 *Nonivasive, cognitive and other interventions, not elsewhere classified* (Blocks 1820-1922).

In the scenario where a patient has multiple hyperbaric oxygen therapy interventions in a single episode of care should the procedure code be assigned:
- only once (procedure code selection based on the average length on the therapy session)
- for each time the intervention is provided
- be the cumulative total of hyperbaric oxygen therapy time?

Can CCAQ please provide advise?

Response: Code the procedure as many times as performed following ACS 0020 *Bilateral/Multiple Procedures*, Classification point 1 The SAME PROCEDURE repeated during the episode of care at DIFFERENT visits to theatre.

Query ID 02-0515: IM Sedation

Reviewed 02/2018 – ADVICE RETIRED – refer to Coding Rule Ref No:Q2994 Published 15-Jun-2015

Query: A paediatric patient was admitted to emergency with a fractured radius with the fracture being reduced under IM sedation (instead of IV sedation). There is a completed Procedural Sedation Record in the chart, and they have crossed out IV and written IM. They have not said why they chose to do the IM sedation, but information (from the internet) said that it is occasionally used when there is difficulty with IV access.

ACS 0031 only says, do not code oral sedation. It does not mention IM sedation. IM ketamine was used and it was definitely for anaesthesia for the reduction and was not used for pain management. Could you please advise if the IM sedation should be coded in this instance?

Response: The CCAQ members referred to ACS 0013 point 2 which states, 'The distinction between sedation and general anaesthesia is often unclear from clinical documentation. For the purposes of classification in ACHI, 92515-XX [1910] Sedation may be assigned where the anaesthetic is administered as per general anaesthesia (i.e. intravenous or inhalational or both) and there is no documentation of the use of an artificial airway, such as an endotracheal tube, laryngeal mask (e.g. LM3, LMA4), pharyngeal mask (e.g. PM3) or Guedel airway.' As IM sedation is neither IV or inhalational it would not be coded.

Query ID 06-0515: Follow up in coeliac disease

Reviewed 02/2018 – ADVICE RETIRED - refer to ACS 0052 *Same-day endoscopy - Surveillance*

Query: Can the committee please provide advice on the appropriate codes to use for the following scenario:

Patient previously diagnosed with coeliac disease – now follows a gluten free diet. Presents for a review gastroscopy to assess duodenum. Gastroscopy and histopathology all came back as normal.

As coeliac disease is a permanent intestinal intolerance to gluten this patient would still have coeliac disease, even though no evidence is evident. Do we code this as K90.0 as you can never eradicate coeliac disease?

I am not sure if ACS 2113 – Follow up examinations for specific disorders applies as technically the patient still has coeliac disease.

Response: The CCAQ members agreed that Coeliac disease will be the principal diagnosis as the condition continues to be managed/treated i.e. there is no end to treatment therefore follow up does not apply.

Post query update: Refer to ACCD Coding Rules June 2015 Same-day endoscopy for chronic incurable diseases.

Query ID 08-0515: Fluid overload in CCF

Reviewed 02/2018 – ADVICE RETIRED

Query: Can the CCAQ please confirm if fluid overload should be coded in the presence of CCF?

Coding Matters advice on Heart Failure (Coding Matters December 2000 Volume 7, Number 3) Congestive heart failure (CHF/CCF) is a syndrome in which the heart is unable to pump at an adequate rate for the body's metabolic requirements. This causes signs and symptoms of volume overload or manifestations of impaired tissue perfusion such as oedema, fatigue and decreased exercise tolerance. It is not necessary to code volume (fluid) overload in a patient with CHF.

Other points to note:
When coding CCF and pleural effusion together in Codefinder a Coding Error pops up referencing the above advice, saying "it is not necessary to code pleural effusion with CCF unless specific treatment (egg drainage) is required for the pleural effusion"

However, when coding CCF and fluid overload together in Codefinder there is no pop-up Coding Error advising coders not to code the two together.

Response: The Coding Matters advice cited is no longer current. Fluid overload and CCF can be coded together with reference to ACS1802 Signs and Symptoms point f. However, each case should be reviewed on a case-by-case basis, if documentation is not clear the clinician may need to be contacted for clarification. Sequence in accordance with ACS0001 and ACS0002.

Query ID 02-0115: Sedation of Mental Health Patients

Reviewed 12/2017 – ADVICE RETIRED

Query: Scenario: Patient with psychosis was fully sedated with ketamine and midazolam prior to transfer out to acute hospital.

I am confident that a code for the sedation is not coded in these scenarios, however I can find no evidence (have looked everywhere) of this being actually stated anywhere.

Can CCAQ please advise if a code is required for sedation of mental health patients or is this an expected procedure for some mental health conditions?

Response: The CCAQ members referred to point 1 under CLASSIFICATION in ACS 0031 *Anaesthesia*

CLASSIFICATION

1. Assign only one code from block [1910] *Cerebral anaesthesia* and/or one code from block [1909] *Conduction anaesthesia* (excluding 92513-XX [1909] *Infiltration of local anaesthetic*) for each **'visit to theatre'** regardless of where in the hospital the procedure is performed, for example operating theatre, endoscopy suite, emergency department, catheter laboratory.

It is implied that sedation is coded when performed for procedural anaesthesia and therefore in the scenario provided it would not be coded.

Query ID 03-0115: ACS 1404 Admission for Kidney Dialysis

Reviewed 12/2017 – ADVICE RETIRED – refer to ACS 1404 *Admission for kidney disease*

Query: This query relates to Australian Coding Standard (ACS) 1404 *Admission for kidney dialysis*.

Scenario: Patient admitted for same day dialysis but the patient collapses prior to discharge. The patient stays overnight and is discharged the next day.

ACS 1404 (8th Edition) notes: For episodes of care where the patient is discharged on the same day as the admission or on the next day after admission, code as principal diagnosis either Z49.1 *Extracorporeal dialysis* or Z49.2 *Other dialysis as appropriate*.

Under the Multi-day episodes of care for dialysis section of ACS 1404 the following is included: Where a kidney dialysis episode of care is multi-day, but the intent for admission was same-day, code as principal diagnosis the condition responsible for extending the patient's length of stay and Z49.1 or Z49.2 as an additional diagnosis.

A similar query was submitted to the Victorian Coding Committee in 2008 (Note this was for 6th Edition and the wording has changed compared to 8th Edition). The query was referred on the NCCH. Refer to VICC query number 2316.

Question: As the episode of care was only extended overnight, is the principal diagnosis for this scenario Z49.1 Extracorporeal dialysis or the reason for the collapse?

Response: The section, Same-Day and Overnight Episodes of Care for Dialysis under ACS 1404 are written in the context of same day intent with no other condition responsible for extending the LOS. In the scenario provided in the query the collapse is the reason for extending the admission overnight and therefore following the second instruction under ACS 1404 Multi-Day Episodes of Care for Dialysis the collapse is sequenced as the PD.

Query ID 01-1014: Stageable Vs. Unstageable Pressure Injury (PI)

Reviewed 12/2017 – ADVICE RETIRED

Query: There is some confusion on the coding of pressure injuries when there are two pressure injuries. One being stageagble and the other unstageable.

Question: If a patient has two pressure injuries. One is unstageable and the other is stage 2. Which one would you code? What are your thoughts please?

Response: The CCAQ members noted that 9th edition changes will include codes for unstageable and allow coding of individual pressure injuries.

If there are established coding practices for this scenario within the HHS then the CCAQ suggest such practices should not change to ensure data consistency.

The following is a recommendation from the CCAQ only:
- Consult with the treating clinician and/or pressure injury nurse to confirm the stage and code according to that newly documented stage.
- If consultation with a clinician to confirm the stage is not possible then code to the highest staged PI as per ACS1221 i.e. the unstageable would not be coded in the scenario provided.

Query ID 01-0914: Subtherapeutic INR

Reviewed 11/2017 – ADVICE RETIRED – refer to ACS 0303 *Abnormal coagulation profile due to anticoagulants*

Query: Scenario: A patient with ESRF is admitted for same-day haemodialysis. Subtherapeutic INR (1.5) is noted at haemodialysis and the patient stays overnight for heparin bridging (IV infusion of heparin) until therapeutic. Subtherapeutic INR is secondary to missing dose of warfarin and dietary changes. The patient is on warfarin for their mechanical mitral valve. The clinician was consulted and confirmed that the patient does not have coagulation deficiency or defect.

We have referred to ACS 1404 paragraph three 'Where a kidney dialysis episode of care is multi-day, but the intent for admission was same-day, code as principal diagnosis the condition responsible for extending the patient's length of stay and Z49.1 or Z49.2 as an additional diagnosis.'

Q1. Please advise what diagnoses should be coded in this scenario.
Proposed codes:
Principal Diagnosis:
Z29.2 *Other prophylactic pharmacotherapy*

Additional Diagnoses:
Z92.1 *Personal history of long-term use of anticoagulants*
Z49.1 *Extracorporeal Dialysis*

Q2. What is the correct code to assign for a patient admitted for heparin bridging due to subtherapeutic INR?

Response: The CCAQ members agreed on the following:
Q1. Agreement with the proposed diagnosis codes.
Principal Diagnosis:
Z29.2 *Other prophylactic pharmacotherapy*
Additional Diagnoses:
Z92.1 *Personal history of long-term use of anticoagulants*
Z49.1 *Extracorporeal Dialysis*

Q2. A patient on Warfarin with subtherapeutic INR codes to Z92.1 *Personal history of long-term use of anticoagulants* following look up term 'underwarfarinisation' and ACS 0303 Abnormal coagulation profile due to anticoagulants. As this is an unacceptable PD, Z92.2 *Other prophylactic pharmacotherapy* is sequenced as the PD to represent the 'heparin bridging' by following look up term
Pharmacotherapy
- prophylactic

Query ID 02-0914: Endoscopic Ultrasounds (EUS)

Reviewed 11/2017 – ADVICE RETIRED

Query: Background
Endoscopic Ultrasounds (EUS) are becoming more prevalent at our hospital. Coders are unsure whether to code the EUS in addition to the other procedures performed and how to code the FNA when performed.

I'm uncertain about the content of the VICC query surrounding EUS. They seem to state that the gastroscopes are performed under EUS. A gastroenterologist from our hospital stated that they use two different scopes for the gastroscopy and EUS as they have different views- this seems to contradict the Gastroenterologist advice in the VICC Query No. 2687. See VICC Query below.

Endoscopic Ultrasounds (EUS) are classified to chapter 20. As per ACS 0042 Procedures normally not coded, EUS shouldn't be coded unless an anaesthetic is required in order for the procedure to be performed or is the principal reason for admission in same-day episodes of care.

Q1. Patient admitted for 4 days with a pancreatic mass. During the admission an Endoscopic Ultrasound (EUS) is performed. Could you please confirm the correct procedure coding of EUS with transduodenal FNA of pancreas performed under sedation?

Proposed Codes:
30688-00- *EUS*
30075-16 *Biopsy of pancreas*
92515-99 *Sedation ASA 99*

Reasoning:
30688-00 assigned as I don't consider the EUS to have been performed in 'association' with other procedures, rather it's the required component before deciding whether it's appropriate to perform a transduodenal FNA. However, I'm not sure this is correct logic. See CCAD Coding Rule Ref No: TN565 below.

30075-16 is assigned for the biopsy of the pancreas. The FNA of the pancreas is performed through the wall of the duodenum. Gastroscopy with biopsy wouldn't be appropriate as it is not a biopsy of the gastrointestinal wall.

Alternatively, could 30094-05 'percutaneous' needle biopsy of pancreas be used instead of 30075-16 *Biopsy of pancreas*.

Q2. Patient admitted for 4 days with pancreatic mass. During the admission an Endoscopic Ultrasound (EUS) is performed with a transduodenal FNA of the pancreas a gastroscopy is also performed. All procedures performed under sedation. Could you please confirm the correct procedure coding?

Proposed codes:
30688-00- *EUS*
30075-16 *Biopsy of pancreas*
30473-00 *Gastroscopy*
92515-99 *Sedation ASA 99*

Reasoning:
In Q2 I coded the gastroscopy in addition to the EUS as they are performed using two different scopes (according to our gastroenterologist).

Gastroscopy with biopsy wouldn't be appropriate as the biopsy is of the pancreas not the gastrointestinal tract. The biopsy is also performed during the EUS not the gastroscopy.

Q3. Could you please confirm the correct procedure coding for a patient who was admitted for a same day EUS and transoesophageal FNA of a submucosal oesophageal mass via performed under sedation.

Proposed Codes:
30688-00 *EUS*
30473-04 *Oesophagoscopy with biopsy*
32515-99 *Sedation ASA 99*

Reasoning:

I coded 30688-00-*EUS* as I don't consider the EUS to have been performed in 'association' with other procedures, rather it's the required component before deciding whether it's appropriate to perform a transoesophageal FNA. See CCAD Coding Rule Ref No: TN565 below.

Additionally, 30688-00 is assigned as it is the principal reason for admission in a same-day episode of care as per ACS 0042.

30473-04 *Oesophagoscopy with biopsy* is coded as the Index leads us to this code. Biopsy, Oesophagus.

This is slightly different to the other examples as the transoesophageal FNA is of the submucosal tissue of the oesophagus rather than another organ.

Q4. Could you please confirm the correct procedure coding for a patient who was admitted for a same day EUS and transoesophageal FNA of a mediastinal lesion performed under sedation.
Proposed Codes
30688-00 *EUS*
90175-01 *Other procedures on mediastinum*
32515-99 *Sedation ASA 99*

Reasoning:
30688-00- *EUS* assigned as I don't consider the EUS to have been performed in 'association' with other procedures, rather it's the required component before deciding whether it's appropriate to perform a transduodenal biopsy. See CCAD Coding Rule Ref No: TN565 below.

30688-00 is also coded as it is the principal reason for admission in a same-day episode of care as per ACS 0042.

90175-01- *Other procedures on mediastinum* is assigned for the FNA of the mediastinum. Or could 38800-00 *Diagnostic thoracentesis* be used following the index. Aspiration, chest, diagnostic.

Response: The CCAQ members agreed with the following response:
Q1. Patient admitted for 4 days with a pancreatic mass. During the admission an Endoscopic Ultrasound (EUS) is performed. Could you please confirm the correct procedure coding of EUS with transduodenal FNA of pancreas performed under sedation?

30075-16 *Biopsy of pancreas*
Plus add a code to specify the type of scope - see description at EUS - i.e. ultrasound in conjunction with endoscopy
30688-00- *EUS*
92515-99 *Sedation ASA 99*

Q2. Patient admitted for 4 days with pancreatic mass. During the admission an Endoscopic Ultrasound (EUS) is performed with a transduodenal FNA of the pancreas a gastroscopy is

also performed. All procedures performed under sedation. Could you please confirm the correct procedure coding?

Agree with proposed codes but sequence the biopsy first.
30075-16 *Biopsy of pancreas*
30473-00 *Gastroscopy*
30688-00- *EUS*
92515-99 *Sedation ASA 99*

Q3. Could you please confirm the correct procedure coding for a patient who was admitted for a same day EUS and transoesophageal FNA of a submucosal oesophageal mass via performed under sedation.

Agree with proposed codes but sequence the eosophagoscopy with biopsy first (CCAQ members assumed the scope did not go further down GI tract than the oesophagus0.
30473-04 *Oesophagoscopy with biopsy*
30688-00 *EUS*
32515-99 *Sedation ASA 99*

Q4. Could you please confirm the correct procedure coding for a patient who was admitted for a same day EUS and transoesophageal FNA of a mediastinal lesion performed under sedation.

Agree with Proposed Codes but add a code to describe the endoscopy being performed.
90175-01 *Other procedures on mediastinum*
Add code for scope performed
30688-00 *EUS*
32515-99 *Sedation ASA 99*

Query ID 01-0814: Systemic Lupus Erythematosus (SLE) with Intestinal Involvement

Reviewed 09/2019 – ADVICE RETIRED

Query: As ICD-10-AM diagnosis code M32.1† Systemic lupus erythematosus with organ or system involvement includes the dagger in the rubric heading, a corresponding asterisk diagnosis code is required.
While a number of possible corresponding asterisk codes are noted (as below), there does not appear to be a corresponding code for intestinal involvement.

Clinical scenario: Patient has SLE with organ involvement (SLE related intestinal dysmobility).

ICD-10-AM 8th Edition Alphabetic Index
Lupus
- anticoagulant, presence of D68.6

- discoid (local) L93.0
- erythematosus (discoid) (local) L93.0
- - disseminated — see Lupus/erythematosus/systemic
- - eyelid H01.1
- - profundus L93.2
- - specified NEC L93.2
- - subacute cutaneous L93.1
- - systemic M32.9
- - - with
- - - - atypical verrucous endocarditis (Libman-Sacks disease) M32.1† I39.8*
- - - - cerebral arteritis M32.1† I68.2*
- - - - dementia M32.1† F02.8*
- - - - encephalitis M32.1† G05.8*
- - - - endocarditis, atypical verrucous M32.1† I39.8*
- - - - glomerular disorder M32.1† N08.5*
- - - - glomerulonephritis M32.1† N08.5*
- - - - lung disorder M32.1† J99.1*
- - - - myopathy M32.1† G73.7*
- - - - nephritis M32.1† N08.5*
- - - - pericarditis M32.1† I32.8*
- - - - polyneuropathy M32.1† G63.5*
- - - - renal tubulo-interstitial disorder M32.1† N16.4*
- - - - respiratory disorder M32.1† J99.1*
- - - drug-induced M32.0
- - - inhibitor (presence of) D68.6
- - - maternal, affecting fetus or newborn P00.8
- - - specified NEC M32.8
- exedens A18.4
- hydralazine
- - correct substance properly administered M32.0
- - overdose or wrong substance given or taken T46.5
- nephritis (chronic) M32.1† N08.5*
- nontuberculous, not disseminated L93.0
- panniculitis L93.2
- pernio (Besnier) D86.3
- systemic — see Lupus/erythematosus/systemic
- tuberculous A18.4
- - eyelid A18.4† H03.1*
- vulgaris A18.4
- - eyelid A18.4† H03.1*

Could CCAQ please advise which is the correct corresponding asterisk code for SLE with intestinal involvement?

Response: The CCAQ members recommended that the treating clinician should be consulted to confirm the underlying cause of the intestinal dysmotility as this may be due to other manifestations of the disease e.g. myopathy or drug treatment, and code accordingly.

In the absence of other underlying causes members agreed assign M32.8 with an additional chapter code to describe the intestinal condition. Follow index look up:
Lupus
- erythematosus
-- systemic
--- specified NEC M32.8

Query ID 02-0814: Healed Hind Water Leak

Reviewed 11/2017– ADVICE RETIRED

Query: Hindwater leaks can occur at any time during a pregnancy. These leaks can selfheal (see below supporting document). The occurrence of these leaks does not necessarily lead to labour and delivery. It is also known as hydrorrhea gravidarum and defined as watery discharge from the vagina during pregnancy.
(http://medical-dictionary.thefreedictionary.com/hydrorrhea+gravidarum).

The current ICD-10-AM 8th Edition Alphabetical Index for hind water leaks is:
Leak, leakage
...- hindwater (see also Rupture/membranes/premature) O42.9 *Premature rupture of membranes, unspecified*

For clinical situations where there is a hindwater leak which self-heals, the assignment of diagnosis code O42.9 *Premature rupture of membranes, unspecified* could be misleading.

Diagnosis code O41.8 *Other specified disorders of amniotic fluid and membranes* is being assigned in some situations to identify that a hindwater leak has occurred and subsequently healed.

Could CCAQ please advise in regards to the correct diagnosis code for a healed hind water leak?

Response: Members agreed that if the condition meets ACS 0001/0002 and is being actively treated then code to O42.9 as per the index look up:
Leak
- amniotic fluid O42.9

In the case of observation of a healed hindwater leak members agreed that Z35.8 maybe an appropriate code to use. But coding choice will vary according to case by case documentation. Follow index look up:
Pregnancy
- supervision
-- specified problem NEC Z35.8

Query ID 02-0714: Acute Bronchitis With COPD

Reviewed 12/2017– ADVICE RETIRED – refer to Coding Rule Ref No:Q2934
Published on 15-Jun-2015

Query: We would like clarification as to the type of excludes note at J20-J22 O*ther Acute Lower Respiratory Infections*.

> *Excludes: chronic obstructive pulmonary disease with acute:*
> *• exacerbation NOS (J44.1)*
> *• lower respiratory infection (J44.0)*

We feel the excludes note is a Type 1, and to translate the medical statement back into code we need to assign the code for the acute bronchitis or bronchiolitis. We would be missing information if we did not code the documented type of infective disorder e.g. acute bronchitis, particularly when the organism is known (J20.0-8 and J21.0 -8).

However, we are currently receiving PICQ edits when we code both COPD and acute bronchitis and the response from PICQ cites ACS 1008 as the rationale. ACS 1008 COPD states:

> *Acute exacerbation of COPD does not require an additional code to reflect the 'acute' and 'chronic' components in the description. Assign only J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified.*
>
> *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 (see COPD with pneumonia). 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.*

So it would appear that an acute bronchitis code should not be assigned in addition to the COPD code. If the organism is known, then that could be indicated by a B95-B97 code. Bronchitis would also not be considered to be an infective condition in its own right because bronchitis is part of the COPD (whereas (for example) pneumonia is not).

Question 1: Can the CCAQ advise us if the PICQ advice is correct?

Question 2: How does CCAQ believe we should code the following?
Pt admitted with acute strep bronchitis exacerbating COPD

<u>Option 1:</u>
J20.2
J44.0
Pathway:
Enter Key Word: -- BRONCHIT

- BRONCHIT -- Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous) (with tracheitis)
- - Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous) (with tracheitis) -- Acute or subacute on chronic
- - - Acute or subacute bronchitis (with bronchospasm or obstruction) -- Due to [e.g., chemicals, coxsackievirus, echovirus...]
- - - - Acute or subacute bronchitis (with bronchospasm or obstruction) due to -- Streptococcus
- - - - - Drug resistance specified as -- Not specified as drug resistant
- - - - - - Chronic bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (inflammatory) (membranous) (with tracheitis) -- Obstructive
- - - - - - - Chronic obstructive bronchitis -- With (acute) [e.g., exacerbation, lower respiratory infection]
- - - - - - - - Chronic obstructive bronchitis with (acute) -- Exacerbation
- - - - - - - - - Chronic obstructive bronchitis with (acute) exacerbation -- Infective

Option 2:
J44.0
B955

Response: The CCAQ members agreed on the following response:
Question 1: Yes, the PICQ advice is correct for the current interpretation of the ACS 1008
Question 2: As per suggested Option 2 that is in accordance with ACS 1008

Query ID 03-0714: End Stage Renal Failure (ESRF) secondary to hypertension with DM

Reviewed 11/2017– ADVICE RETIRED

Query: ESRF secondary to hypertension codes to I12.0, or I13.1 or I13.2 with hypertensive heart disease. Codes I12.0 and I13.1 include CKD stage 5, and so N18.5 is not coded additionally. However, in the presence of Diabetes Mellitus, E11.21 & E11.22 requires a code from N18* for specificity.
Use additional code to identify the presence of chronic kidney disease (N18.-)

I believe this is due to ACS 1438 Chronic Kidney Disease under the Diabetic nephropathy classification instruction to:
Assign a code from N18.- Chronic kidney disease in conjunction with the diabetic nephropathy code, to indicate the severity of the kidney disease.

Does the *code also* at DM with incipient/established nephropathy override the *includes* note at I120 and I13.1?
Or should the code also be broadened to capture the hypertensive kidney failure codes, given these codes do indicate the severity of the kidney disease (i.e. fulfil the intent of the code also)?

Response: The CCAQ members were in agreement that the *Use additional* instruction at E11.21 and E11.22 is not meant to override the *includes* note at I12.0 and I13.1 for ESRF, therefore you would not add an additional N18.- code.

Query ID 02-0514: Chemotherapy for clinical trial

Reviewed 09/2019 – ADVICE RETIRED

Query: What is the PD in day only chemotherapy for a neoplasm that is part of a drug clinical trial.

Scenario: *Same-day patient admitted for chemotherapy for neoplasm. The patient is a participant in a chemotherapy drug trial. The drug trial does not include normal comparison or controls. Therapeutic drug monitoring (for toxicity and anaemia) is a component of the treatment/trial.*

Australian Coding Standard (ACS) 0026 Admission for clinical trial, drug challenge or therapeutic drug monitoring notes that if the reason for admission is stated as being for a clinical trial, then a PD of Z00.6 Examination for normal comparison and control in clinical research program should be assigned.

ACS 0026 also includes that if the reason for admission is stated as being for drug challenge or therapeutic drug monitoring, the condition of the patient should be assigned as the PD.

ACS 0044 Chemotherapy notes that episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the patient is discharged on the same day as the admission is assigned Z51.1 Pharmacotherapy session for neoplasm as the PD.

Question: As the drug trial does not include normal comparison or control and there is therapeutic drug monitoring, should the PD be the neoplasm as per ACS 0026? If so, as the neoplasm is being treated by same-day chemotherapy, should the PD be Z51.1 as per ACS 0044?

Response: Based on the information provided in the coding query the CCAQ members did not believe ACS 0026 would apply as the reason for admission did not fit the definition of a 'clinical trial', drug challenge' or 'therapeutic drug monitoring' as described under the standard. Therefore, code as per ACS 0044 and assign Z51.1 as the PD.

Query ID 01-0514: Post dural puncture in obstetric patient

Reviewed 10/2017– ADVICE RETIRED

Query: What is the Index pathway and code(s) to assign for a 'post spinal / epidural / dural puncture / CSF leak' headache in an obstetric patient, occurring in the puerperium of the delivery episode? The headache is a result of the anaesthetic procedure and not the

anaesthetic drugs. Is it a single code of O89.4, or combined coding of G97.1 + headache + externals?

Response: The CCAQ members agreed on the following Index pathway and codes:
Headache
- spinal and epidural anaesthesia-induced
- - postpartum, puerperal O89.4 *Spinal and epidural anaesthesia-induced headache during the pueperium*
No additional G97 code required as already in the code title of O89.4.

Query ID 01-0114: Total femur replacement

Reviewed 10/2017– ADVICE RETIRED

Query: Patient admitted for total right femur replacement for treatment of chronic infection post multiple ORIF right femur. Total femur is removed and replaced with a Depuy LPS total femur with hinged knee (see operation report).

As I was unable to find a single suitable code the following codes are suggested as a possibility of covering all components of the surgery.

48424-07, 48424-05 and 48424-04 to cover the ostectomy of the entire femur
49315-00 Partial arthroplasty hip to cover the acetabular shell exchanged for polar cup
45917-00 Hemiarthroplasty knee to cover the connection of the hinged knee to the tibia end
47921-00 Insertion of internal fixation rod to cover the prosthesis in between

Response: The CCAQ members agreed to code out the key components of the procedure, as per the operation report, with available ACHI codes. Therefore, members agreed that the codes suggested in the query sufficiently reflected the documented procedures. The query will also be forwarded to the ACCD for their consideration.

Query ID 02-0114: PD Selection for AMI With CABG

Reviewed 07/2022 – ADVICE RETIRED - *superseded by Coding Rule Ref no: Q2878 Principal diagnosis selection for a patient admitted with acute myocardial infarct (AMI) or acute coronary syndrome (ACS) with coronary artery bypass grafting (CABG) consequently performed*

Query: This query involves the removal of sequencing instructions in ACS 0940, and when to code AMI or ACS as the principal diagnosis.

Can the CCAQ clarify how to apply ACS 0001 to assign the principal diagnosis when a patient presents with an acute myocardial infarction or acute coronary syndrome and during the admission the patient has coronary artery bypass grafting performed for underlying CAD.

With only ACS 0001 to guide us, we are coding the principal diagnosis according to the condition listed by the clinician on discharge summary. This Pdx is sometimes the AMI, but at most times the underlying CAD - and this potentially causes issues with data consistency, as the same types of admissions are being coded differently dependent on the documented Pdx.

Reference is made to ACS 0001 Principal diagnosis, example 1, which suggests AMI is sequenced as the principal diagnosis over CAD in admissions where AMI is the presenting complaint.

We are unsure as to how exactly the "after study" concept is applied to choose AMI over CAD, particularly when CAD is listed first.

Furthermore, would the "after study" concept still have been applied had CAD been the only diagnosis written in the principal diagnosis field?

Response: The CCAQ members agreed to code the AMI (or ACS) in the scenario provided. The interpretation of the phrase 'after study'; should be read in context with the remaining sentence in that definition. In particular the words '...the condition that was chiefly responsible for occasioning the episode of care'. AMI and ACS are conditions in their own right and in the scenario provided the CCAQ members agreed the AMI was the acute condition occasioning the episode of care. The CCAQ members agreed there is no clear answer to AMI vs CAD as PD in similar scenarios and each admission circumstance and related documentation needs to be assessed as Example 1 under ACS 0001 directs. CCAQ agreed to also forward this query to the ACCD.

Query ID 01-0913: Day admission for Neulasta and Pentamidine

Reviewed 08/2017 – ADVICE RETIRED

Query: PD Selection in day admissions for Neulasta and Pentamidine
Q1 What is the correct Principal Diagnosis code to use for a patient admitted as a day case to receive Neulasta? Patient has on previous admission received chemotherapy as part of their cancer treatment. According to MIMS - Neulasta is used to decrease severe neutropenia duration, incidence of infection following chemotherapy. With this scenario the patient is not neutropenic.
Code suggestion:
Z29.2 Other prophylactic pharmacotherapy or
Z51.1 Pharmacotherapy session for neoplasm but this excludes Z29.2

Q2 What is the correct Principal Diagnosis for a patient admitted for nebulised prophylactic pentamidine? This is used in these cases to prevent pneumocystis carinii pneumonia in cancer patients. Code suggestion
Z29.2 other prophylactic pharmacotherapy

Response:
Q1. The CCAQ members assumed the documentation indicated the Neulasta was given for prophylactic treatment (ordinarily this needs to be confirmed with the treating clinician). Based on that premise the CCAQ members agreed with PD Z29.2 Other prophylactic pharmacotherapy.
Q2. Day Admission for prophylactic pentamidine
Members agreed with Z29.2.

Query ID 02-0913: Gastric mesh erosion

Reviewed 08/2017– ADVICE RETIRED (procedure code out of date)

Query: Patient was admitted for Laparoscopic removal of mesh that was eroding through lesser curve of gastric wall. Mesh was from a previous gastroplasty. Can the CCAQ suggest the procedure codes for the following operation:

"Laparoscopy
Dense adhesions around top end of stomach near mesh site
Anterior gastrotomy, identified mesh which was eroding through lesser curve
Resected part of lesser curve around mesh
Closed lesser curve defect from outside with 2/0 PDS and extra stitch inside
Closed anterior gastrotomy with 3/0 PDS
Specimen removed." - The specimen included both stomach and mesh.

Response: The CCAQ members used Q&A December 2012 Mesh erosion as a guide. The following codes were agreed:

92086-00 [1896] *Removal of other device from gastrointestinal tract (removal of mesh)*
30520-00 [880] *Local excision of lesion of stomach (resection part of lesser curve around mesh)*
30390-00 [984] *Laparoscopy*

Query ID 04-0913: Osteoporotic fracture sub-capital neck of femur (NOF)

Reviewed 07/2022 – ADVICE RETIRED – *superseded by Coding Rule Ref no: Q3478 Fracture of femoral neck due to osteoporosis and fall*

Query: Osteoporotic fracture sub-capital neck of femur (NOF) after tripping over dog at home. Clinical clarification confirmed fracture was due to osteoporosis and fall. How should this be coded?
M80.95 *unspecified osteoporosis with pathological fracture hip*
+ external cause codes for fall OR,

M80.95 *unspecified osteoporosis with pathological fracture hip*
S72.03 *subcapital fracture NOF*

+ external cause codes for fall

Response: As clinical clarification confirmed fracture was due to osteoporosis and fall the CCAQ members agreed to code to both as follows:
M80.95 *Unspecified osteoporosis with pathological fracture Pelvic region and thigh*
S72.03 *Fracture of subcapital section of femur*
+ external cause codes for fall

Query ID 01-0813: Congenital anomalies

Reviewed 07/2017– ADVICE RETIRED

Query: Congenital Anomalies in the birth episode:
Do other hospitals code congenital abnormalities in their newborns? Our older coders are and our new coders do not as it does not meet ACS additional diagnosis

Response: CCAQ members agreed with the following responses based on the NCCC Q&A, June 2011:

Q1. If the conditions meets ACS 0002 it should be coded this includes "If a condition is significant enough to warrant review/evaluation by a clinician, in the admitted episode of care, then it has met the criterion of 'increased clinical care and/or monitoring' and a code should be assigned."

Coding Q&A, June 2011 extract below:

Q: In what circumstances should conditions noted on the examination of a newborn be coded?
Previous advice published in Coding Matters (Vol 17, No 1), stated: "If a condition is significant enough to warrant review/evaluation by a clinician or referral for an external opinion then it has met the criteria for 'increased clinical care and/or monitoring' and coders should assign a code for the condition" Is this advice current?

A: Conditions noted on a newborn examination should be assessed on an individual basis and coded if they meet the criteria in ACS 0002 *Additional diagnoses*. The condition should be coded if therapeutic treatment is commenced, a diagnostic procedure is performed or the condition warrants increased clinical care and/or monitoring. The application of this last criterion to determine whether a newborn condition should be coded has been subjective and not assisted by advice published in Coding Matters (Vol 17, No 1). This advice should be amended to state:

"If a condition is significant enough to warrant review/evaluation by a clinician, in the admitted episode of care, then it has met the criterion of 'increased clinical care and/or monitoring' and a code should be assigned."

Query ID 02-0813: Intravenous dextrose

Reviewed 07/2017– ADVICE RETIRED

Query: Do other hospitals code IV dextrose as nutritional or electrolyte when there is no documentation of electrolyte imbalance

Response: IV Dextrose can be coded as nutritional or electrolyte and for this reason coders should be guided by the documented reason for the dextrose. If documentation does not provide sufficient clarity then this must be queried with the treating clinician/s. In the event that clarification can't be sort refer to QCC query #0206-08 and default to coding IV dextrose to nutritional substance 96199-07 Intravenous administration of pharmacological agent, nutritional substance.

Query ID 04-0813: ACS 0112 MRSA

Reviewed 07/2022 – ADVICE RETIRED – refer ICD-10-AM 12th Edition

Query: ACS 0112 Infection with Drug Resistant Organism, under CLASSIFICATION, advises 'If the clinician has documented in the record that the organism causing the infection is resistant to an antibiotic or other antimicrobial drugs, then the appropriate code from Z06.- Resistance to antimicrobial drugs must be assigned as an additional code to identify the antibiotic or other antimicrobial agent to which the organism is resistant.'

Does the infection with drug resistant microorganism have to be documented by the clinician in the record to allow Coders to allocate any of these Z06.- codes?
or
Can ACS 0010 GENERAL ABSTRACTION GUIDELINES, page 8, TEST RESULTS,
Findings that provide more specificity about a diagnosis be applied?

Response: Refer to ACCD 8th Edition Workshop FAQ Part 1 (published 17/10/13) and 10 Commandments Vol 16 no. 2, FAQ, Q24. Drug resistance has to be documented by the clinician in the health record in order to assign additional resistance codes. Coders cannot use resistance and sensitivities reported on microbiology results alone.

Example - Do not code resistance from this microbiology result unless documented by a clinician elsewhere in the health record