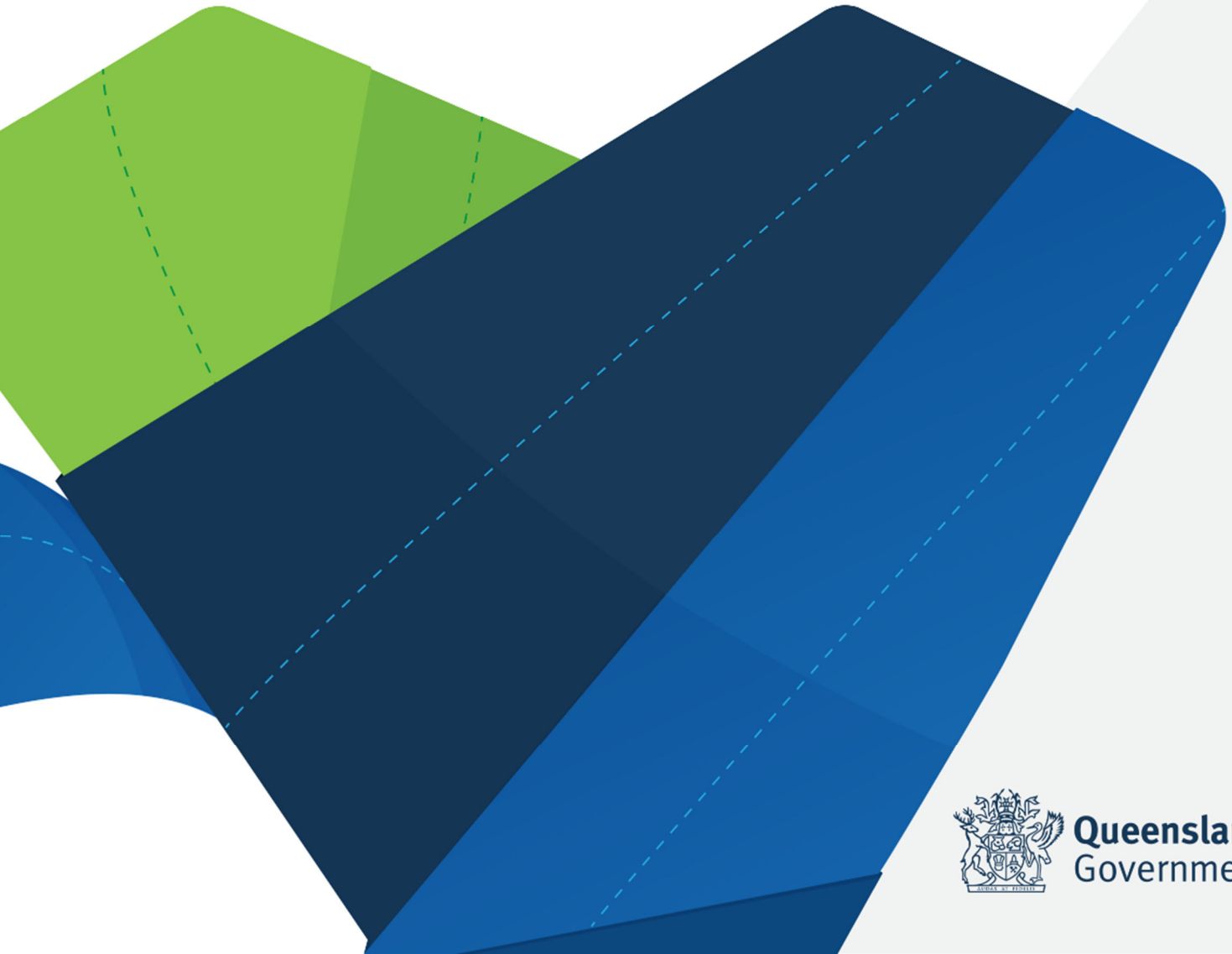
Clinical Coding Queries and Responses

Clinical Coding Authority of Queensland

Current as at December 2023



Queensland Government

IMPORTANT NOTE

The coding advice provided by the Clinical Coding Authority of Queensland (CCAQ) is applicable to the coding query to which it pertains.

Care should be taken when applying this coding advice for similar scenarios. If in doubt, a new query should be submitted to CCAQ.

Where CCAQ coding advice is superseded by coding rules published by the Independent Hospital and Aged Care Pricing Authority (IHACPA), then IHACPA coding rules take precedence.

CCAQ coding advice can be applied to coding practice as soon as it is received unless otherwise directed by CCAQ.

CCAQ coding advice is not to be applied retrospectively.

RETIRED ADVICE

CCAQ coding advice is regularly reviewed to ensure consistency with national coding advice and current coding practice. Advice that is no longer current or has been superseded is 'retired' and has been removed from this document.

Retired CCAQ coding advice is available for historical reference purposes only.

Clinical Coding Queries and Responses December 2023- Clinical Coding Authority of Queensland

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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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November 2023

Query ID: 02-1023 Biomimetic Haematoma

Query: Biomimetic haematoma or membrane-induced reconstruction for traumatic bone defect
We have cases in our hospital where biomimetic haematoma implants were used to repair bone defects. Some were mixed with autologous blood. Some surgeries use the scaffold or 3D printed scaffold that will be packed with this biomimetic haematoma. Biomimetic Hematoma (BH) implant was a biological implant that mimics the intrinsic structural properties of normal fracture hematoma, consistently and efficiently enhanced the healing of large bone defects (Biomimetic-Hematoma-Novel-Carrier-Delivers-Extremely-Low-Dose-rhBMP–2-for-Highly-V-Glatt.pdf (llrs.org))

Our question is about the ACHI code for biomimetic haematoma. What code that we can assigned for this biomimetic haematoma?

Response: CCAQ agree that 14203-01 should be used in the interim and that the issue be sent to IHACPA for advice/a new ACHI code.

September 2023

Query ID 01-0923 Endoscopic resection and plication (RAP) where performed for gastroesophageal reflux

Query: We would like to have advice from CCAQ on how to classify endoscopic resection and plication. According to the doctor that performed this procedure in our hospital and clinical reference on this procedure, this procedure is for reflux (It is known as anti-reflux procedure). It involves endoscopic multiple resections of the mucosa of the distal oesophagus (around 2cm above GOJ) and endoscopic multiple resections of the mucosa of the proximal stomach (around 3 to 4cm below GOJ). The plication is performed in those resected areas using an endoscopic suturing device.

This procedure can also be performed with other endoscopic procedures including bariatric procedures and also can be done on a patient with modified stomach anatomy from gastric bypass or sleeve (bariatric) surgeries.

Please advise us on the best fit ACHI procedure codes for endoscopic RAP for reflux. Example procedure report included.

Response: The procedure codes assigned are determined by the individual operation record. For the scenario provided these are the operation components of:

1. the anatomical areas where mucosal resection occurred,
2. the anatomical areas where the plication repair occurred and
3. whether the procedure was post bariatric surgery.

For the scenario provided, code:

Resection/- Mucosa, endoscopic/- Oesophagus
90297-00 [861] Endoscopic mucosal resection of oesophagus
Resection/- Mucosa, endoscopic/- Stomach
90297-01 [880] Endoscopic mucosal resection of stomach.
Procedure/- Oesophagus NEC/- Other/unspecified
90301-00 [869] Other procedures on oesophagus
Repair/- Stomach/- NEC
90305-00 [887] Other procedure on stomach

Query ID 02-0923 Gender affirmation surgery and other second stage procedures

Query: The query sought advice regarding the correct Principal Diagnosis for second stage procedures for Gender affirmation surgery and other second stage procedures.

Current practice is predominantly using the directions of NCA Q3527 and coding:
Z41.1 Other plastic surgery for unacceptable cosmetic appearance
F64 Gender incongruence

However, for second stage procedures there is significant indecision as to whether a code from block Z42 should be used.

Response: **Z41.1 Other plastic surgery for unacceptable cosmetic appearance** should be assigned for second stage procedures for gender affirmation surgery. NCA Q3527 is applicable to second stage procedures. In the given scenario **F64 Gender incongruence** would be assigned as an associated diagnosis.

Surgeries for a reason other than the cosmetic appearance should be based on the documentation for that surgery. For example, if an operation report provided the indication of a subsequent procedure as a correction of a chordae, the chordae should be the Principal Diagnosis for that subsequent operation.

Query ID 05-0923 Reactive Airways Disease triggered by other acute respiratory condition

Query: In the paediatric setting we see documentation of the acute respiratory condition 'triggering' the RAD (E.g., a viral URTI) but the only management/treatment provided whilst an inpatient is specifically for the RAD, such as salbutamol stretching or NIV, as the viral illness may have resolved before admission and/or there is no treatment indicated for same.

Reactive Airways Disease [RAD] is now indexed in ICD-10-AM. However, the pathway *disease/- reactive airway(s) NEC/- with/- acute respiratory condition -see condition* instructs the coder to code the acute respiratory condition, and therefore **J98.8 Other specified respiratory disorders** is not assigned.

Response: (1) The Alphabetic Index needs to be followed based on the clinical documentation and (2) coding documentation queries should be raised if there is conflicting clinical information. Documentation should be clarified, such as if the documented acute respiratory condition 'triggering' the RAD (the viral URTI from the example) is a current condition. If the query confirms that the underlying condition is a current condition, the index needs to be followed even if the current condition (the viral UTRI from the example) itself not being treated.

Of note, a public submission has been made to IHACPA to review the classification of RAD, and as a part of previous submissions, the coding of RAD is indicated for review by IHACPA in future classification editions.

For the scenario provided, follow the index to assign the following codes:

> *Disease/- reactive airway(s) NEC/- with/- acute respiratory condition -see condition;*
> *Infection/- respiratory/- upper/- viral NEC*
> **J06.9 Acute upper respiratory infection, unspecified.**

Query ID 06-0923 Developmental and Epileptic Encephalopathy (DEE)

Query: We are seeking advice on the correct code/s for Developmental Epileptic Encephalopathy (DEE). This condition is not indexed under encephalopathy or epilepsy in ICD-10-AM 12th Edition. As there is currently no single code that fully identifies DEE, we have been assigning **G43.9 Encephalopathy, other/unspecified** with **G40.8- Epilepsy, other, with/without intractable epilepsy**. Sequencing is determined case by case according to the clinical documentation and ACS 0001.

Can you please advise the best code/s to describe DEE.

Response: Both the epilepsy and the encephalopathy should be coded, sequenced as per ACS 0001, referring to the documentation for each episode of care.

The specific type of epilepsy should be assigned if known, following the alphabetic index. The cause of the epilepsy should be coded if documented.

Epilepsy coded from documentation of DEE without further specification follows the pathway:

Epilepsy/- specified type NEC
G40.8- Other epilepsy

Encephalopathy coded from documentation of DEE without further specification follows the pathway:

Encephalopathy
G93.4 Encephalopathy, unspecified

07-0923 Ovarian Platelet Rich Fibrin (PRP) for infertility

Query: What ACHI code is assigned for administration of platelet rich plasma into the ovary? We are starting to see increased admissions for ovarian PRP via laparoscopy with an infertility diagnosis.

(1) Following the alphabetic index: *Administration/- type of agent/- plasma/- platelet rich*, there are two subterms listed – *joint* and *wound dressing*. There is no subterm for "ovary" or for the administration of PRP not otherwise specified/not elsewhere classified.

(2) Following the alphabetic index: *Administration/- type of agent/- blood (products)/- plasma (FFP) (fresh frozen)* classifies to **92062-00 [1893] Administration of other serum**. This code is also used for transfusions of plasma. In our query, the PRP is administered via laparoscopy and not via transfusion. We are uncertain whether a code from block 1893 is correct.

(3) It is noted where patients are admitted for administration of poppy seed oil (Lipiodol) to treat infertility, the alphabetic index: *Administration/- type of agent/- poppy seed oil (Lipiodol)/- with any other gynaecological procedure – code specific procedure(s) performed,* provides classification guidance to only code the documented specific procedures(s) e.g., laparoscopy.

(4) Please could CCAQ advise which ACHI code (if any) is the best fit or Ovarian PRP administered via laparoscopy?

Response: (1) Regarding the subterms listed under *Administration/- type of agent/- plasma/- platelet rich*, please refer to the note under the *Administration* look up in the ACHI alphabetic index:

Terms listed under the lead term 'Administration' are split by three main subterms; Administration/indication, Administration/specified site and Administration/type of agent.

It is noted that both subterms under the pathway *Administration/- type of agent/- plasma/- platelet rich* lead to intervention codes NOT in the subterm group for the type of agent. *Dressing, wound* leads to **96255-00 [1601] Wound management NEC**, and *joint* leads to **50124-01 [1552] Administration of agent into joint or other synovial cavity, NEC**.

The most specific type of intervention by the type of agent for PRP is "plasma". The alphabetic index should be followed to determine which of the three subterm groups an *Administration* intervention is coded to.

(2) Regarding the use of codes from block 1893 for interventions that are not transfusions, CCAQ refers to *Conventions used in the ACHI Tabular List,* which states:

"Inclusion terms are not exhaustive. NEVER code directly from the ACHI Tabular List. Reference first the ACHI Alphabetic Index, as it contains many more clinical concepts than the ACHI Tabular List."

Where the alphabetic index leads to block 1893 for an intervention that is not a transfusion, and there are no instructional notes preventing the assignment of that code, a code from block 1893 should be used.

This applies to the path:

Administration/- type of agent/- blood (products)/- plasma (FFP) (fresh frozen)
92062-00 [1893] Administration of other serum.

The alphabetic index also leads to block 1893 through the path:

Administration/- type of agent/- plasma
92062-00 [1893] Administration of other serum

(3) The ACHI alphabetic index has different instructions for coding the administration of poppy seed oil and coding the administration of blood products, even though both treatments may be used for infertility. This is congruent with ACS 0302, which instructs:
"The administration of blood and blood products is coded whenever performed..."

The instructional notes of the index should be followed for coding the administration of poppy seed oil: *Administration/- type of agent/- poppy seed oil (Lipiodol)/- with any other gynaecological procedure – code specific procedure(s) performed.*

(4) For the scenario provided, follow the index to assign the following procedure codes:

Laparoscopy (diagnostic) (exploratory)
30390-00 [984] Laparoscopy
Administration/- type of agent/- blood (products)/- plasma (FFP) (fresh frozen)
92062-00 [1893] Administration of other serum

CCAQ notes that there is currently a Coding Query submitted to IHACPA using the same example use of PRP.

July 2023

Query ID 01-0723: Clarification of ACS 0933 *Cardiac catheterisation and coronary angiography*

Query: ACS 0933 *Cardiac catheterisation and coronary angiography* states 'Assign additional codes if ventriculography, aortography or coronary artery blood flow measurement (e.g., fractional flow reserve (FFR), instant wave-free ratio (iFR)) is performed in conjunction with cardiac catheterisation and coronary angiogram".

I seek to clarify the following:
1. From this statement, is this instructing that only when cardiac catheterisation and coronary angiography are performed in the same operative sitting are we allowed to assign procedure codes for aortography, ventriculography and coronary artery blood flow measurements when they are undertaken as well?

This is compounded by the fact that when following the 3M Codefinder pathway for heart catheterisation alone (avoiding the option to code alongside coronary angiography) you will be prompted by a 'code also performed' screen which eludes that these three procedures can be assigned with heart catheterisation alone.

2. Does this statement also pertain to percutaneous cardiac procedures performed via cardiac catheterisation such as transcatheter aortic valve implantation (TAVI), transcatheter valvuloplasty (PBAV, MitraClip, TriClip) and Left Atrial Appendage (LAA) occlusion - all of which the procedure code contains the includes note of "cardiac catheterisation" but are not as likely to be performed in conjunction with coronary angiography?

Example: TAVI performed with aortography.

Response: CCAQ advise that ACHI codes for aortography, ventriculography and coronary artery blood flow measurement may be assigned when performed with cardiac catheterisation and/or coronary angiography.

Additionally, ACHI codes may be assigned for aortography, ventriculography and coronary artery blood flow measurement when performed in conjunction with percutaneous cardiac interventions via cardiac catheterisation such as transcatheter aortic valve implantation (TAVI) and transcatheter valvuloplasty.

In the example provided, for a TAVI performed with aortography, assign ACHI codes 38488-08 [623] *Percutaneous replacement of aortic valve with bioprosthesis* and 59903-03 [1990] *Aortography.*

Query ID 02-0723: Insertion of temporary pacing wires during transcatheter cardiac interventions

Query: It has been noted on operation reports for predominantly transcatheter aortic valve implantations (TAVI) and sometimes percutaneous coronary interventions (PCI) that a temporary pacing wire (TPW) will be inserted intra-operatively.

Codes 38256-00 [647] *Insertion of temporary transvenous electrode into atrium* and 38256-01 [647] *Insertion of temporary transvenous electrode into ventricle* contain the Excludes note instructing coders "that performed in conjunction with cardiac surgery - omit code" alongside ACS 0936 *Cardiac pacemakers and implanted defibrillators* which mentions "When the insertion of temporary pacemaker or defibrillator electrode (pacing wires) is performed in conjunction with cardiac surgery - do not code".

This instruction seems to rely on the definition of "cardiac surgery" and whether transcatheter/percutaneous cardiac procedures are included in this term or if this note is solely referring to open cardiac procedures.

I seek to clarify the following:
1. Should the Excludes note on the Insertion of TPW codes be applicable when the insertion is performed in conjunction with transcatheter cardiac interventions?

2. If confirmed, are transcatheter cardiac interventions to be included in the definition of "cardiac surgery"? Noting that this Excludes note is also present on other cardiac interventions such as cardioversion.

Response: CCAQ advise that where temporary pacing wires are inserted during a transcatheter cardiac intervention, the 'excludes' note at block [647] *Insertion of temporary transvenous electrode for cardiac pacemaker or defibrillator* should be followed and an ACHI code not assigned.

For the purpose of applying ACS 0936 *Cardiac pacemakers and implanted defibrillators* and the excludes note "that performed in conjunction with cardiac surgery - omit code" at block [647], CCAQ advise that transcatheter cardiac interventions can be considered to be cardiac surgery.

Query ID 03-0723: Aortic valve replacement (AVR) specificity when performed with thoracic aorta surgery

Query: As of current, Clinical Coders are directed via the pathways to assign a procedure code from blocks [684] *Repair of ascending thoracic aorta*, [685] *Repair of aortic arch and ascending thoracic aorta*, [687] *Replacement of ascending thoracic aorta*, and [688] *Replacement of aortic arch and ascending thoracic aorta* when coding an aortic valve replacement performed in conjunction with a repair/replacement of the thoracic aorta.

However, we have found in the assignment of this one code we are losing the specificity of the type of valve prosthesis being implanted, which is reflected in codes from block [623] *Replacement of aortic valve*.

I seek to clarify if it is acceptable to assign an additional procedure code to adequately reflect the type of valve replacement prosthesis (i.e., mechanical, bioprosthetic, homograft) utilized during an aortic surgery where the aortic valve is being replaced in conjunction with a repair/replacement of the thoracic aorta.

Response: When an aortic valve replacement is performed in conjunction with a repair or replacement of the thoracic aorta, assign one code only for the repair and replacement following the appropriate terms in the ACHI index at Repair/aorta or Replacement/aorta. Do not assign an additional procedure code from block [623] to specify the valve prosthesis type. Other systems, such as surgical prosthesis or billing systems may be utilised to determine the valve type if required.

Query ID 04-0723: Classification of septal myomectomy

Query: Mayo Clinic defines a septal myomectomy or myectomy (both terms have documented on operation reports) as an open-heart procedure in which the surgeon removes part of the thickened, overgrown septum between the ventricles.

The indication for septal myomectomy is often documented as hypertrophic cardiomyopathy (HCM) or hypertrophic obstructive cardiomyopathy.

We had received prior in-house instruction to assign 38748-00 [616] *Ventricular septectomy* when septal myomectomy is performed on the basis that it is in the fact the tissue of the septum which is being excised.

However, there has been debate as to whether it is correct to assign 38748-00 [616] *Ventricular septectomy* or assign a code via the pathway of Myectomy/cardiac/ventricle which brings you to 38763-00 [610] *Left ventricular myectomy* or 38763-01 [610] *Right ventricular myectomy* depending on which laterality has been operated on.

Since the term myomectomy contains the singular pathway option for uterine myomectomy, and there is a recent prevalence of this procedure being called a septal 'myectomy' instead, I seek clarification on the correct procedure code to be assigned when a septal myo/myectomy has been performed.

Response: CCAQ will seek advice from IHACPA on ACHI code assignment when a septal myomectomy or myectomy is performed. In the interim, CCAQ advise facilities to continue with their current practice, seeking clinical clarification on specific procedures performed where required, in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines*.

Query ID 05-0723: Percutaneous tricuspid valve repair performed with other percutaneous cardiac intervention

Query: As per CCAQ Query ID 04-1022: Percutaneous tricuspid valve repair with MitraClip it was advised to assign either 38480-02 [632] *Repair of tricuspid valve, 1 leaflet* or 38481-02 [632] *Repair of tricuspid valve, 2 or more leaflets* (depending on operation report documentation) in conjunction with 38200-00 [667] *Right heart catheterisation* to reflect percutaneous repairs of the tricuspid valve utilising the MitraClip closure device.

With the commencement of percutaneous tricuspid valve repairs (or TriClip as we've seen them termed recently), it's been noted that these procedures are often being performed alongside other percutaneous cardiac interventions, namely repairs of the mitral valve (MitraClip).

Therefore it has come into question whether 38200-00 [632] *Right heart catheterisation* is required to be assigned in the above scenario as the percutaneous nature is already present in the assignment of 96222-00 [626] *Percutaneous mitral valvuloplasty using closure device* (of which contains cardiac catheterisation in the Includes note).

Furthermore, the addition/omission of the heart catheterisation code results in a notable DRG change.

Can you please confirm based on the advice provided in CCAQ Query ID 04-1022, if a percutaneous tricuspid valve repair is performed in the same operative sitting as another percutaneous cardiac intervention (the code of which containing the Includes note detailing cardiac catheterisation) should 38200-00 [667] *Right heart catheterisation* be assigned as an additional procedure?

Response: The advice to assign additional code 38200-00 [667] *Right heart catheterisation* for a percutaneous tricuspid valve repair in CCAQ Query 04-1022 *Percutaneous tricuspid valve repair with MitraClip* was provided to allow a facility to differentiate between open and percutaneous tricuspid repairs in the absence of a percutaneous tricuspid repair code.

Where both a percutaneous tricuspid valve repair and percutaneous mitral valve repair is performed, an additional code to describe the percutaneous approach (38200-00 [667] *Right heart catheterisation)* is not required, as this concept is included in 96222-00 [626] *Percutaneous mitral valvuloplasty using closure device.*

Query ID 06-0723: Coding of lymph node metastasis from histology report

Query: By sampling or excising lymph nodes during a procedure such as a hysterectomy or colectomy, can a code be assigned for a lymph node metastasis from the histology report? ACS 0010 *Clinical documentation and general abstraction guidelines* states lab results

should be coded where they clearly add specificity to an already documented condition that meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Example: Indication for surgery 'ovarian mass'. Surgery performed was total abdominal hysterectomy/bilateral salpingo-oophorectomy (TAH/BSO) with radical excision of lymph nodes. No mention in the body of operation report that macroscopic metastasis of lymph node is evident. No discharge summary for episode. Clinician entry in progress notes post-surgery details patient progress post procedure but does not outline findings. Histology report states ovarian carcinoma with regional lymph node metastasis.

Can C77.5 *Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes* be assigned if not documented by the clinician or lymph node removal indicates (albeit undocumented) that the surgeon is assessing metastasis of the ovarian lesion therefore according to ACS 0010 the lymph node mets provide greater specificity about the documented ovarian mass/carcinoma?

Response: CCAQ advise that where a procedure such as a hysterectomy or colectomy is performed with radical excision of lymph nodes, an ICD-10-AM code may be assigned for lymph node metastases when documented on the histopathology report alone.

In the example provided, the 'ovarian mass' was confirmed on histology as ovarian carcinoma and the associated excised lymph nodes were reported as lymph node metastasis. Assigning both C56 *Malignant neoplasm of ovary* and C77.5 *Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes* fully describes the episode of care.

June 2023

Query ID 01-0623: Coding tobacco/nicotine dependence and withdrawal from smoking cessation pathways

Query: 1. Can we please confirm if tobacco/nicotine dependence and withdrawal can be coded from the smoking cessation pathway alone? E.g., tobacco/nicotine dependence/withdrawal documented on pathway but patient only documented as a current smoker within the progress notes, with no documentation of withdrawal.

2. If we are able to code dependence and withdrawal from this pathway can we please confirm what we do in cases where we might have differing documentation within the clinical record – e.g. clinicians have documented nicotine dependence or withdrawal in the progress notes but patient is not reported as nicotine dependent or experiencing withdrawal on the clinical pathway.

Response: CCAQ advise that where a smoking cessation pathway has been completed by a clinician, documentation on the pathway may be used to assign a code for tobacco/nicotine dependence and withdrawal.

Where documentation on the pathway differs to that in the clinical record (such as in the progress notes), CCAQ recommend assigning a code for the more specific condition. E.g., documentation of nicotine dependence or withdrawal in the progress notes but patient is not reported on the pathway as being nicotine dependent or experiencing withdrawal, assign a code for nicotine dependence/withdrawal. Where there is conflicting documentation, such as 'nicotine dependent' on the pathway and 'not nicotine dependent' in the progress notes, seek further clinical clarification as per ACS 0010 *Clinical documentation and general abstraction guidelines.*

Query ID 02-0623: Urinary incontinence

Query: Situation – assignment of additional diagnosis R32 *Unspecified urinary incontinence* in patients admitted for the management of acute ischemic stroke.

Background
Let us consider a patient admitted for the management of acute ischemic stroke.
Patient was previously completely independent with activities of daily living including being independent with toileting and urinary/faecal continent.
After the acute onset of ischemic stroke the patient was found to have acute onset urinary incontinence requiring nursing staff to assist with use of incontinence aids and/or frequent changes of bed linen.
Note that there was no consultation or requirement for any other diagnostic/interventional procedure to manage urinary incontinence.

Note that these patients often have other deficits from the stroke such as (not limited to) hemiplegia, ataxia and cognitive disturbances and may often require additional assistance for application of incontinence aids and/or change bed linen.

If documented as 'Acute urinary incontinence' and requiring nursing staff to apply incontinence aids and/or change bed linen, does the condition meet ACS 0002 standards to be coded as an additional diagnosis of R32 - Unspecified urinary incontinence?

Or is the use of incontinence aids and/or frequent changes of bed linen (in a patient with other manifestations of stroke) considered 'General Nursing Care' and does not meet ACS 0002 standards?

Response: In the scenario provided, CCAQ consider the management of urinary incontinence (the use of incontinence aids and/or frequent changes of bed linen) to be general nursing care, therefore not meeting the criteria in ACS 0002 *Additional diagnoses.*

Query ID 03-0623: Diagnosis codes for encrusted ureteric stents

Query: 1. Can we please confirm the diagnosis codes for an encrusted ureteric stent?
Code options:
A)
T83.89 *Other specified complications of genitourinary devices, implants and grafts*
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.2- *Place of occurrence*
B)
T83.89 *Other specified complications of genitourinary devices, implants and grafts*
N20.1 *Calculus of ureter*
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.2- *Place of occurrence*
C)
N20.1 *Calculus of ureter*
Z96.0 *Presence of urogenital implants*

Example of operation report:
Indication
- Stented November after bilateral URS
- Stents attempted removal 13/2/23 - heavily encrusted
Findings
- Bilateral ureteric stents in situ
- Heavy encrustation bilaterally
- Left URS - lasered stone off stent, cleared all stent from collecting system
- Right URS - lasered stone off but stent split in two and unable to retrieve remnant coil despite extensive attempts
- Bilateral stents replaced

Details of procedure
GA
Ceftriaxone ampicillin
Rigid cystoscopy
Left stent grasped and taken to meatus
Wired left collecting system
Rigid URS, lasertripsy to stone encrusted onto stent, small damage to stent, pulled stent and it ripped
Removed remnant stent with triaxial
Wire in situ
Removed distal coil right stent
Lasered encrusted upper coil, small bit of damage and split when attempted to remove
Unable to access remnant coil, attempted with access sheath/flexi however poor vision
Concern over duration of procedure
Stented right kidney then left with 6fr firm
Bladder emptied

Response: CCAQ advise that encrustation of a ureteric stent would be considered a complication of the device. Assign T83.89 *Other specified complications of genitourinary devices, implants and grafts* following the index Complication(s)/genitourinary NEC/device, implant or graft/specified NEC. Assign appropriate external cause codes.

Query ID 04-0623: Procedure code and DRG for PEARS procedure

Query: We are seeking advice for a suitable ACHI procedure code for the Personalised External Aortic Root Support (PEARS) procedure. Currently we are using the same ACHI procedure code for normal aortic procedures and PEARs procedures however they are completely different procedures. Through consultation with other facilities, the ACHI code that we are currently using along with other facilities for coding the PEARS procedure is 38559-00 [685] *Repair of aortic arch and ascending thoracic aorta*. Attached are relevant reference sources and a IHACPA Public Submission that has already been sent from another facility.

Can you please confirm if 38559-00 [685] *Repair of aortic arch and ascending thoracic aorta* is the best fit ACHI procedure code?

Response: CCAQ agree that 38559-00 [685] *Repair of aortic arch and ascending thoracic aorta* is the best fit ACHI code for the Personalised External Aortic Root Support (PEARS) procedure.

Query ID 05-0623: Squamous ductal eccrine carcinoma

Query: What morphology code is assigned for a squamoid ductal eccrine carcinoma excised from the temple (skin)?

Response: CCAQ sought advice from Cancer Alliance Queensland and referenced ICD-O-3.2 for the correct morphology for a squamoid ductal eccrine carcinoma. Assign morphology code M8560/3 *Adenosquamous carcinoma* following the ICD-10-AM index Carcinoma/adenosquamous.

Query ID 06-0623: Platelet rich fibrin (PRF)

Query: We are starting to see increased documentation of platelet rich fibrin application during dental surgery e.g. "surgical removal of all molars, PRF in sockets".

Looking up: Administration/specified site or Administration/type of agent/fibrin does not have an available subterm reflective of dental surgery.

Looking up: Administration/indication/dental procedures classifies to 97927-00 Provision of medication/medicament for dental procedure located in block [485] Dental drug therapy.

As platelet rich fibrin is produced from your own blood, we are not certain that 97927-00 [485] is reflective of PRF application?

Some coders feel that 14203-01 [1906] Direct living tissue implantation is more appropriate.

Please could CCAQ advise on what they believe is the correct ACHI code to assign for platelet rich fibrin applied during dental surgery?

Response: CCAQ advise that for platelet rich fibrin applied during dental surgery, assign 97927-00 [485] *Provision of medication/medicament for dental procedure* following the index Administration/indication/dental procedure.

May 2023

Query ID 01-0523: Lumbar discogenic pain

Query: We seek clarification on the appropriate diagnosis code to assign for lumbar discogenic pain as the indication for spinal fusion.

Scenario: L4/5 discogenic pain is the documented indication for L4/5 posterior lumbar interbody fusion.

Should lumbar discogenic pain be coded to:
M54.5 *Low back pain*, following lead term 'Pain' / sub-term 'back' / sub-term 'low'
Or
M51.2 *Other specified intervertebral disc displacement*, following lead term 'Disease', then sub-term 'discogenic'.

Is 'low' considered to be synonymous with 'lumbar' in this context?

If so, should excludes note at M54.5 be followed with M51.2 assigned?

Response: CCAQ advise that for lumbar discogenic pain, assign M54.5 *Low back pain* following the index Pain/back/low or Pain/lumbar region.

The diagnostic term provided was lumbar discogenic *pain*, therefore lead term ‘pain’ should be used, rather than lead term ‘disease’.

The excludes note at M54.5 is not followed as there was no documentation of pain due to intervertebral disc displacement.

Query ID 02-0523: Intracardiac echocardiography (ICE)

Query: What procedure code is assigned for intracardiac echocardiography (ICE)?

Similar to intravascular ultrasound, intracardiac echocardiography (ICE) uses a catheter that has an ultrasound probe on the tip. The catheter is inserted intravascularly, usually via the femoral vein or brachial vein, and gently moved to the heart and placed inside of the heart chambers (atrium and can be advanced into ventricle). Intracardiac echocardiography (ICE) provides real-time visualization of cardiac structures during intracardiac procedures such as electrophysiological study and ablation or any other intracardiac catheterization interventions.

Currently, we do not have an ACHI code for intracardiac echocardiography or ultrasound. ACHI, however, provides us with a procedure code for an intravenous ultrasound. This

procedure is listed as an exemption in ACS 0042 *Procedures normally not coded*, classification point 11. Imaging services.

Would CCAQ please consider providing advice on the procedure code for intracardiac echocardiography (ICE)?

Response: CCAQ advise that for intracardiac echocardiography (ICE), assign 96272-00 [1949] *Intravascular ultrasound [IVUS]* following the ACHI index Ultrasound/intravascular.

Query ID 03-0523: Arginine glucagon stimulation test (AGST)

Query: We are seeking clarification on an ACHI code for an arginine glucagon stimulation test [documented as AGST] generally performed to investigate short stature or to diagnose growth hormone deficiency.

Clinical advice confirms that arginine is administered then bloods collected to assess the function of the pituitary gland.

We note similar tests, short Synacthen test [SST] and adrenocorticotropic hormone (ACTH) stimulation test are assigned ACHI code 30097-00 [1858], however both these tests are specifically indexed:
Test/adrenocorticotropic hormone stimulation and Test/synacthen (tetracosactrin) stimulation.

Previous local advice had been given to our coding team to code to 13839-00 [1858] *Collection of blood for diagnostic purposes* however it is felt that this is not a true representation of the test as it involves more than simply taking a blood sample. We have been unable to find any advice from other states coding committees or national advice on this question.

In the interim pending CCAQ response, recommendation is to code to 92204-00 [1866] *Diagnostic tests, measures or investigations, NEC* following pathway Test NEC or Investigation NEC.

Can CCAQ please confirm the most appropriate ACHI code to capture an arginine glucagon stimulation test?

Response: CCAQ advise that for an arginine glucagon stimulation test, assign 92204-00 [1866] following the ACHI index Test NEC, where the procedure meets the guidelines in ACS 0042 *Procedures normally not coded*.

Refer also to Coding Rule Q3701 *Clonidine and saline suppression tests*, where guidance is provided on coding these similar tests.

Query ID 04-0523: Morel-Lavallee lesion

Query: How do we classify a Morel-Lavallee lesion of the thigh (a traumatic injury without an open wound)?

Admitted with documentation of an infected Morel-Lavallee lesion L thigh.

Procedure performed: washout and debridement of Morel-Lavallee lesion with infected looking seroma. Vacuum suction stapled to skin.

It would be great to have some CCAQ advice on this as it is more complicated than just a thigh haematoma.

Can we add codes for S76.4 injury to fascia and S75.9 for the closed degloving injury and/or T79.8 Other early complications of trauma?

Response: A Morel-Lavallee Lesion (MLL) is a closed traumatic soft tissue degloving injury characterized by separation of the dermis from the underlying fascia due to a shearing force (https://www.orthobullets.com/trauma/422820/morel-lavallee-lesion).

CCAQ advise that a Morel-Lavallee lesion should be coded as a closed degloving injury. For a Morel-Lavallee lesion of the thigh, assign S75.9 *Injury of unspecified blood vessel at hip and thigh level* following the index Injury/blood vessel NEC/thigh, along with the appropriate external cause codes. Refer also to ACS 1914 *Degloving injury*.

For an infected Morel-Lavallee lesion, assign T79.3 *Post traumatic wound infection, not elsewhere classified* as an additional code (code first the site of injury), following the index Infection/post traumatic NEC.

Query ID 05-0523: Starvation ketosis

Query: How do we classify documentation of starvation ketosis when it is clear that the starvation ketosis is due to nil dietary intake over a period of days?

Do we assign an additional code to identify the cause of ketosis as per the 'use additional external cause code' instruction at block E88?

Or do we assign an additional code to capture the limited dietary intake?
Index look up: Inadequate, diet E63.1 *Imbalance of constituents of food intake*.

Response: CCAQ advise that for starvation ketosis, assign E88.8 *Other specified metabolic disorders* following the index Ketosis NEC. An additional external cause code may be assigned where supported by the documentation, following the 'use additional external cause code' instruction at E88.

April 2023

Query ID 01-0423: Pathological and insufficiency fractures with dislocation and open wound

Query:

Coding scenario: A 73-year-old patient presented following an intoxicated fall at home sustaining a compound tri-malleolar fracture with ankle dislocation. Patient admitted under Orthopaedics and Plastics for an ankle ORIF and a non-innervated free ALT flap for the open wound. Orthopaedics document and treat the fracture as an insufficiency fracture with no documentation of osteoporosis.

Diagnostic Coding Assigned:

M84.47 *Pathological fracture, not elsewhere classified, ankle and foot*

M24.37 *Pathological dislocation and subluxation of joint, not elsewhere classified, ankle and foot*

External cause codes

Procedural codes

The problem is the pathological fracture M code means we can't capture the patient's injury in its totality & specificity i.e., the compound / open fracture component when following the classifications exclusion advice at the traumatic fracture S codes in Chapter 19:

Excludes: fracture:

- pathological:
    - NOS (M84.4)
    - with osteoporosis (M80.-)

In this scenario the patient required an ALT free flap for the open wound which indicates there was an open wound component though alternately in another patient with a similar fracture not requiring an ALT free flap then the open wound specificity is then lost in the coding when following the classification's directive.

1. Would CCAQ be able to provide further advice on the correct coding of these scenarios to capture these types of injuries in their totality and specificity given the classification doesn't appear to provide specific codes or an alternate option?

2. Would CCAQ consider the assignment of code M24.37 *Pathological dislocation and subluxation of joint, not elsewhere classified, ankle and foot* to be correct based on the documentation of ankle dislocation only with the pathological fracture code without "pathological dislocation" documented?

Response: CCAQ advise that for the scenario provided, the following diagnosis codes should be assigned to capture the insufficiency (pathological) fracture due to fall and the full extent of the injuries:

M84.47 *Pathological fracture, not elsewhere classified, ankle and foot*

S93.0 *Dislocation of ankle joint*
S91.82 *Open wound (of any part of ankle and foot) communicating with a dislocation*
External cause codes

S93.0 *Dislocation of ankle joint* is assigned rather than M24.37 *Pathological dislocation and subluxation of joint, not elsewhere classified, ankle and foot* as only the fracture was documented as pathological, not the dislocation.

S91.81 *Open wound (of any part of ankle and foot) communicating with a fracture* is not assigned due to the requirement for either S82.- or S92.- to be coded first, as per the instructional note at S91.81: '*Code first the fracture (S82.-, S92.-)*'. The compound nature of the injury is reflected in assignment of S91.82 *Open wound (of any part of ankle and foot) communicating with a dislocation.*

Note: assign the principal diagnosis in accordance with ACS 0001 *Principal diagnosis* and 1907 *Multiple injuries*.

March 2023

Query ID 01-0323: Mucosal membrane pressure injuries

Query: Can we please confirm the correct complication code to assign for mucosal membrane pressure injuries? Are they considered to be mechanical complications of devices by default, or should they be reflected as 'other' complications?

The includes notes for mechanical complication of device are:

- breakdown (mechanical)
- displacement
- leakage
- malposition
- mechanical obstruction
- perforation
- protrusion

From ACS 1221 *Pressure Injury*:

Mucosal membrane pressure injuries:

- are not classified to L89.- *Pressure injury* as they do not occur in skin and subcutaneous tissue. See Alphabetic Index: Ulcer/by site
- are complications of medical devices. See ACS 1904 *Procedural complications/Classification of procedural complications (Diagnosis codes)/Complications classified to T80-T88.*

Coding scenarios:

1. Mucosal membrane PI of penis due to IDC
2. Mucosal membrane PI of nose due to NGT
3. Mucosal membrane PI of lip due to ETT

Code options:

1. Mucosal membrane PI of penis due to IDC

T83.0 Mech comp of urinary catheter
N48.5 Ulcer of penis
Y84.6 Urinary catheterisation
Y92.2*

T83.89 Other complication of genitourinary devices implants and grafts
N48.5 Ulcer of penis
Y84.6 Urinary catheterisation
Y92.2*

2. Mucosal membrane PI of nose due to NGT

T85.5 Mech comp of gastrointestinal prosthetic device implant and graft
J34.0 Abscess / furuncle of nose (ulcer of nose)
Y84.8 Other medical procedures
Y92.2*

T85.82 Other comps following insertion of gastrointestinal prosthetic implant and graft
J34.0 Abscess / furuncle of nose
Y84.8 Other medical procedures
Y92.2*

3. Mucosal membrane PI of lip due to ETT

T85.61 Mech comp of resp prosthetic devices implants and grafts
K13.0 Diseases of lips (ulcer of lip)
Y84.8 Other medical procedures
Y92.2*

T85.88 Other comps of internal prosthetic implant and graft NEC
K13.0 Diseases of lips (ulcer of lip)
Y84.8 Other medical procedures
Y92.2*

Response: CCAQ advise that device related mucosal membrane pressure injuries should be classified as 'other/NEC' device complications, following the appropriate index pathway for the device type.

An additional diagnosis code from Chapters 1 to 18 can be assigned where it provides further specificity regarding the condition/complication (ACS 1904 *Procedural Complications*), following the Alphabetic index at Ulcer/by site (ACS 1221 *Pressure Injury*).

For the scenarios provided, assign the following codes:

1. Mucosal membrane pressure injury of penis due to IDC
T83.89 *Other specified complications of genitourinary devices, implants and grafts*
N48.5 *Ulcer of penis*
Y84.6 *Urinary catheterisation*
Y92.2- *Place of occurrence, health service area*

Index:
Complication(s)/urethral catheter (indwelling) NEC T83.89
Ulcer/penis (chronic) N48.5

2. Mucosal membrane pressure injury of nose due to NGT
T85.82 *Other complications following insertion of gastrointestinal prosthetic devices, implants and grafts*
J34.0 *Abscess, furuncle and carbuncle of nose*

Y84.8 *Other medical procedures*
Y92.2- *Place of occurrence, health service area*

Index:
Complication(s)/digestive/device, implant or graft NEC T85.82
Ulcer/nose, nasal (infective) (passage) (septum) J34.0

3. Mucosal membrane pressure injury of lip due to ETT
T85.88 *Other complications of internal prosthetic device, implant and graft, not elsewhere classified*
K13.0 *Diseases of lips*
Y84.8 *Other medical procedures*
Y92.2- *Place of occurrence, health service area*

Index:
Complication(s)/respiratory/device, implant or graft/specified NEC T85.88
Ulcer/lip K13.0

Query ID 02-0323: Mucograft

Query: We seek clarification on the appropriate ACHI code to assign for "Mucograft" applied during an oral and maxillofacial procedure.

Scenario: operation record documents "placement of mucograft with 3-0 gut suture" following removal of PTFE membrane and screw for wound dehiscence following dental implant placement and bone grafting to left and right maxilla.

The prosthesis label documents "Geistlich Mucograft, collagen matrix" which our research indicates is a type of synthetic graft.

Looking up graft/skin/synthetic classifies to 90672-00 [1640] - noting that the pathway graft/mucous membrane has a cross reference to see also graft/skin.

Should we be assigning ACHI code 90672-00 Synthetic skin graft when clinical notes document application of mucograft? If not, what ACHI code would you indicate is more appropriate?

https://clinicaltrials.gov/ct2/show/NCT01440426
https://www.geistlich.com.au/dental-professionals/products/matrices/mucograft/

Response: Mucograft® is a 3D collagen matrix designed specifically for soft tissue regeneration in the oral cavity (https://www.geistlich.com.au/dental-professionals/products/matrices/mucograft).

CCAQ advise that where Mucograft® is applied during an oral procedure, assign 97235-00 [456] *Gingival graft, per tooth, implant or extraction socket*, following the ACHI Index Graft/gingival, dental procedure.

Query ID 04-0323: Microneedling burn scar

Query: We would like to clarify the most appropriate ACHI code for 'microneedling' of scar (performed on both burn scars and keloid/hypertrophic etc).

This technique uses an electrical device to create hundreds of microchannels that penetrate skin layer followed by administration of a steroid; this increases the absorption of the steroid and changes the pathological scar collagen, improving dermal collagen production.

There is no direct pathway using lead term 'microneedling' or 'needling'. Current practice at our facility is to use lead term 'rollering,skin' to assign 90676-00.

We note on occasion the anaesthetic record documents 'revision of scar' however the inclusion terms at 45519-00 indicate this intervention is quite invasive and has a significant impact on DRG complexity. Other ACHI options are Administration/agent/scar 30207-00 (as steroid injected as component of intervention)

Could CCAQ members please provide advice on whether current coding practice using lead term 'Rollering' is appropriate or provide guidance as to the most appropriate ACHI intervention code to assign?

Response: CCAQ advise that for microneedling of a scar, assign 90676-00 [1660] *Other procedures on skin and subcutaneous tissue* following the ACHI Index Procedure/skin (subcutaneous tissue) NEC.

February 2023

Query ID 01-0223: Rheumatic heart disease

Query: We have patients who are identified as being on the Queensland Rheumatic Heart Disease Register and are opportunistically reviewed by the RHD nurse. An example of the notes is provided:

29 August 2022
Chart Review: RHD patient admission identified and cross-checked with QLD RHD Register and Control Program database.
Reason for this admission: Knuckle injury
RHD PMHx:
History of recurrent acute rheumatic fever 2009 and 2011.
Secondary prophylaxis with Bicillin started.
Reasonable adherence with same as per Qld RHD Register, but often under-reported.
Lase dose given 14/8/22
Last echo 21/7/2020 – rheumatic mitral valve with mild regurgitation.
RHD Care Plan:
Has a Priority 3 care plan with the RHD Register.
Requires echocardiograms every 2 years.
Overdue for next echo, due 21/7/2022
I will contact clinic for referral for cardiac outreach clinic, and f/u there.
I will see patient while admitted, plan for OT today noted.
Next Bicillin due 11/9/2022

30 August 2022
Patient visited on the ward. Introduced self and role – happy to talk.
Could be eligible to cease Bicillin injections if TTE remains stable. Explained same, will need new referral for cardiac outreach clinic. Patient happy for me to contact PHCC for cardiac outreach clinic.

Can this scenario be classified as increased clinical care under ACS 0002 *Additional diagnoses/Increased clinical care* which states "Increased clinical care under this criterion is evidenced by a clinical consultation (review) and a care plan to manage a condition within the episode of care. The care plan may include increased monitoring and/or observation (see Examples 11,12 & 13), confirmation to continue with an existing care plan (see Example 14)…".

Does the clinical consultation (review) in this case include an RHD nurse?
Does the continuation of a RHD care plan in this case follow Example 14 in ACS 0002?

Response: CCAQ members agreed that a rheumatic heart disease nurse is a clinician working within their scope of practice as defined in the ACS Glossary, therefore meeting the clinical consultation criterion in ACS 0002 Additional diagnoses/Increased clinical care.

CCAQ members however did not consider that the documentation in the example provided constituted continuation of a care plan to manage the condition within the episode of care, therefore not meeting the care plan criterion for increased clinical care in ACS 0002.

Query ID 02-0223: HeRO graft for haemodialysis

Query:
1. Can we please confirm the correct procedure code for insertion of a HeRO graft for haemodialysis? This seems to be a new procedure that we are starting to see at our facility.

2. Can we please confirm how to code complications of a HeRO graft for haemodialysis? i.e., should these be coded as a complication of an arteriovenous fistula (AVF) vs vascular dialysis catheter vs arterial graft?

From Google:
The HeRO Graft is a haemodialysis access graft for patients who are failing fistulas or grafts or are catheter-dependent due to the blockage of veins leading to the heart. It is documented as a "subcutaneous AV access solution" and it is a prosthetic graft but has no venous anastomosis.
https://www.merit.com/peripheral-intervention/access/renal-therapies-accessories/merit-hero-graft/

Code options:
Block: 765 Procedures for surgically created arteriovenous fistula

Is 34512-01 [765] *Construction of arteriovenous fistula with prosthesis* appropriate?

With regards to complication codes, would we code as complication of arteriovenous fistula? E.g., infection of HeRO graft – would this be coded to:

T82.76 *Infection and inflammatory reaction due to surgically created arteriovenous fistula and shunt*
OR
T82.77 *Infection and inflammatory reaction due to vascular dialysis catheter*
OR
T82.73 *Infection and inflammatory reaction due to other vascular grafts*

Response: A HeRo (Haemodialysis Reliable Outflow) graft is fully subcutaneous AV access solution for haemodialysis in patients with central venous stenosis. It comprises an ePTFE component anastomosed to the brachial (or other inflow) artery and an outflow catheter which enters the central venous circulation through the internal jugular vein, subclavian vein, or other vein that provides access into the central venous system. The distal tip of the catheter is positioned in the mid- to upper right atrium. The inflow and outflow components are joined by a titanium connector.
(https://www.uptodate.com/contents/arteriovenous-graft-creation-for-hemodialysis-and-its-complications?search=hero%20graft&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1).

CCAQ advise that for insertion of a HeRO graft for haemodialysis access, assign 34512-01 [765] *Construction of arteriovenous fistula with prosthesis* following the ACHI Index Formation (of)/arteriovenous fistula/with/prosthesis (Gore-Tex).

For complications of a HeRO graft, follow the ICD-10-AM Index at Complication(s)/arteriovenous fistula or shunt, surgically created and select the

appropriate sub term for the type of complication. In the example provided, for an infection of a HeRo graft, assign T82.76 *Infection and inflammatory reaction due to surgically created arteriovenous fistula and shunt.*

Query ID 03-0223: Documentation of adhesions from previous surgery

Query: We have clinicians who are documenting "adhesions from previous surgery" as their indication for division of adhesions.

ACS 1904 *Procedural complications/Overview dot point one* instructs the terms 'secondary to' or 'due to' infer a causal relationship in contrast to terms such as 'postop', 'following' or 'associated with'.

Audit feedback indicates documentation of 'from' such as 'adhesions from previous hernia repair' is inappropriate to classify as a procedural complication as per ACS 1904 dot point one and that a documentation query is required to confirm that adhesions are 'due to' or 'secondary to' previous surgery.

Looking up the alphabetic index of diseases "Complication(s)" it's noted that 'from' is listed as a non-essential modifier.

Could CCAQ please provide their advice on clinician use of terminology such as 'from' when classifying adhesions documented as from previous surgery?

Is a documentation query required for clarification or does CCAQ consider this documentation to be synonymous with due to/secondary to as per ACS 1904?

Response: CCAQ advises that 'from' infers a causal relationship, and that documentation of 'adhesions from previous surgery' is sufficient to meet the first dot point in ACS 1904 Procedural complications. A documentation query would not be required to confirm a causal relationship between the adhesions and previous surgery.

Query ID 05-0223: Condition onset flag for malnutrition

Query: What condition onset flag applies when a patient is admitted with 'inadequate energy and protein intake' and goes on to develop malnutrition several weeks after admission?

Initial review by dietitian: Inadequate protein and energy intake related to poor appetite and increased requirements secondary to liver cirrhosis as evidenced by patient reports, diet history, patient consuming <10% of EER + EPR.

Subsequent reviews by dietitian confirmed the patient was 'at risk'.

Review by dietitian 6 weeks into the admission: Moderate malnutrition and inadequate energy and protein intake related to poor appetite and increased requirements secondary

to liver cirrhosis as evidenced by patient reports, diet history, patient consuming <50% of EER+EPR.

Response: In the scenario provided, inadequate protein and energy intake was the initial problem (a patient with inadequate protein and energy intake may be at risk of developing malnutrition but does not necessarily have a diagnosis of malnutrition) and the patient went on to develop malnutrition during the episode of care. Therefore, CCAQ advise that for this example, a code for malnutrition should be assigned with a condition onset flag of 2 (not present on admission). Refer also to ACS 0048 *Condition onset flag.*

Query ID 06-0223: Botox tarsorrhaphy

Query: Could CCAQ please advise the appropriate ACHI code selection for a Botox tarsorrhaphy?
Patient with lower lid paralytic ectropion at risk for exposure keratopathy undergoes Botox tarsorrhaphy.

OP report excerpt:
RE UL Botox tarsorrhaphy
Verbal consent
Alcohol prep on skin
20 units of Botox injected into right Muller muscle complex
Globe not tethered
Expect onset of right ptosis over the next 3 days

Should we code only the Botox injection as a typical surgical (suture) tarsorrhaphy has not been performed?
Injection – Botox – eyelid 18370-03 [230]

Or do we need to follow ACHI index per documented term tarsorrhaphy?
Tarsorrhaphy 42584-00 [236]

Or do we code both?

Response: Tarsorrhaphy is a surgical procedure in which the eyelids are sutured together to protect the cornea (https://www.sciencedirect.com/topics/medicine-and-dentistry/tarsorrhaphy).

Botox tarsorrhaphy involves injection of Botox into the upper eyelid resulting in a protective ptosis (https://eyewiki.aao.org/Tarsorrhaphy).

CCAQ advise that for Botox tarsorrhaphy, assign only 18370-03 [230] *Administration of agent into eyelid* following the ACHI Index Administration/type of agent/botulinum toxin/eyelid.

Query ID 07-0223: Pre-admission information – ACS 0010

Query: Pre-admission clinics are routinely used in Queensland Health Services to collect clinical information of patients; with booked same day procedures; in the outpatient setting

prior to admission. Clinics aim to streamline clinical assessment on the day of procedure and to avoid cancellations due to health contraindications.

ACS 0010 "Abstraction in the current episode of care" refers to the 'episode of care' being the 'admitted episode of care' to be the primary source of information for coding.

Although pre-admission assessments are often filed within the current episode of care, this definition arguably excludes patient information collected in a pre-admission clinic and collected for the purpose of informing inpatient care.

"Abstraction from other sources of information", lists outpatient notes as a source of information that may be used in the stated circumstances, such as "multiple episodes within an admitted patient stay". The conditions listed under "multiple episodes" include tobacco use disorders, diabetes, and chronic conditions. These conditions are coded when documented and do not need to meet ACS 0002. Under the "current episode" rule, clinical assessment forms completed prior to admission, including conditions otherwise always coded when documented, would not be considered for coding.

Clarification is requested:
1. Are pre-admission assessment forms eligible to be used to code the conditions listed at the "multiple episodes within an admitted patient stay" scenario? Does this apply where there is only one episode of admitted patient stay following a pre-admission clinic?

2. Please advise the correct coding in this scenario:

50 yo female admitted for same day procedure for treatment of haemorrhoids.
Pre-admission assessment form includes PHx NIDDM, history of smoking – quit one year ago, and current treatment for depression.
PHx is consistent with GP referral and surgical OPD notes.
Day procedure operation report includes: Rectal haemorrhoids, banded, NAD
Anaesthetic report includes: ASA 2, sedation.

Response: CCAQ advise that preadmission forms may be used where they clarify ambiguous documentation, add further specificity to an already documented condition or to determine the reason for admission, as per ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information*.

For the scenario provided, assign the following codes:
K64.9 Haemorrhoids, unspecified
32135-00 [941] Rubber band ligation of haemorrhoids
92515-29 [1910] Sedation, ASA 29

Codes for NIDDM, smoking status and depression (supplementary code) are not assigned.

Query ID 08-0223: Primary source of information – ED notes

Query: ACS 0010 "Abstraction in the current episode of care" refers to the 'episode of care' being the 'admitted episode of care'. In Queensland, it is valid to admit patients to an emergency department or service (ED), noting the time of admission is deemed to be the time the clinician makes a decision that the patient should be admitted for their care, not

the time that the patient presented to the ED. (QHAPDC 2022/33 7.2 Admission Time). However, the preceding emergency presentation time would be the likely time that the patient history is documented.

"For classification purposes, primary sources of information are located within the current episode of care." The current episode of care appears to exclude a non-admitted emergency presentation preceding admission.

"Abstraction from other sources of information", lists ED notes as a source of information that may be used in the stated circumstances, such as "multiple episodes within an admitted patient stay". Listed conditions coded under this rule include tobacco use disorders, diabetes and chronic conditions, which are coded whenever documented (i.e., do not need to meet ACS 0002). Under the "current episode" rule, ED notes taken prior to admission, including conditions otherwise always coded when documented, would not be considered for coding.

Clarification is requested:
1. Are ED notes required to be from an admitted ED episode in order to code the conditions listed under the "multiple episodes within an admitted patient stay" scenario? Listed conditions include tobacco use disorders, diabetes and chronic conditions.

2. Are all ED notes eligible to be referred to in order the code the conditions listed under the "multiple episodes within an admitted patient stay" scenario? Does this apply where there is only one episode of admitted patient stay following the emergency department presentation?

Please advise the correct coding in this scenario:
60 yo male presented to ED with chest pain. Pt states the pain is like his angina pain.
PHx includes known stable angina, old MI, NIDDM, current smoker.
Pt stated he had spent all day moving furniture and thought he had overexerted muscles, however he was experiencing anxiety about chest pain as it was getting worse, and came to ED.

ED Clinical notes include:
15:00 TNR showed raised troponin levels
ECG showed reduced EF, baseline for this patient not known.
Plan: admit MEU, repeat TNR, monitor

MEU Clinical notes include:
15:30 Pt admitted to MEU with suspected unstable angina.
19:00 Repeat TNR showed no troponin increase. ECG normal. Discharge to follow up in community.

Response: CCAQ advise that emergency department notes (prior to a formal admission) may be used where they clarify ambiguous documentation, add further specificity to an already documented condition or to determine the reason for admission, as per ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information*.

Multiple episodes within an 'admitted patient stay' in ACS 0010 refers to multiple admitted episodes within an admitted patient stay, not to an emergency department presentation with a subsequent admission.

For the scenario provided, only I20.0 *Unstable angina* is coded. Codes for NIDDM and smoking status would not be assigned.

Query ID 09-0223: Therapeutic plasmapheresis

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

Response: Therapeutic plasmapheresis, also known as therapeutic plasma exchange, is a procedure that removes plasma from the blood and replaces it with donor plasma or another colloid solution such as albumin, FFP or cryoprecipitate. (https://litfl.com/apheresis-plasmapheresis-and-plasma-exchange/).

Therapeutic plasmapheresis should be coded as many times as performed within the episode of care, following the guidelines in ACS 0020 *Bilateral/multiple procedures/The same procedure repeated during the episode of care at different visits to theatre.*

Note: plasmapheresis is not one of the procedures listed as an exception under Multiple procedures/Classification point 1 in ACS 0020. Although a procedural component of plasmapheresis is the replacement of fluid with a substance such as donor plasma or albumin, plasmapheresis is not classified in ACHI as a blood transfusion therefore ACS 0302 *Blood transfusions* does not apply.

December 2022

Query ID 01-1222: Testing for COVID-19

Reviewed 04/2023 – ADVICE UPDATED (for clarification without change to code assignment)

Query: Should we be assigning ACHI code 96273-00 [1866] *Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2]* when clinical notes indicate that GeneXpert 4Plex swab is performed within admission time and clinical notes indicate negative or positive COVID-19 result?

GeneXpert 4Plex is a molecular test that simultaneously detects and differentiates SARS-CoV-2 (Covid-19 virus), influenza A (Flu A), influenza B (Flu B), and respiratory syncytial virus (RSV).

Response: GeneXpert 4Plex is a multiplex nucleic acid test that can be run in a laboratory or outside a laboratory (point of care) by trained people using specialised equipment (https://www.tga.gov.au/resources/covid-19-test-kits/xpert-xpress-cov-2flursv-plus).
GeneXpert 4Plex is used to detect COVID-19, influenza A and B and respiratory syncytial virus.

Where a GeneXpert 4Plex test is performed within the admission time, and there is documentation of testing for COVID-19, assign procedure code 96273-00 [1866] *Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2].*

Refer to the guidelines in ACS 0113 *Coronavirus disease 2019 (COVID-19)* and the advice in TN1601 Twelfth Edition FAQ: *Testing for severe acute respiratory syndrome coronavirus 2*:

"...do not assign 96273-00 [1866] Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] based on the presence of a test result alone; testing for COVID-19 must be specified in the clinical documentation within the current episode of care irrespective of the reason for the test."

Query ID 02-1222: Own ventilation machine – operator of device

Query: I'm writing to seek clinical advice on ACS 1006 *Ventilatory Support* and when a patient is using their own home device.

Our Coding Advice States "Do not code ventilation when the patient brings their own ventilatory support devices (e.g., CPAP machine) into hospital and the patient operates the device".

Often documentation is lacking about who is physically 'operating' the device.

There might be documentation stating that the treating team has directed a change in the non-invasive ventilation (NIV) settings/pressures, however we don't know who 'physically operated' the device when they bring in their own.

For example, a patient might present in decompensated respiratory failure and be on their own (home) NIV machine during their admission. Documentation states 'titrate NIV', or 'increase IPAP' or 'change/increased oxygen via pts own device'.

There is no documentation stating who physically changed the NIV settings/pressures.

Question 1:

Is it reasonable to assign a NIV procedure code for patients who are using their own NIV machine but have settings changed as directed by the clinical team in the documentation?

Or must we clarify who 'operated' the machine?

Question 2.

Can you clarify what it means to 'operate' the machine? Does it include adjusting settings?

Clinicians have advised the treating team will usually physically adjust the settings (push the buttons) on the patient's machine. But the patient will otherwise independently use the device.

Response: ACS 1006 *Ventilatory support/Classification point e.* states: Do not code ventilation when the patient brings their own ventilatory support devices (e.g., CPAP machine) into hospital and the patient operates the device.

Where documentation supports operation of the device by someone other than the patient (or their carer), assign a code for non-invasive ventilation. If it is unclear from the documentation who is operating the device, a clinical documentation query may be required to clarify the operator.

Query ID 03-1222: Voluntary Assisted Dying

Query: QCAEC have been asked to provide a response by DOH, SSB and various working groups on how to capture voluntary assisted dying (VAD) in coding when it is implemented in QLD in January 2023. There is an expectation that some of patients will choose VAD whilst in hospital or will specifically be admitted to hospital for VAD.

Currently, voluntary assisted dying is not covered under any classifications or standards for clinical coding. The QCAEC's view (awaiting CCAQ confirmation) is that coders will reflect the underlying disease, illness, or medical condition for which the person is accessing voluntary assisted dying however we are unable to provide specific coding for VAD.

Some examples and coding issues are listed below:

• Max is admitted to hospital for treatment of adenocarcinoma of the sigmoid colon with liver and lung metastases. While admitted, Max makes a first request for voluntary assisted dying. A first assessment for voluntary assisted dying is completed by Dr Smith, an oncologist with the healthcare facility. Would the coding only include the adenocarcinoma of the sigmoid colon with liver and lung metastases? There is currently no code available to indicate a VAD assessment has been completed.

• Linh has hypertensive congestive heart failure and kidney failure (CKD stage 5). She has been found eligible for voluntary assisted dying and has made a practitioner administration decision. Linh prefers to die in hospital. Linh is admitted to hospital for administration of the

voluntary assisted dying substance. Mr Brown, a nurse practitioner at the healthcare facility and authorised voluntary assisted dying practitioner, administers the VAD substance to Linh in the cardiology ward. There is currently no code available as a principal diagnosis or a procedure code for this scenario – would we just code the underlying medical reason for the VAD?

Coding and reporting issues and questions for VAD:

• There is no specific ICD-10-AM diagnosis or ACHI procedure code to identify and/or code for VAD patients i.e., no way to identify this cohort of patients in current coding practices for patients who decide during their stay or patients who are admitted specifically for this purpose.

• Is an acute care type (01) accurate for this type of patient – should there be a separate care type for VAD patients (who are solely admitted for this purpose)?

• What are other states/IHACPA doing? I spoke to HIMs from 4 different states and IHACPA representatives – they are not capturing this data at all, just coding underlying condition. They are relying on individual state VAD reporting systems.

• Is there a need for a "new" emergency use code in ICD-10-AM to identify this cohort of patients – if there was a specific code – if admission for VAD, then this could be used as the principal diagnosis or as an additional code if VAD was enacted during the stay (this would easily identify this cohort of patients). Speaking to IHACPA representatives at recent HIMAA Conference - no interest as very small numbers and these types of patients can be collected via other systems.

Evidently, our current coding practices are not able to identify VAD patients and their intervention. I would like CCAQ's view on this issue so that our State Educator can provide some guidance when VAD is introduced in January 2023.

Response:

Voluntary assisted dying in Queensland gives eligible people diagnosed with a life-limiting condition, who are suffering intolerably and dying, an additional end-of-life choice by allowing them to choose the timing and circumstances of their death.

It involves the administration of a substance prescribed by a medical practitioner, with the purpose of bringing about the person's death. It is instigated by the person's voluntary request and follows a process of requests and assessments (Queensland Voluntary Assisted Dying Handbook – Version 1.0).

The Queensland Voluntary Assisted Dying Handbook states "Coding should reflect the underlying disease, illness, or medical condition for which the person is accessing voluntary assisted dying".

The delivery of voluntary assisted dying in Queensland will be supported by the Queensland Voluntary Assisted Dying Information Management System (QVAD-IMS). The QVAD-IMS will enable data collection and reporting to support the functions of the VAD Review Board.

Voluntary assisted dying is an end-of-life choice and is distinct from palliative care (Queensland Voluntary Assisted Dying Handbook – Version 1.0), therefore a palliative care type may not be appropriate for an episode of care involving voluntary assisted dying.

The care type assigned to an episode of care will be the care type that best describes the primary clinical purpose or treatment goal. There may be more than one episode of care within the one hospital stay period (QHAPDC Manual 2022-2023 Collection Year v1.0).

Refer to the QHAPDC for definitions of the care types available for an admitted patient and assign the care type that best describes the primary clinical purpose or treatment goal.

For the scenarios in the query, assign the following codes:

Scenario 1 – A patient admitted for treatment of adenocarcinoma of the sigmoid colon with liver and lung metastases. While admitted, the patient makes a first request for voluntary assisted dying and a first assessment is completed by the doctor and documented in the progress notes.

Principal diagnosis

C18.7 *Malignant neoplasm of sigmoid colon*

M8140/3 *Adenocarcinoma NOS*

Additional diagnoses

C78.7 *Secondary malignant neoplasm of liver and intrahepatic bile duct*

C78.0 *Secondary malignant neoplasm of lung*

M8140/6 *Adenocarcinoma, metastatic NOS*

An intervention code for the VAD assessment is not assigned.

Scenario 2 – A patient admitted with hypertensive congestive heart failure and kidney failure (CKD stage 5). The patient has completed the request and assessment process and has made a practitioner administration decision. The patient prefers to die in hospital and is admitted for administration of the voluntary assisted dying substance.

Principal diagnosis

I13.2 *Hypertensive heart and kidney disease with both (congestive) heart failure and kidney failure*

An intervention code for administration of the VAD substance is not assigned.

Query ID 04-1222: Colonoscopy with ileoscopy

Query: Please advise if it is appropriate to assign ACHI procedure codes for both a long colonoscopy 32090-00 [905] *Fibreoptic colonoscopy to caecum* and an ileoscopy 30473-05 [1005] *Panendoscopy to ileum* in the below scenario.

A particular clinician documents on a colonoscopy report that the instrument was passed to the terminal ileum with normal ileoscopy to 7cms or ileoscopy to 7cms showing focal erosions to the approximately 3cms proximal to the ileo-caecal valve.

I feel this tends to be indicative of more than just viewing the ileum in a routine colonoscopy.

I note that the code 32090-00 *Fibreoptic colonoscopy to caecum* includes the viewing of the ileum, however this clinician indicates an ileoscopy.

I also note that the clinical descriptor of the code states panendoscopy to ileum, however the pathway does not indicate nor enforce choosing the route (as via panendoscopy appears to be a non-essential modifier). Please also note the addition of the ileoscopy will impact on the DRG if only a colonoscopic procedure is performed i.e., DRG G48B vs G46B.

Please advise if it is appropriate to code both procedure codes in these circumstances.

Response: ACS 0024 *Panendoscopy* states: "An endoscopy of the ileum (including ileal biopsy) can be performed via the upper gastrointestinal tract or the lower gastrointestinal tract". Examples 1 and 2 demonstrate procedure code assignment for panendoscopy of the upper and lower gastrointestinal tracts with viewing of the ileum.

CCAQ advise that where an endoscopy (or panendoscopy) of the lower gastrointestinal tract is performed with viewing of the ileum, assign 32090-00 [905] *Fibreoptic colonoscopy to caecum.*

Query ID 05-1222: Postoperative pain

Query: The query seeks guidance on coding assignment where there is documentation of postoperative pain. We are unclear on when post procedural pain meets ACS 0002 *Additional diagnoses* and 1904 *Procedural complications* before assigning the code T81.83 *Pain following a procedure, not elsewhere classified*. Therefore, we are conflicted on whether the post-procedural pain meets ACS 0002 in these scenarios and based on ACS 1904 *Procedural complications/Routine postoperative care* vs ACS 1904 *Procedural complications/Care beyond routine intra-operative/postoperative care*.

This patient had a total knee replacement. Post op day 2 in ICU, the doctor noted pain as an issue, with a care plan made for analgesia with Panadol, Palexia and femoral nerve block ropivacaine 10ml/hr and to be seen by another doctor post ward transfer. Progress notes on 26/01 by a Geriatrician noted that pain continued to be an issue and diagnosed pain post-surgery and to continue analgesia. Rehab assessment also noted to monitor pain and adjust meds in rehab. The patient has had multiple reviews from different clinicians all diagnosing pain with one clinician changing the pain management by prescribing Lyrica as per progress notes and Medication chart. Physiotherapy notes indicate slowly progressing limited by pain. Documentation query was sent and confirmed as due to due to surgery.

Can the committee advise if documentation of post-op pain in the above scenario meets both ACS 0002 *Additional diagnoses* and ACS 1904 *Procedural complications*?

Response: To determine if postoperative pain meets the criteria in ACS 0002 *Additional diagnoses* and ACS 1904 *Procedural complications* the documentation would need to support that the postoperative pain "significantly affect(ed) patient management in an episode of care" (by meeting the criteria in ACS 0002) and that the pain management provided to the patient was in excess of routine care in the intraoperative/postoperative period (as per ACS 1904), i.e., there was consultation/treatment by a clinician resulting in a change of management or the treatment for the pain delayed discharge.

Documentation regarding postoperative pain should be considered on a case-by-case basis, as pain management will vary based on individual factors relating to the patient, such as age and medical and physical condition, and the procedure performed.

Query ID 07-1222: Coronary PTCA of multiple vessels with single stent

Query: This query relates to the code assignment of the following scenarios and whether they are individually coded out per vascular intervention or bundled together into one code.

There is a loss of description of multiple vessel intervention (scenario 1) in following the "with stenting" pathway so seeking clarification with regards to ACS 0020 Bilateral/multiple procedures and other possibly relevant instruction in published advice.

Scenario 1: Percutaneous transluminal coronary angioplasty (PTCA) with a total of 4 POBA (plain old balloon angioplasty) into 3 arteries (proximal and mid LAD, proximal RCA and left circumflex) and 1 stent into a single artery (proximal LAD).

Code options:

38306-00 [671] Percutaneous insertion of 1 transluminal stent into single coronary artery

Or

38306-00 [671] Percutaneous insertion of 1 transluminal stent into single coronary artery with

38303-00 [670] Percutaneous transluminal balloon angioplasty of 2 or more coronary arteries

Scenario 2: PTCA with a total of 2 POBA (plain old balloon angioplasty) into 1 artery (proximal and mid LAD) and 1 stent into a single artery (mid LAD).

Code option:

3830600 [671] Percutaneous insertion of 1 transluminal stent into single coronary artery

Can we clarify which classification point in ACS 0020 *Bilateral/Multiple Procedures* is relevant to PTCA with or without stenting to multiple coronary arteries?

ACS 0020 Classification point 2. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions; or

ACS 0020 Classification point 3. The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and different lesions.

Other queries considered in the raising of this query were around both peripheral and coronary vascular lesions:

Thrombectomy and embolectomy of multiple arteries (2 of 3) (ACCD) – "The includes note "that with stenting" at block [702] Arterial embolectomy and thrombectomy only applies if the stenting is performed to the same artery.

PTA (percutaneous transluminal angioplasty) of multiple peripheral vessels (ACCD) – "assign multiple ACHI codes when interventions are performed on multiple peripheral vessels, as the procedures are performed on different lesions."

CCAQ Query 08-0318: Coronary PTCA of multiple vessels – "The CCAQ members agreed that for both scenarios, the index is to be followed and one code assigned – 38306-02 Percutaneous insertion of stents into multiple coronary arteries."

Response: For PTCA with or without stenting to multiple coronary arteries follow ACS 0020 *Bilateral/multiple procedures - Multiple procedures - Classification point 2 - The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions* and assign one code.

For both scenarios, assign 38306-00 [671] *Percutaneous insertion of 1 transluminal stent into single coronary artery* once only following the index Angioplasty/transluminal balloon/coronary artery/with stenting/single stent (percutaneous).

November 2022

Query ID 01-1122: Cannula drainage of lacrimal sac performed for dacryocystitis

Query: Can we please get some advice on the ACHI code for the cannula drainage of lacrimal sac performed on the ward without an insertion of stent or tube?

The pathway for drainage of lacrimal sac is forcing us to code as though performed with tube/stent insertion (glass or other) and from research this device is left in place for approximately 3 months:

Drainage/lacrimal sac/by insertion of nasolacrimal tube (stent)

42608-00 [242] *Insertion of other nasolacrimal tube/stent into lacrimal/conjunctival sac for drainage*

Other codes we have considered are:

42614-01 [241] *Probing of lacrimal passages, unilateral* (in this case)

90088-00 [250] *Other procedures on lacrimal system*

Operation report details:

1st drainage done on ward last night, 7pm – 1ml purulent material extracted (sent for M/C/S)

2nd drainage today in clinic, 1.5ml pus drained (sent for M/C/S)

Same technique but Nummit (Emla equivalent) applied 20 mins prior

Verbal consent

BNX

Xylocaine with adrenaline (1% with 1:100,000) epidermis infiltration

Betadine prep and drape, sterile gloves

22G cannula used to infiltrate lacrimal sac collection

Needle extracted

3mm syringe attached and pulled back

Betadine wash post

20ml normal saline irrigation of eye post

Response: CCAQ advise that a clinical documentation query should be submitted in the first instance to confirm the exact procedure performed. Where a documentation query is not possible, assign 90088-00 [250] *Other procedures on lacrimal system* following the ACHI Index Procedure/lacrimal system NEC.

Query ID 02-1122: Internal limiting membrane (ILM) flap procedure for macula hole

Query: We are seeking advice on the appropriate ACHI code to assign for an ILM (internal limiting membrane) flap performed with a pars plana vitrectomy (PPVx) for a full thickness macular hole.

Details of procedure:

Anaesthetic block
Consent, time out
Prep, drape, speculum
25G PPVx
Core and peripheral vitrectomy
IVTA
Membrane blue
ILM peel to arcades
ILM flap
360 degree indented exam
Cryotherapy to temporal break and anterior edge of old HST
FAX
SF6
Subconj dexamethasone and cephazolin
Pad, shield

Pars plana vitrectomy for this condition includes the ILM or epiretinal membrane peeling but there is no inclusion for a flap:

42725-00 [207] Removal of vitreous, pars plana approach

Pars plana vitrectomy

Includes: capsulotomy
division of vitreal bands
fluid and gas exchange
removal of epiretinal membranes
replacement with vitreous substitutes (silicone oil)

Our research would seem to suggest this is more than the usual/conventional treatment and is indicated for large macular holes - and so we wonder if it should be captured additionally and if so by which ACHI code?

Response: CCAQ advise that where an internal limiting membrane flap is performed in conjunction with a pars plana vitrectomy, the ILM flap would be considered an inherent component of the procedure.

Assign procedure code 42725-00 [207] *Removal of vitreous, pars plana approach*, following the ACHI Index Vitrectomy/pars plana approach. An additional code for the ILM flap is not required.

Query ID 03-1122: Submandibular abscess associated with a dental abscess

Query: Could CCAQ please advise if the excludes note at K12.2 *Cellulitis and abscess of mouth* is precluding us from assigning both K12.2 for submandibular abscess and K04.7 *Periapical abscess without sinus*? Or can we assign both to ensure a code for both the problem and underlying cause concepts are assigned and sequenced as per ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*?

In cases of dental abscess complicated by Ludwig's angina it seems quite clear we can code both conditions, however when viewing cases of abscess only there are mixed opinions.

Often in our Faciomaxillary admissions submandibular abscess is listed as the principal diagnosis with dental abscess listed as a secondary diagnosis which is why we wonder if we should be interpreting the submandibular space abscess as a complication / problem due to the underlying cause dental abscess.

For reference also is a VICC query around submasseteric space abscess secondary to a molar infection Q3193 Submasseteric abscess which seems to be in support of capturing the sites of abscess/infection, when documented (although we do not necessarily agree with the suggested code).

Response: CCAQ advise that where documentation supports a problem and underlying cause relationship, or where both the submandibular abscess and dental abscess meet ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* in their own right, both K12.2 *Cellulitis and abscess of mouth* and K04.7 *Periapical abscess without sinus* can be assigned.

Query ID 04-1122: Gender dysphoria

Query: I am seeking further clarification / guidance on ICD-10-AM code assignment for gender dysphoria. This condition can also be referred to, in clinical documentation, as gender reassignment, gender affirmation or gender confirmation. I have attached the current Coding Rule Q3527 *Surgery for gender dysphoria*, for your convenience. As you would be aware this coding rule refers to a patient admitted for "chest masculinisation surgery".

The query raised is with respect to a patient, who identifies as male, admitted for gender affirmation surgery. Surgery is inclusive of a hysterectomy and bilateral salpingo-oophorectomy. In this instance would the CCAQ apply Coding Rule Q3527 to this admission, as there are nil other medical conditions specified for the surgery i.e. polycystic ovarian syndrome. I have noted scenarios below:

If Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* is assigned as principal diagnosis per CR Q3527 the DRG J11Z *Other skin, subcutaneous tissue and breast procedures* does not accurately reflect the procedure/s performed.

If F64 *Gender incongruence* is assigned the DRG U67Z *Personality disorders and acute reactions* does not accurately reflect the procedure/s performed.

CCAQ note: DRGs referred to in this query relate to a previous AR-DRG version (not current V10.0).

Response: CCAQ acknowledge that Coding Rule Q3527 *Surgery for gender dysphoria* refers to an admission for chest masculinisation surgery and cannot be applied to this scenario.

Where a patient is admitted for gender affirmation surgery involving a hysterectomy and salpingo-oophorectomy (which would not be considered a plastic surgery procedure) assign Z41.89 *Other procedures for purposes other than remedying health state* following the Disease Index Surgery/elective/specified type NEC.

Query ID 05-1122: U07.3 Personal history of COVID-19

Query: A clinical coding query has been raised by our clinical coding team and requires clarification as opinions differ.

In the opinion of the CCAQ, are coders able to assign U07.3 *Personal history of COVID-19* based on nursing documentation?

ACS Glossary terms below, for your convenience:

A Clinician is a health care provider trained as a health professional. Includes registered and non-registered practitioners, and teams of health professionals who spend most of their time providing direct clinical care (Australian Commission on Safety and Quality in Health Care and Australian Institute of Health and Welfare 2021).

The term 'clinician' refers to the treating medical or surgical clinician, anaesthetists and other consulting health professionals who document in the health care record. A clinician may also refer to allied health professionals, midwives and nurses.

Scope of practice is defined by the health service organisation and is dependent on the practitioner operating within the bounds of their qualifications, education, training, current experience and competence, and within the capability of the facility or service in which they are working (The Commission 2015).

Clinicians document clinical findings, decisions and actions in the health care record within the scope of their practice.

We are all aware that the term "Scope of Practice" (SOP) is intricately aligned with code assignment as it can potentially impact the DRG. It is really important that we understand when we can justify "SOP" codes relevant to our treating clinicians and ensure that code assignment is as consistent as possible.

Response: CCAQ acknowledge the definitions of Clinician and Scope of Practice in the Australian Coding Standards Glossary and note that a clinician may refer to a nurse, and that "Clinicians document clinical findings, decisions and actions in the health care record within the scope of their practice".

Therefore, where history of COVID-19 is documented by a nurse, assign U07.3 *Personal history of COVID-19* following the guidelines in ACS 0113 *Coronavirus disease 2019 (COVID-19)*.

Note this advice does not apply to personal history of COVID-19 documented on health screening tools and forms. Refer to Twelfth Edition FAQ*: Personal history of coronavirus disease 2019* (Ref: TN1601) and ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts.*

Query ID 06-1122: Wound ooze following spinal fusion

Query: Could the Committee please confirm the correct complication code to assign for wound ooze following spinal fusion?

Coding Rule Q2804 Wound Ooze (retired 2017) stated post-procedural wound ooze is classified to T81.8 *Other complications of procedures, NEC.*

Recent audit feedback indicated wound ooze following insertion of a prosthetic device (e.g., spinal fusion) is classified to T82-T85 for complications related to prosthetic devices, implants or grafts.

Which of the following codes is assigned for wound ooze following spinal fusion?

A) T84.89 *Other specified complications following insertion of internal orthopaedic prosthetic devices, implants and grafts*

B) T81.89 *Other complications following a procedure, not elsewhere classified.*

Response: As per ACS 1904 *Procedural complications:*

"Where a condition is not related to a prosthetic device, implant or graft and:
- it is related to a body system, assign an appropriate code from the body system chapter listed above
- the complication is not related to a body system, assign an appropriate code from T80–T81 or T86–T88."

Wound ooze is not related to a prosthetic device, implant or graft, nor is it related to a body system therefore an appropriate code from T80-T81 or T86-T88 should be assigned.

CCAQ advise that where wound ooze meets criteria for coding as per ACS 1904 *Procedural complications* assign T81.89 *Other complications following a procedure, not elsewhere classified* following the Alphabetic Index Complication (s)/postprocedural/specified NEC.

Query ID 07-1122: Fragility facture and minimal trauma, low energy trauma fracture

Query: We would like to seek advice on assigning a code for fractures, when documented as 'fragility fracture', and fractures documented as 'secondary minimal trauma fall' and 'secondary to low energy trauma'.

Clinicians at our facility have provided feedback, that these types of fracture are pathological/insufficiency, type fractures.

Could you please advise if fragility fractures, and fractures documented as 'secondary minimal trauma' and 'low energy trauma', are types of pathological/insufficiency fractures, and should be coded as pathological/insufficiency fractures when documented as 'fragility fracture', and 'fracture secondary to minimal trauma/low energy trauma fracture'?

Response: CCAQ advise that fragility fractures and fractures documented as secondary minimal trauma fall or low energy trauma cannot be assumed to be pathological or insufficiency fractures. A clinical documentation query should be submitted to clarify the diagnosis.

If a documentation query is not possible, assign a code following the Alphabetic Index Fracture/by site.

October 2022

Query ID 01-1022: Diagnosis code – suture material

Query: Can CCAQ please advise on the diagnosis code for each of these scenarios?

Q1: Patient presents with a lump at the knee and during operation it is noted 'for removal of meniscal suture'. They previously had a meniscus repair.

Q2: Removal of foreign body – suture material found – removed.

Is the suture material coded as:

i. Foreign body

ii. Residual foreign body

iii. Complication procedure

iv. Other please specify.

Response: CCAQ advise that for scenario one, there is insufficient documentation to establish a link between the lump and the suture requiring removal, or any complication. A clinical documentation query may help with determining the diagnosis, but from the information provided, assign R22.4 *Localised swelling, mass and lump, lower limb* following the Alphabetic Index Lump – *see also Mass* and Mass/localised/limb/lower.

For scenario two, CCAQ are unable to provide a response to this scenario as there is insufficient documentation to assign a code. A clinical documentation query would be required to clarify the diagnosis in order to assign the most appropriate code.

Query ID 02-1022: Wrong intraocular lens inserted requiring exchange

Query: Could CCAQ please advise if the following scenario meets the criteria of the Procedural complication/unintentional event?

Patient admitted for cataract surgery and had phacoemulsification of crystalline lens with insertion of intraocular lens performed. It was discovered en route to recovery (i.e., still in surgical suite) that the incorrect (power) lens had been implanted. Patient was taken back to theatre for intraocular lens exchange.

There was no documented injury or harm to patient. Patient discharged same day as planned.

As per ACS 1904 *Procedural complications/Unintentional event(s)* an unintentional event (previously termed misadventure) is defined as injury or harm caused during medical or surgical care.

If it is advised this needs to be captured as a complication or misadventure, can we also be advised of the correct code selection.

Response: As was stated in the query, ACS 1904 *Procedural complications* defines an unintentional event as "injury or harm caused during medical or surgical care". CCAQ advise that the scenario provided does not meet the criteria in ACS 1904 *Procedural complications* to code as an unintentional event as there was no injury or harm caused.

A code can be assigned for the procedure requiring the return to theatre; however, a diagnosis code cannot be assigned for insertion of the wrong lens.

Query ID 03-1022: Cauterisation of Little's area for chronic epistaxis

Query: Can we please confirm how to code cauterisation of Little's area for chronic epistaxis when the patient is not currently bleeding in this admission?

Coding scenario:

69F new referral for recurrent nasal bleeding requiring multiple emergency department (ED) presentations, on lifelong dual antiplatelet therapy (DAPT) for critical limb ischemia.

History:

recurrent R) sided nasal bleeds

-bleeding anteriorly and posteriorly

-often spitting up clots

difficult to stop bleeding, has had multiple ED presentations

on lifelong DAPT for limb ischemia

Examination:

prominent vessels in Little's area of right nostril

-also noted in left nostril but to a much lesser extent

Plan:

verbal consent obtained

topicalised with co-phenylcaine

silver nitrate cautery performed

topical kenacomb ointment BD

review in 3/52

Code options are:

41674-01 [374] *Destruction procedures on nasal septum* which excludes "that for arrest of nasal haemorrhage (see block [373])"

41677-00 [373] *Arrest of anterior nasal haemorrhage* – this code includes packing which is not done as the patient is not currently bleeding

Western Australian Coding Rule 1111/06 *Arrest of nasal haemorrhage* advises that 41677-00 [373] *Arrest of anterior nasal haemorrhage* should be used even if the patient is not currently bleeding.

Response: CCAQ advise that for cauterisation of Little's area for chronic epistaxis when the patient is not currently bleeding within the admission, assign procedure code 41677-00 [373] *Arrest of anterior nasal haemorrhage* following the ACHI Alphabetic Index Cauterisation/nose, nasal/for arrest of nasal haemorrhage (anterior) (Little's area).

Query ID 04-1022: Percutaneous tricuspid valve repair with Mitraclip™

Query: We are performing percutaneous repairs of the tricuspid valve with a Mitraclip™ closing device.

ACHI have percutaneous valvuloplasty codes for every valve except the tricuspid valve.

For example, the code for percutaneous mitral valve repair with closure device (Mitraclip™) is 96222-00 [626] *Percutaneous mitral valvuloplasty using closure device*.

For the tricuspid valve, we thought best to code:

38481-02 [632] *Repair of tricuspid valve, 2 or more leaflets*

38200-00 [667] *Right heart catheterisation* to reflect the transcatheter/percutaneous component.

You may have to forward to ACE for a new code. In the interim, please advise what codes we should use for percutaneous closure of tricuspid valve with Mitraclip™.

Response: CCAQ advise that for a percutaneous repair of the tricuspid valve using a Mitraclip™ device, assign procedure code 38480-02 [632] *Repair of tricuspid valve, 1 leaflet* or 38481-02 [632] *Repair of tricuspid valve, 2 or more leaflets* following the ACHI Alphabetic Index Valvuloplasty/heart/tricuspid valve (open)/leaflet.

CCAQ acknowledge the following Excludes note at Block [667] Cardiac catheterisation:

> ***Excludes:*** that:
> • performed as operative approach only in cardiac catheter-based intervention - omit code

However, CCAQ support the assignment of 38200-00 [667] *Right heart catheterisation* in this scenario to distinguish this percutaneous procedure from open tricuspid valve repairs.

Query ID 05-1022: History of prematurity

Query: We often have documentation of conditions (e.g., chronic neonatal lung disease) in children related to premature birth. We can capture the conditions but there is no way to capture the 'history' of prematurity or potentially the sequelae of prematurity.

Examples of documentation:

• 7-year-old female with exacerbation chronic neonatal lung disease due to premature birth (23/40)

• 2-year-old female with severe respiratory distress / severe asthma exacerbation on background of chronic neonatal lung disease due to extreme prematurity (26+5/40)

• 3-year-old male with multiple conditions associated with extreme prematurity (26+6/40)

Could we make a submission to IHACPA for consideration of a history and/or sequelae code for conditions related to prematurity?

Response: CCAQ advise that diagnosis code Z87.6 *Personal history of certain conditions arising in the perinatal period* could be assigned to indicate that a current condition is related to premature birth, when supported by documentation.

Query ID 06-1022: Replacement of percutaneous gastrostomy PEG with low profile Mic-Key button

Query: Clinical advice indicates that it is common to replace a long tube PEG with a 'low profile' button device (e.g., Mic-Key) within a certain timeframe particularly in the paediatric setting. Primarily this is done non-endoscopically however often an upper endoscopy will be performed in conjunction.

Pathway - Replacement / button / gastrostomy, nonendoscopic obviously contains the non-essential modifier to specify the approach as without endoscopy (30483-00) or Replacement / tube / gastrostomy, percutaneous endoscopic [PEG] contains the non-essential modifier to specify the approach as with endoscopy (30482-00)

However, we note VICC advice #3816 June 2022 for the same question to be posed here advises to assign the nonendoscopic code 30483-00 when clinical documentation/op report states a low-profile gastrostomy device has replaced the original PEG. There is no instruction or mention of how to code when an endoscopy is performed at the same time.

In order to have Qld specific advice on this, could CCAQ please provide advice on the most appropriate ACHI code for replacement of a long tube PEG with a low-profile device when performed in conjunction with or via endoscopy?

Response: CCAQ advise that for replacement of a long tube PEG with a low-profile button device performed in conjunction with an endoscopy, assign 30483-00 [870] *Insertion of percutaneous nonendoscopic gastrostomy button* following the ACHI Index Replacement/button/gastrostomy, nonendoscopic. Assign an additional code for the endoscopy following the guidelines in ACS 0023 *Minimally invasive interventions.*

September 2022

Query ID 01-0922: Using Emergency Department notes to code multiple injuries

Query: Please advise if Emergency Department (ED) notes from outside admission times can be used to assign codes for injuries in a multiple trauma in accordance with ACS 1907 *Multiple injuries*?

Scenario: The patient was admitted with a fractured femur due to a fall. A wound care plan has been completed during the admission for an open wound of the elbow from the fall. ED notes completed prior to the admission time document a minor head injury and skin tear to shoulder. CT scan of head was performed in ED and reported as NAD. These injuries are not documented in the admission notes.

Can the head injury and skin tear to the shoulder be coded in addition to the fractured femur and open wound of elbow?

According to ACS 1907 *Multiple Injuries*, "When coding the initial admission of a multiple trauma, all injuries documented must be coded to represent the totality of multiple trauma."

According to ACS 0010 *Clinical documentation and general abstraction guidelines* these emergency department notes are outside the current episode of care and can only be used for the guidelines listed in ACS 0010.

Do the Emergency Department notes add specificity to the totality of the multiple trauma?

See also ACE advice published 15 June 2022 – Abstraction from outside an episode of care for coding diabetes mellitus.

Response: CCAQ advise that in the scenario provided, the head injury and skin tear to the shoulder should not be coded, as they were only documented in the Emergency Department notes which were outside the admission time of the current episode of care.

Information from outside the current episode of care can only be used to inform code assignment in the specific circumstances listed in ACS 0010 *Clinical documentation and general abstraction guidelines/Abstraction from other sources of information.*

Query ID 02-0922: Breast implant-associated anaplastic large cell lymphoma

Query: Could CCAQ advise on correct code assignment for breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) ALK-negative. BIA-ALCL is a rare immune-cell cancer that develops in the breasts, and it's been linked to textured breast implants. Our clinicians have confirmed it is a condition associated with textured breast implants.

Our suggested codes are as below, however if patient comes in for same day chemotherapy will we be assigning T85.88 *Other complications of internal prosthetic device, implant and*

graft, not elsewhere classified (or code suggested by CCAQ) after Z51.1 *Pharmacotherapy session for neoplasm?*

T85.88 *Other complications of internal prosthetic device, implant and graft, not elsewhere classified*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Health Service area*

C84.7 *Anaplastic large cell lymphoma, ALK-negative*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Health Service area*

Response: CCAQ advise that for documentation of breast implant-associated anaplastic large cell lymphoma the following codes should be assigned, following the index Lymphoma/anaplastic/large cell/breast-implant associated and Neoplasm/breast/malignant:

C50.- *Malignant neoplasm of breast*

M9715/3 *Anaplastic large cell lymphoma, ALK negative*

Admissions for same-day chemotherapy for breast implant-associated anaplastic large cell lymphoma should be coded in accordance with ACS 0206 *Pharmacotherapy for neoplasms.*

Query ID 03-0922: Intestinal failure

Query: Could CCAQ advise correct code assignment for "Type 1 intestinal failure" and "Type 2 intestinal failure" without documentation of malnutrition?

Our research indicates intestinal failure is the inability of the gut to absorb sufficient macronutrients (carbohydrates, protein, and fat), micronutrients (vitamins, minerals, and electrolytes), or water, resulting in the need for intravenous supplementation to maintain health or facilitate growth.

We usually see Type 1 and Type 2 intestinal failure documented for patients who have had abdominal surgery or have a chronic condition such as Crohn's disease. These patient's sometimes have an ileus documented. Patients are usually on total parenteral nutrition and seen by the parenteral nutrition team as well as dieticians.

Response: Intestinal failure is not a term indexed in the ICD-10-AM Alphabetic Index.

CCAQ advise that for documentation of type 1 or type 2 intestinal failure, a clinical documentation query should be submitted to determine the underlying cause of intestinal failure.

Query ID 04-0922: Evusheld®

Query: Could the Committee please advise what ICD-10-AM and ACHI codes they would assign for same-day patients admitted for prophylactic treatment with Evusheld®.

We are starting to see patients presenting to day oncology for intra-muscular injection of Evusheld® with the clinicians documenting 'Evusheld® prophylaxis'.

"Evusheld® is a combination of 2 long-acting monoclonal antibodies, tixagevimab and cilgavimab, derived from the B-cells from donated plasma of patients previously infected with the SARS-CoV-2 virus".

Coding Rule Ref No: Q3753 *Monoclonal antibodies for treatment of COVID-19* advises to assign a code from block [1920] *Administration of pharmacotherapy* with extension -02 *Anti-infective agent* (includes antiviral) when monoclonal antibodies are given to treat COVID-19. Does this advice also apply when monoclonal antibodies are given as prophylactic treatment?

Scenario 1: Patient with history of common variable immunodeficiency has a doctor's letter stating patient has not developed any immunity to COVID-19 despite multiple doses of vaccination. COVID-19 IgG is negative. For Evusheld® prophylaxis.

Scenario 2: Patient with stage III follicular lymphoma and AstraZeneca COVID vaccines x 2 admitted for Evusheld® prophylaxis.

https://www.health.qld.gov.au/__data/assets/pdf_file/0023/1150970/tixagevimab-prescribing-guideline.pdf

https://www.astrazeneca.com.au/media/press-releases/2022/astrazenecas-evusheld.html

Response: CCAQ advise that for same-day episodes of care for prophylactic treatment with Evusheld®, the following codes should be assigned, in accordance with ACS 0044 *Pharmacotherapy*:

Z29.29 *Prophylactic pharmacotherapy, not elsewhere classified*

96197-02 *Intramuscular administration of pharmacological agent, anti-infective agent*

Follow the ICD-10-AM Alphabetic Index at Administration, prophylactic/pharmacotherapy and the ACHI Alphabetic Index at Pharmacotherapy/intramuscular with procedure code extension -02 *Anti-infective agent*.

Query ID 05-0922: Postoperative peritoneal and female pelvic adhesions

Query: We are seeking clarification on coding postoperative peritoneal and female pelvic adhesions when documentation in operation records or from completed coding queries state that adhesions have been divided at both sites. (Also supported by personal history of past procedures at both sites.)

Presently the coding practice at this facility has been to code only N99.4 *Postprocedural pelvic peritoneal adhesions*. This was based on 'Excludes Notes' found at K66.0 *Peritoneal adhesions* and N73.6 *Female pelvic peritoneal adhesions*.

How are the Excludes notes to be interpreted?

Should only N99.4 *Postprocedural pelvic peritoneal adhesions* be coded when both types of adhesions are divided? Or should K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*, K66.0 *Peritoneal adhesions* and N99.4

Postprocedural pelvic peritoneal adhesions all be coded as they relate to two different anatomical sites?

Response: CCAQ advise that where there is documentation of both abdominal peritoneal and female pelvic peritoneal adhesions due to a previous procedure (i.e., different anatomical sites) and where adhesions at both sites meet criteria for coding, the following codes can be assigned, along with the relevant external cause codes:

K91.89 *Other intraoperative and postprocedural disorders of digestive system, not elsewhere classified*

K66.0 *Peritoneal adhesions*

N99.4 *Postprocedural pelvic peritoneal adhesions*

Query ID 06-0922: Laparoscopic revision of hiatus hernia and Toupet fundoplication

Query: What procedure code/s should be assigned for laparoscopic revision of hiatus hernia and Toupet fundoplication with adhesiolysis? Operation note attached (Appendix A).

There are no codes in the procedure classification for revision fundoplasty with repair of hiatus hernia.

Conventions of ACHI Alphabetic Index:

Subterms

Essential modifiers are subterms that *effect* the code selection. These subterms form individual line entries.

ACHI Index:

Fundoplasty

- with cardiopexy 30530-00 [886]

- abdominal approach(Nissen's fundoplication) 30527-02 [886]

- - with

- - - closure of diaphragmatic hiatus 30527-03 [886]

- - - - and oesophagogastric myotomy 30533-01 [864]

- - - oesophagoplasty 30529-00 [886]

- endoluminal 30527-06 [886]

- laparoscopic approach(Nissen's fundoplication) 30527-00 [886]

- - with

- - - closure of diaphragmatic hiatus 30527-01 [886]

- - - - and oesophagogastric myotomy 30533-05 [863]

- revision 31466-00 [886]

Response: CCAQ advise that for the scenario provided, assign 31466-00 [886] *Revision fundoplasty*, following the ACHI Index:

Repair/hernia/diaphragmatic (hiatus)/with/fundoplasty – *see Fundoplasty*

Fundoplasty/revision

An additional code for the laparoscopic approach (30390-00 [984] *Laparoscopy*) should be assigned in accordance with ACS 0023 *Minimally invasive interventions*.

Note that in the operation report provided with the query, there was insufficient documentation to assign a code for adhesiolysis. A documentation query may be warranted to confirm whether adhesiolysis was performed.

Query ID 07-0922: Electric scooter accidents

Query: Can CCAQ please advise the external cause category for electric scooter (or e-scooter) occupants in the context of e-scooter transport accidents. According to the definitions in Chapter 20 *External causes of morbidity and mortality/Transport accidents (V00-V99)* a person using a scooter is classified as a pedestrian however we are seeing a variety of codes being applied such as motorbike occupant / scooter occupant etc.

Please note that a fall from a motorised scooter is classified to W02.9 *Fall involving other and unspecified pedestrian conveyance*.

Response: The ICD-10-AM Disease Tabular/Definitions related to transport accidents (Chapter 20) defines a pedestrian as:

> ...any person involved in an accident who was not at the time of the accident riding in or on a motor vehicle, railway train, streetcar or animal-drawn or other vehicle, or on a pedal cycle or animal.
>
> ***Includes:***
>
> ...
>
> user of a pedestrian conveyance such as:
>
> · baby carriage
>
> · ice-skates
>
> · perambulator
>
> · push-cart
>
> · push-chair
>
> · roller-skates
>
> · scooter
>
> ...

CCAQ advise that for transport accidents involving e-scooter occupants, follow the ICD-10-AM External Causes of Injury Index at Accident/transport/pedestrian (in) to assign the appropriate external cause code from category V00-V09 Pedestrian injured in transport accident.

Refer also to ACS 2009 *Mode of pedestrian conveyance* for additional classification guidelines.

Query ID 08-0922: Delirium with unspecified dementia and behavioural and psychological symptoms of dementia

Query: Scenario – patient with delirium and unspecified dementia, with behavioural and psychological symptoms of dementia (BPSD) documented.

Coding Rule Ref No: Q3625 *Delirium superimposed on dementia* states: "Where dementia without further specification is documented with delirium, do not assign a code from subcategory F03 *Unspecified dementia*".

Now that the F03 *Unspecified dementia* codes have been expanded to include 'with or without mention of psychological or behavioural disturbance', how do we capture BPSD in a patient with delirium and unspecified dementia?

Response: CCAQ consider that although the presence of behavioural and psychological symptoms of dementia (BPSD) doesn't provide further specification on the *type* of dementia, it does add further relevant clinical information.

CCAQ advise that for a patient with delirium and unspecified dementia with behavioural and psychological symptoms of dementia, F03.01 *Unspecified dementia with psychological or behavioural disturbance* should be assigned in addition to F05.1 *Delirium superimposed on dementia*.

August 2022

Query ID 01-0822: Subdural hygroma

Query: IHPA published Coding Rule Traumatic subdural hygroma (Ref Q3631) in December 2021, advising that a traumatic subdural hygroma should be classified to S06.8 *Other intracranial injuries*.

Our query relates to a diagnosis of subdural hygroma, not documented as due to trauma, or where the aetiology is unknown.

In ICD-10-AM, the default code for a hygroma not further specified is D18.1 *Lymphangioma, any site* and M9173/0 *Cystic lymphangioma*.

Subdural hygromas refer to the accumulation of fluid in the subdural space. They may be caused by trauma, be post-surgical or may be idiopathic.

https://radiopaedia.org/articles/subdural-hygroma

A cystic hygroma, or lymphangioma, is a birth defect that appears as a sac-like structure with a thin wall that most commonly occurs in the head and neck area of an infant.

https://www.hopkinsmedicine.org/health/conditions-and-diseases/cystic-hygroma

A lymphangioma is a benign malformation composed of dilated cystic lymphatic tissue that can occur anywhere on the skin and mucous membranes.

https://www.sciencedirect.com/topics/medicine-and-dentistry/lymphangioma
https://www.ncbi.nlm.nih.gov/books/NBK470333/

It does not seem clinically appropriate to classify a subdural hygroma as a lymphangioma (D18.1, M9173/0).

Can CCAQ please:

1. Advise on the most appropriate code for a subdural hygroma, not specified as due to trauma or other cause

2. Consider referring this query to IHPA for their advice and consideration of future improvements to the classification

Response: CCAQ advise that for documentation of a subdural hygroma not due to trauma or where the aetiology is unknown, the default codes at lead term Hygroma should be assigned:

D18.1 *Lymphangioma, any site*

M9173/0 *Cystic lymphangioma*

Query ID 02-0822: Admission for bridging Clexane

Query: I am seeking advice on coding and condition onset flag (COF) assignment in an admission for administration of bridging Clexane in preparation for replacement of a mechanical mitral valve (due to a mechanical complication) in a subsequent admission.

ACS 0303 *Anticoagulant use and abnormal coagulation profile* advises Z92.1 *Personal history of long term (current) use of anticoagulants* is assigned as an additional diagnosis if a patient is on long term anticoagulants and the bridging anticoagulant is administered prior to or following a planned procedure.

In ACS 0303 *Anticoagulant use and abnormal coagulation profile* Example 3 bridging Clexane was required due to the presence of the heart valve replacement, therefore it is relevant to the episode of care.

Refer also to Coding Rules related to preparatory care (Z51.4):

Coding Rule Ref: Q2620 *Principal diagnosis for insertion of fiducial markers (use of Z51.4 Preparatory care for subsequent treatment, not elsewhere classified)*

Coding Rule Ref: TN197 *Brachytherapy planning*

Coding Rule Ref: Q2687 *Principal diagnosis for prophylactic PEG insertion prior to oropharyngeal radiation therapy*

Coding Rule Ref: Q2687 the NCCH advises that coders should assign a code for the condition as the principal diagnosis for brachytherapy planning, as 'planning' is considered part of the treatment of the neoplasm. Z51.4 *Preparatory care for subsequent treatment, not elsewhere classified* is a non-specific code and the data collection is better served by coding the condition with the intervention code specifically describing the reason for admission. (Coding Matters March 2010 Volume 16, Number 4).

Scenario: Patient on long term warfarin admitted to Hospital in the Home for bridging Clexane in preparation for upcoming replacement of their mechanical mitral valve (to be performed in a subsequent admission). No other preoperative work up was performed during admission. There was documentation of subtherapeutic INR during admission.

Bridging Clexane was required due to the presence of the existing heart valve. There is an excludes note at Z95 Presence of cardiac and vascular implants and grafts: *Excludes: complications of cardiac and vascular devices, implants and grafts (T82.-).*

In this instance would it be correct to code Z51.4 *Preparatory Care for subsequent treatment, NEC* (COF 1) as the principal diagnosis followed by T82.0 *Mechanical complication of heart valve prosthesis* (COF 1); Y83.1 *Surgical operation with implant of artificial internal device* (COF 1); Y92.23 *Health service area, not specified as this facility* (COF 1) and Z92.1 *Personal history of long term (current) use of anticoagulants* (COF 1)?

Response: CCAQ agree that in the scenario provided, the following codes and condition onset flags should be assigned:

(1) Z51.4 *Preparatory care for subsequent treatment, NEC* as principal diagnosis, followed by

(1) T82.0 *Mechanical complication of heart valve prosthesis*

(1) Y83.1 *Surgical operation with implant of artificial internal device*

(1) Y92.23 *Health service area, not specified as this facility*

(1) Z92.1 *Personal history of long term (current) use of anticoagulants*

Query ID 03-0822: Cold agglutinin haemolytic anaemia

Query: Please advise on the correct principal diagnosis code for a day-only admission for Rituximab with documentation of cold agglutinin haemolytic anaemia with CD20 positive NHL circulating clone.

Response: Based on the information provided, CCAQ advise that D59.1 *Other autoimmune haemolytic anaemias* should be assigned as principal diagnosis following the index Anaemia/haemolytic/cold type (secondary) (symptomatic).

A clinical documentation query could be completed to clarify the condition being treated.

Query ID 04-0822: Post procedural neuropraxia due to total knee arthroplasty

Query: Could the Committee please advise which of the following postprocedural complication codes should be assigned for neuropraxia secondary to total knee arthroplasty?

G97.8 *Other intraoperative and postprocedural disorders of nervous system*

OR

T84.89 *Other specified complications following insertion of internal orthopaedic prosthetic devices, implants and grafts*

Reviewing ACS 1904 *Procedural complications* dot point three and Example 6 it is unclear whether this condition is classified as a postprocedural nervous system disorder or a complication of a device.

Response: CCAQ note that as per ACS 1904 *Procedural complications/Classification of procedural complications (diagnosis codes)*:

'As procedural complications may be classified to any of the above categories [specific body system chapters or T80-T88], the following rules apply:

Where a complication is related to a prosthetic device, implant or graft, assign T82–T85 *Complications of prosthetic devices, implants and grafts*, except where directed by an Includes note or the Alphabetic Index…'

CCAQ advise that for neuropraxia secondary to total knee arthroplasty, assign G97.8 *Other intraoperative and postprocedural disorders of nervous system* following the index Neurapraxia, neuropraxia – see Injury, nerve and Injury/nerve/postprocedural, along with the appropriate external cause codes.

July 2022

Query ID 01-0722: Arterial access system (AVAS) intervention

Query: The introduction of a new intervention/device has prompted me to reach out for clarification of ACHI code assignment for this device. The Arterial Access System device (AVAS) is currently being used in the treatment of unresectable hepatic/liver neoplasms.

I am hoping you can advise on the most accurate intervention code/s that reflect the AVAS system, including insertion of the device and administration of chemotherapy.

Response: The AVAS device is a "long term arterial implant anastomosed to either the femoral or axillary artery" and provides the ability to isolate and independently target a tumour within a specific organ in the body. High concentrations of chemotherapy can be used with fewer side effects.

https://www.allvascular.com/clinicians/avas

https://www.medicalresearch.nsw.gov.au/projects/arterial-access-system-avas/

CCAQ advise that for the initial insertion of the AVAS device, the following codes should be assigned:

34524-00 [694] *Catheterisation/cannulation of other artery* following the index Catheterisation/artery (open) AND

33818-00 [709] *Repair of axillary artery by direct anastomosis* following the index Anastomosis/artery/axillary to reflect the anastomosis of the device to the artery.

As the AVAS device allows for the isolation and specific targeting of the tumour with the chemotherapy agent, the chemotherapy infusion via the AVAS device should be classified as pharmacotherapy for local effect (not systemic effect) with the following code assigned:

35317-02 [741] *Peripheral arterial or venous catheterisation with administration of other therapeutic agent* following the index Pharmacotherapy/for/local effect (open) (percutaneous) (via peripheral arterial or venous catheterisation) (see also Administration).

Applicable codes for anaesthesia should also be assigned as per ACS 0031 *Anaesthesia*.

June 2022

Query ID 01-0622: Perinephric haematoma following kidney transplant

Query: Can you confirm the correct complication and external cause codes to assign for a perinephric haematoma due to a kidney transplant procedure?

Pt admitted for a kidney transplant for end stage renal failure due to polycystic kidney disease. Postoperatively there was a haemoglobin drop and an ultrasound showed a 10cm haematoma around the left kidney transplant. Pt was taken back to theatre where they found bleeding from the arterial anastomosis. The haematoma was evacuated, and the anastomosis was oversewn.

Response: For the scenario provided (perinephric haematoma due to a kidney transplant procedure) CCAQ advise to assign the following complication and external cause codes:

T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified*

Y83.02 *Kidney transplant as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*

Y92.24 *Health service area, this facility.*

Query ID 02-0622: Pacemaker induced cardiomyopathy

Query: What diagnosis codes should be assigned for "pacemaker induced cardiomyopathy"?

Response: CCAQ advise that as the complication (cardiomyopathy) is related to a prosthetic device, implant or graft (pacemaker), the following codes should be assigned, in accordance with ACS 1904 *Procedural complications/Classification of procedural complications (diagnosis codes):*

T82.89 *Other specified complications of cardiac and vascular prosthetic devices, implants and grafts*

I42.9 *Cardiomyopathy, unspecified*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Health service area.*

May 2022

Query ID 01-0522: Pseudomonas (bacteria) in urine

Query: We have clinicians who are documenting a specific bacterial agent in urine as their diagnosis for commencement of antibiotics. In this scenario a mid-stream urine sample was collected to investigate urinary symptoms, with the pathology report documenting a culture of Pseudomonas.

Looking up the alphabetic index of diseases Bacteria/in urine there is a cross reference to "see Bacteriuria", which classifies to N39.0 *Urinary tract infection, site not specified*:

Bacterium, bacteria, bacterial — *see also condition*

- agent NEC, as cause of disease classified elsewhere B96.88

- in blood — *see Bacteraemia*

- in urine — *see Bacteriuria*

- infection NEC, resulting from HIV disease B20

Bacteriuria, bacteriuria (asymptomatic) N39.0

- in pregnancy O23.4

- puerperal, postpartum O86.2

Audit feedback indicates that following the pathway Bacteria/in urine in these instances is inappropriate and that a documentation query is required to confirm the antibiotics are treating a UTI.

Could CCAQ provide their advice on coding this scenario in accordance with ACS 0010 *Clinical documentation and general abstraction guidelines* and the classification conventions.

A) Use lead search term 'bacteria' sub-term 'in urine' and assign N39.0?

B) Generate a documentation query to confirm treatment of a UTI?

Response: CCAQ advise that in the scenario provided, where the clinician has documented the presence of bacteria in the urine, and it meets ACS 0002 *Additional diagnoses*, the index pathway Bacteria/in urine – *see Bacteriuria* may be followed to assign N39.0 *Urinary tract infection, site not specified.*

Query ID 02-0522: Adverse reaction to COVID-19 vaccine – place of occurrence

Query: Please provide advice on which place of occurrence code should be assigned for an adverse reaction to a COVID-19 vaccine that is administered in a general practitioner's clinic or a private pharmacy.

Coding Rule Ref TN1551 COVID-19 vaccines causing adverse effects in therapeutic use (Published 16/3/2021) notes assignment of Y92.23 *Place of occurrence, health service area, not specified as this facility*, though in the data Y92.24 *Place of occurrence, health service area, this facility* is also being assigned where appropriate.

In the ICD-10-AM Tabular, the types of facilities included in these codes is quite specific, but they do not include GP clinic/rooms or private pharmacies.

ICD-10-AM and ACS 0113 *Coronavirus Disease 2019 (COVID-19)* (Twelfth Edition) does not provide any clarity.

Response: Coding Rule Ref Q3507 *Place of occurrence for adverse effect of drug* (published 18/12/20) states:

"All prescribed drugs are considered to be prescribed within the health system, so where there is an adverse reaction from a drug prescription completed outside of the hospital network (i.e. through a GP), it is considered 'within' the health service area."

CCAQ advise that for an adverse reaction to a COVID-19 vaccine administered in a general practitioner's clinic or private pharmacy, assign Y92.23 *Health service area, not specified as this facility.*

Query ID 03-0522: ACHI code for administration of intravenous Methotrexate for ectopic pregnancy

Query: Please advise what ACHI code should be assigned for intravenous administration of Methotrexate for ectopic pregnancy.

ACHI Index includes the following pathway which does not provide an option for intravenous administration:

Administration

...

- type of agent — see also Administration/indication or Administration/specified site

- - fetotoxic

- - - for

- - - - ectopic pregnancy

- - - - - directly into fetus (laparoscopic) 35674-01 [1256]

- - - - - - via laparotomy 35677-02 [1256]

- - - - - intramuscular (Methotrexate) 35677-03 [1256]

- - - - - using ultrasound guidance 35674-00 [1256]

- - - - fetal reduction (gas) (potassium chloride) 90463-00 [1330]

Response: CCAQ advises the correct code to assign for intravenous administration of Methotrexate for ectopic pregnancy is 35677-03 [1256] *Fetotoxic management for removal of ectopic pregnancy* using either of the following index pathways:

Management/ectopic pregnancy/by/pharmacotherapy (Methotrexate) 35677-03 [1256]

Removal/ectopic pregnancy/by/pharmacotherapy (Methotrexate) 35677-03 [1256]

Query ID 04-0522: Admission for collection of blood samples

Query: Please provide advice on admissions for the purpose of collecting a blood sample. Some patients require routine blood tests, but samples are unable to be taken in the community for various reasons.

Should we be coding Z01.7 *Laboratory examination*, Z51.88 *Other specified medical care* or is there another suitable code?

Response: CCAQ advises that where a patient requires an admission for blood tests (i.e., the criteria for an admission are met), assign a code for the condition requiring/reason for the blood test.

If a condition/reason for the blood test is not documented, a documentation query should be generated to confirm the diagnosis.

Query ID 05-0522: Cirrhosis due to hepatitis C and alcohol

Query: What cirrhosis code is assigned for patients with cirrhosis due to both hepatitis C and alcohol?

Research indicates cirrhosis is classified based on morphology or aetiology.

Morphology Classification:
Morphologically, cirrhosis is (1) micronodular, (2) macronodular, or (3) mixed. This classification is not as clinically useful as etiologic classification.

Micronodular cirrhosis (uniform nodules less than 3 mm in diameter): Cirrhosis due to alcohol, hemochromatosis, hepatic venous outflow obstruction, chronic biliary obstruction, jejunoileal bypass, and Indian childhood cirrhosis.

Macronodular cirrhosis (irregular nodules with a variation greater than 3 mm in diameter): Cirrhosis due to hepatitis B and C, alpha-1 antitrypsin deficiency, and primary biliary cholangitis.

Mixed cirrhosis (when features of both micronodular and macronodular cirrhosis are present): Usually, micronodular cirrhosis progresses into macronodular cirrhosis over time.

Reference: https://www.ncbi.nlm.nih.gov/books/NBK482419/

Should cirrhosis of mixed type, indexed to K74.6 *Other and unspecified cirrhosis of liver*, be assigned, along with additional diagnosis codes F10.1 *Harmful use of alcohol* and B18.2 *Chronic Viral Hepatitis C*?

Response: CCAQ advises that for cirrhosis documented as due to both hepatitis C and alcohol, assign the following codes to reflect the different cirrhosis aetiologies:

K74.6 *Other and unspecified cirrhosis of liver*

B18.2 *Chronic viral hepatitis C* or B94.2 *Sequelae of viral hepatitis*, depending on documentation, as per ACS 0104 *Viral hepatitis*

K70.3 *Alcoholic cirrhosis of liver*

F10.- *Mental and behavioural disorders due to use of alcohol* (with 4th character assigned based on documentation, as per ACS 0503 *Drug, alcohol and tobacco use disorders*)

Query ID 06-0522: Plastic bronchitis

Query: We are seeking clarification on how to most appropriately code the (rare) diagnosis of plastic bronchitis.

Research indicates that this condition is caused by an abnormal circulation of lymphatic fluid which can leak into the chest, causing lymphatic fluid to build in the airways and forms 'casts'.

Procedures to treat plastic bronchitis include lymphangiography and/or embolisation of lymph nodes and bronchoalveolar lavage to drain casts.

The disease index pathway at lead term 'bronchitis' offers options for acute or chronic (if documented) and defaults to either unspecified or acute, depending on the patient's age.

This does not seem sufficient to capture the clinical concept of this condition.

Should a code such as I89.9 *Noninfective disorder of lymphatic vessels and lymph nodes, unspecified* be assigned, following the index pathway Disease/lymphatic, to further specify the type of bronchitis as being due to a lymphatic condition?

Response: CCAQ advises that for documentation of plastic bronchitis (not specified as acute or chronic) the code assigned will depend on the age of the patient.

For a patient less than 15 years of age, assign J20.9 *Acute bronchitis, unspecified* following the index pathway:

Bronchitis/in those under 15 years of age (see also *Bronchitis/acute or subacute*) J20.9

For a patient 15 years of age and above, assign J40 *Bronchitis, not specified as acute or chronic* following the index pathway:

Bronchitis (15 years of age and above) (diffuse) (fibrinous) (hypostatic) (infective) (membranous) (with tracheitis) J40

An additional code for the underlying cause may be assigned if documented, as per ACS 0001 *Principal diagnosis/Problems and underlying conditions* and ACS 0002 *Additional diagnoses/ Problems and underlying conditions*.

Query ID 07-0522: Condition onset flag (COF) for delirium in high-risk patient

Query: What condition onset flag (COF) should be assigned for delirium when the notes on admission state:

Issues

ICH post fall

subcapital NOF

high risk delirium

The patient goes on to develop symptoms of delirium within 24 hours of admission. The clinician's impression on day 3 was 'multifactorial delirium', and after discussion with the RACF where the patient resides, the clinician documented 'cognition - fluctuates'.

Referring to ACS 0048 *Condition onset flag* for 'a previously existing condition' isn't specifically referenced. It is unclear from documentation why the patient is at risk of delirium. Referring to ACS 0048 for 'a condition that is suspected at the time of admission'; the patient is at high risk but not documented as having delirium on admission.

Response: CCAQ advises for the scenario provided, assign Qld COF 2 (Condition with onset during the episode of admitted patient care) for delirium, as the delirium was not documented as present on admission, but developed after admission.

April 2022

Query ID 01-0422: Parasitic myositis due to *Haycocknema perplexum*

Query: What codes (and index pathway) should be assigned for parasitic myositis due to *Haycocknema perplexum*?

Response: Parasitic diseases are classified in ICD-10-AM as either an infection or infestation, as per the note in the Alphabetic Index at lead terms Infection and Infestation:

Infection, infected (opportunistic) *(see also Infestation)* B99

Note: Parasitic diseases may be described as either 'infection' or 'infestation'; both lead terms should therefore be consulted.

Infestation *(see also Infection)* B88.9

Note: Parasitic diseases may be described as either 'infection' or 'infestation'; both lead terms should therefore be consulted.

For documentation of parasitic myositis due to *Haycocknema perplexum*, assign the following codes:

M60.0- *Infective myositis* (assign fifth character to indicate site of involvement)

B83.8 *Other specified helminthiases*

following the index pathways:

Myositis/infective M60.0-

Infection/helminths/specified type NEC B83.8

Query ID 02-0422: Flare of hereditary angio-oedema related to COVID-19 vaccine

Query: Please advise what diagnosis codes should be assigned for a flare of hereditary angio-oedema related to a COVID-19 vaccine.

A patient with a history of hereditary angio-oedema is admitted with a diagnosis of acute flare of angio-oedema related to the Pfizer (COVID-19) vaccine.

Coding Rule TN1556 *Code assignment and sequencing for COVID-19 vaccines causing adverse effects in therapeutic use* states that:

Minor and unspecified adverse reactions (complications) to non-serum vaccines are classified to T88.1 *Other complications following immunisation, not elsewhere classified* – such as eczema, reaction (allergic) and rash in accordance with the ICD-10-AM Alphabetic Index.

For other specified adverse effects (complications) of a COVID-19 vaccination, such as pulmonary embolism, assign an appropriate chapter code and appropriate external cause codes.

It is unclear if a flare of hereditary angio-oedema is considered a minor complication and assigned a principal diagnosis of T88.1 *Other complications following immunisation, not elsewhere classified* with D84.1 *Defects in the complement system* assigned as an additional diagnosis, or if it is considered a specified adverse effect and assigned a principal diagnosis of D84.1 *Defects in the complement system*?

Response: As this scenario was a flare of a pre-existing condition (hereditary angio-oedema) with a causal link to the COVID-19 vaccine, CCAQ advise to assign the appropriate chapter code and external cause codes.

For the scenario provided, assign the following codes:

D84.1 *Defects in the complement system*

Y59.0 *Viral vaccines*

Y92.23 *Health service area, not specified as this facility*

U07.7 *Emergency use of U07.7 [COVID-19 vaccines causing adverse effects in therapeutic use].*

Query ID 03-0422: Haemorrhoids with multiple degrees

Query: Can two diagnoses be assigned to reflect different grades of haemorrhoids, where different procedures are required for each grade, within current 11th edition conventions and current coding rules?

A patient is admitted with fourth degree haemorrhoids requiring an open haemorrhoidectomy and second-degree haemorrhoids requiring a haemorrhoid artery ligation procedure.

When 4th and 2nd degree haemorrhoids are both coded this generates a fatal error in PICQ™ which references retired coding advice (Eighth edition education workshop FAQs – Part 1 TN565 *Haemorrhoids* (retired 30 June 2019)).

Response to VICC Query 3091 *Haemorrhoids with different degrees* also references retired 8th edition FAQs and recommends to only assign the most severe grade of haemorrhoids.

There is no classification convention (e.g., excludes notes) or current national coding rule that instructs coders that different stages of haemorrhoids should not be assigned when documented.

Response: CCAQ advise where multiple haemorrhoid degrees are documented, assign one code to reflect the highest degree.

In the scenario provided, assign K64.3 *Fourth degree haemorrhoids.*

Query ID 04-0422: Single anastomosis duodeno–ileal bypass with sleeve gastrectomy (SADI-S) procedure for obesity

Query: What ACHI code is assigned for a laparoscopic sleeve gastrectomy with single anastomosis duodeno-ileal bypass (SADI-S) procedure for obesity?

Response: CCAQ advise for a laparoscopic sleeve gastrectomy with single anastomosis duodeno-ileal bypass (SADI-S) procedure, assign as a best fit 90940-00 [889] *Duodenal-jejunal bypass [DJ bypass]* and 30393-00 [984] *Laparoscopy.*

Query ID 05-0422: Delayed delivery of twin and assignment of Z37 *Outcome of delivery*

Query: What Z37 *Outcome of delivery* codes should be assigned on the mother's record for each hospital in the following scenario, involving a twin pregnancy with delivery of twin 1 (stillborn) at hospital A and the delayed delivery five weeks later of twin 2 (liveborn) at hospital B.

Response: CCAQ advise that for hospital A, assign outcome of delivery code Z37.1 *Single stillbirth* and for hospital B assign Z37.0 *Single live birth.*

The Chapter 15 *Pregnancy, childbirth and puerperium codes* (O00-O99) assigned will reflect the twin pregnancy and the delayed delivery of twin 2.

Query ID 06-0422: Traumatic total hip replacement (THR) dislocation and fractured prosthesis requiring revision arthroplasty

Query: Please advise the correct diagnosis codes to assign for a dislocated and fractured hip prosthesis due to trauma requiring a revision arthroplasty.

The patient had a fall resulting in a dislocated and broken hip prosthesis. They were taken to theatre for a revision THR (exchange of spacer) due to the femoral head dissociating from the stem (the ball had snapped off the stem) secondary to dislocation.

Following review of Coding Rule TN199 *Fracture of hip prosthesis due to trauma* and ACS 1309 *Dislocation or complication of hip prosthesis*, it is unclear which of the following codes should be assigned for traumatic dislocations / fractures of a hip joint prosthesis requiring a revision arthroplasty:

A) S73.0- *Dislocation of hip* and Z96.64 *Presence of hip implant*

B) T84.0 *Mechanical complication of internal joint prosthesis*

C) S73.0- *Dislocation of hip* and T84.0 *Mechanical complication of internal joint prosthesis.*

Response: Advice from CCAQ is to continue with current coding practice. CCAQ will seek advice from IHPA regarding correct code assignment, in light of the revised 12th edition ACS 1309 *Dislocation or complication of hip prosthesis*.

Query ID 07-0422: Cellulitis of breast

Query: We are seeking advice on code assignment for a diagnosis of "cellulitis of breast".

Should L03.3 *Cellulitis of trunk* or N61 *Inflammatory disorders of breast* be assigned?

Scenario 1: Postoperative wound infection with cellulitis at previous mastectomy site

T81.4 *Wound infection following a procedure, not elsewhere classified*

L03.3 *Cellulitis of trunk*

Y83.6 *Removal of other organ (partial)(total)*

Y92.2- *Place of occurrence, health service area*

Or

T81.4 *Wound infection following a procedure, not elsewhere classified*

N61 *Inflammatory disorders of breast*

Y83.6 *Removal of other organ (partial)(total)*

Y92.2- *Place of occurrence, health service area*

Scenario 2: Infected breast prosthesis / implant with overlying cellulitis

T85.75 *Infection and inflammatory reaction due to breast prostheses and implants*

L03.3 *Cellulitis of trunk*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Place of occurrence, health service area.*

Or

T85.75 *Infection and inflammatory reaction due to breast prostheses and implants*

N61 *Inflammatory disorders of breast*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Place of occurrence, health service area*

Response: CCAQ advise that for documentation of cellulitis of breast, assign L03.3 *Cellulitis of trunk* following the Alphabetic index Cellulitis/chest wall or Cellulitis/trunk. For the scenarios provided, assign:

Scenario 1

T81.4 *Wound infection following a procedure, not elsewhere classified*

L03.3 *Cellulitis of trunk*

Y83.6 *Removal of other organ (partial)(total)*

Y92.2- *Place of occurrence, health service area*

Scenario 2

T85.75 *Infection and inflammatory reaction due to breast prostheses and implants*

L03.3 *Cellulitis of trunk*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.2- *Place of occurrence, health service area.*

Query ID 08-0422: Prerenal acute kidney injury/failure

Query: We are seeking advice on code assignment for prerenal acute kidney injury/failure, in the absence of documentation of acute tubular necrosis or medullary necrosis.

Response: CCAQ advise that for documentation of prerenal acute kidney injury/failure assign N17.9 *Acute kidney failure, unspecified.*

March 2022

Query ID 01-0322: Reduction of cord lipoma with inguinal hernia repair

Query: What code should be assigned for reduction of cord lipoma (without documentation of excision) performed in association with an inguinal hernia repair, or is it inherent in the inguinal hernia repair and not coded? There is no ACHI code for reduction of spermatic cord lipoma.

Advice from our surgeons is that reduction of a spermatic cord lipoma is a part of the inguinal hernia repair procedure. Based on this clinical advice we have not been assigning a diagnosis or a procedure code for the lipoma, rather treating it as an incidental finding as per ACS 0002 Additional diagnoses and coding:

A diagnosis code from category **K40 Inguinal hernia**

A procedure code from block **[990] Repair of inguinal hernia**

VICC recently released advice (Query 3777 Reduction of spermatic cord lipoma, September 2021) that reduction of spermatic cord lipoma is also known as an excision of lipoma and advises to assign 30644-08 [1181] *Excision of lesion of spermatic cord or epididymis*.

Response: CCAQ agreed that advice should be sought from the clinician to confirm the nature of the procedure performed, and the clinical significance of the condition to determine whether it meets ACS 0002 Additional diagnoses.

CCAQ noted current VICC advice (ref no 3777 Reduction of spermatic cord lipoma) and has submitted a query to IHPA for clarification on whether reduction of a spermatic cord lipoma is inherent in an inguinal hernia procedure, and which procedure code should be assigned when reduction of spermatic cord lipoma is documented.

In the interim, continue with current coding practice until national coding advice is received.

Query ID 02-0322: Insertion of intrauterine device (IUD) for postmenopausal bleeding

Query: Please advise if Z30.1 *Insertion of contraceptive device* should be assigned in the following scenario:

A 64 year old female is admitted for insertion of an intrauterine device and dilation and curettage under general anaesthesia for treatment of postmenopausal bleeding.

Response: Z30.1 *Insertion of contraceptive device* should be assigned where documentation indicates the IUD was inserted for contraceptive management.

If the documented indication for the IUD insertion is a condition, such as postmenopausal bleeding, assign a code for the condition. Z30.1 *Insertion of contraceptive device* would not be assigned.

For the scenario provided, assign diagnosis code N95.0 *Postmenopausal bleeding.*

Query ID 03-0322: Diagnosis code assignment for removal of intrauterine device (IUD)

Query: Q1. Should Z30.5 *Surveillance of contraceptive device* be assigned for a female patient admitted with a mechanical complication of an intrauterine device and during the operative procedure the IUD is removed? Or is the clinical concept of the IUD captured with the assignment of principal diagnosis T83.3 *Mechanical complication of intrauterine device*?

Q2. Is this the same for the following codes, where there is removal of an IUD?

T83.6 *Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract*

T83.81 *Haemorrhage and haematoma following insertion of genitourinary prosthetic devices, implants and grafts*

T83.83 *Pain following insertion of genitourinary prosthetic devices, implants and grafts*

T83.89 *Other specified complications of genitourinary devices, implants and grafts*

Response: Where a patient is admitted for removal of an IUD due to a complication of the device assign appropriate diagnosis codes for the complication.

Additional code Z30.5 *Surveillance of contraceptive device* is not required, as the concept of the IUD is reflected in the complication codes and the procedure code for removal of the device.

Query ID 04-0322: Admission for taking blood tests

Query: What principal diagnosis code should be assigned in the following scenario:

A patient with a neoplasm is participating in a clinical trial. They are admitted for either a blood test or a urine test with nursing review related to the clinical trial. Should the principal diagnosis be:

a. Z01.7 *Laboratory examination*

b. Z00.6 *Examination for* normal *comparison and control in clinical research programme*

c. Other code?

Response: Where documentation indicates that blood or urine tests were performed for monitoring of a patient participating in a clinical trial for their neoplasm, assign a code for the neoplasm as principal diagnosis.

If the reason for the blood or urine test is not clear, a documentation query may be required for clarification.

Where the reason for the blood or urine test is not documented and clarification from the clinician is not possible, assign Z01.7 *Laboratory examination*, using index pathways Examination/laboratory or Test(s)/laboratory.

Note Z00.6 *Examination for normal comparison and control in clinical research programme* is not assigned for patients with a reported diagnosis, as indicated by the title at Z00:

Z00 General examination and investigation of persons without complaint or reported diagnosis

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Query ID 05-0322: Repeat or revision of atrial fibrillation (AF) ablation procedure

Query: Should procedure code 38640-00 [664] *Reoperation for other cardiac procedure, not elsewhere classified* be assigned in the following scenario:

The patient was admitted for “Redo atrial fibrillation cryoablation procedure”. The patient had a previous cryoablation for AF performed in 2018.

ACS 0934 Cardiac and vascular revision/reoperation procedures states 'Revision or reoperation procedures are more complex than initial cardiac and vascular procedures and result in a significant increase in resource consumption. They are most commonly performed for valve replacements, CABGs (coronary artery bypass grafts) and in paediatric procedures such as conduit replacement in congenital heart disease.'

Examples in the ACS are significant cardiac and vascular procedures i.e. Reoperation CABG, replacement of conduit, reoperation of a femoro-popliteal bypass graft. The standard does not refer to minimally invasive, percutaneous procedures such as AF ablation.

Upon reviewing journal articles, the terminology used for this type of procedure is 'repeat ablation' rather than 'revision' or 'redo'. Repeat ablation is primarily considered for those with symptomatic AF recurrences, occurring at least 3 months or more post-ablation. I would not consider repeat ablation procedures as 'revision' or 'reoperation' in line with ACS 0934 as they are essentially the same procedure, they are not correcting a previous surgery, they are not more complex, and they do not result in a significant increase in resource consumption.

Response: CCAQ advise that 38640-00 [664] *Reoperation for other cardiac procedure, not elsewhere classified* would not be assigned for a patient admitted for a ‘redo’ or ‘repeat’ cryoablation procedure.

ACS 0934 states:

Note that reoperation codes should only be assigned when it is necessary to 'redo' or revise the same cardiovascular procedure.

The previously performed ablation procedure is not being redone or revised; the same procedure is being performed at a subsequent time.

Query ID 06-0322: Vaccination / Immunisation in multiday admitted episode of care

Query: Should ICD-10-AM and ACHI codes be assigned where vaccinations or immunisations are administered during a multiday admitted episode of care?

ACS 1500 Diagnosis sequencing in obstetric episodes of care provides guidance for prophylactic vaccination/need for immunisation for obstetric patients, but for non-obstetric patients where the need for immunisation/vaccination meets ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, can an ACHI intervention code be assigned or does ACS 0042 Procedures normally not coded apply?

Response: CCAQ advise that vaccinations or immunisations administered during a multiday episode of care would not be coded, in line with ACS 0042 Procedures normally not coded.

Diagnosis and intervention codes may be assigned for vaccinations or immunisations where specific classification advice has been provided, such as in an ACS or a Coding Rule (for example ACS 1500 Diagnosis sequencing in obstetric episodes of care).

Query ID 07-0322: Documentation of 'due to' versus 'complicating'

Query: Please confirm if code D68.3 *Haemorrhagic disorder due to circulating anticoagulants* can be assigned in the following scenario:

46 Y female presented for management of small haematoma in the thigh 10 days after great saphenous vein aneurysm resection. Note that the patient was discharged after the aneurysm resection on anticoagulation treatment (Rivaroxaban) and was compliant with medication.

Medical Officer documentation states that 'current presentation *with haematoma is complicated by background of anticoagulation* with Rivaroxaban'.

If you disagree with assigning D68.3 *Haemorrhagic disorder due to circulating anticoagulants*, can you please advise the most appropriate diagnosis code for the above documentation OR what specific terminology is required in the documentation to capture the clinical information that describes that anticoagulation treatment is contributing to haematoma formation.

Response: While the documentation in the scenario provided suggests that anticoagulation may be a factor in the current presentation, a clear causal relationship needs to be documented between the bleeding and anticoagulant use before D68.3 *Haemorrhagic disorder due to circulating anticoagulants* can be assigned, in accordance with ACS 0303 Abnormal Coagulation Profile due to Anticoagulants.

Terms such as 'due to' or 'secondary to' would indicate a clear causal relationship.

A documentation query is recommended in this instance to clarify the relationship between the anticoagulation and the haematoma.

Query ID 08-0322: Hypersensitivity pneumonitis secondary to methotrexate

Query: What diagnosis codes (including external cause codes) should be assigned for hypersensitivity pneumonitis secondary to methotrexate?

Response: CCAQ advise that for a diagnosis of hypersensitivity pneumonitis secondary to methotrexate, the following diagnosis codes should be assigned:

J67.9 *Hypersensitivity pneumonitis due to unspecified organic dust*

Y43.1 *Antineoplastic antimetabolites*

Y92.2- *Health service area*

following the index pathways:

Pneumonitis/hypersensitivity J67.9

Methotrexate Y43.1 (Table of drugs and chemicals causing adverse effect in therapeutic use)

Place of occurrence of external cause/health service area Y92.2-

Note that hypersensitivity pneumonitis NOS is an inclusion term at J67.9, and that:

Conditions/entities are not always explicit in a code title; those that are of particular public health importance or that occur frequently usually have their own category. Otherwise, categories are assigned to groups of separate but related conditions. Consequently, there are residual categories for other and miscellaneous conditions that are not allocated to more specific categories (ICD-10-AM Diseases Tabular/Introduction).

February 2022

Query ID 01-0222: Morphology

Query:

Question 1 – 'Component'

When the word 'component' is used in a histopathology report, how is this word 'component' terminology to be understood?

A common example is 'mucinous adenocarcinoma with a signet ring cell component'.

Do we code this to a mucinous adenocarcinoma (M8480/3) or use the higher morphology and code as a signet ring cell carcinoma (M8490/3)?

Question 2 – 'Microscopic section of histology report'

Can the 'Microscopic' section of the histopathology report be used to assign a more specific morphology code, or can we only use what is written in the 'Summary' section of the histopathology report?

Example of this - in the microscopic section, it states 'mucinous adenocarcinoma' but in the summary only 'adenocarcinoma' is stated.

Can we use the more specific morphology from the 'microscopic' section and code 'mucinous adenocarcinoma (M8480/3)' or do we only use what is written in the 'Summary' section and code just 'adenocarcinoma (M8140/3)'?

Response:

Question 1 – 'Component'

CCAQ agreed that when the word 'component' is used in a histopathology report it adds specificity to the morphological diagnosis and should be used to determine code assignment.

In the example provided, assign a code for signet ring cell carcinoma (M8490/3) as it is the morphology with the highest number, as per **ACS 0233 Morphology**, point 5:

5. In a histopathology report, if a morphological diagnosis contains more than one qualifying term classifiable to:

- **different morphology codes**, select the higher number as it is usually more specific (see Example 1).

Question 2 – 'Microscopic section of histology report'

CCAQ agreed that the more specific morphology from the microscopic section of the histology report should be used for morphology code assignment, as per **Coding Rule Ref no: Q3147 *Selection of morphology codes from pathology reports.***

For the example provided, assign a code for mucinous adenocarcinoma (M8480/3).

Query ID 02-0222: Head strike without documentation of head injury

Query: If a patient is admitted post trauma with "Head strike" documented but not "Head injury" and investigations such as a CT head are performed, is S09.9 *Unspecified injury of head* able to be assigned or would a documentation query need to be generated?

Response: CCAQ agreed that a head injury code cannot be assigned from documentation of head strike.

A documentation query may be generated to clarify the diagnosis, in accordance **with ACS 0010 Clinical Documentation and General Abstraction Guidelines.**

Query ID 03-0222: Intrapleural lysis

Query: What ACHI code should be assigned for intrapleural lysis using recombinant deoxyribonuclease (DNase) and tissue plasminogen activator (tPA)?

Intrapleural lysis with DNase and tPA is performed via an intercostal catheter for treatment of loculated pleural effusions.

Response: CCAQ agreed that ACHI code 38806-00 [560] *Insertion of intercostal catheter for drainage* should be assigned for intrapleural lysis.

An additional code for the drug treatment (DNase and tPA) is not required, as per **ACS 0042 Procedures Normally Not Coded/Classification point 8**:

Procedures are normally not coded where they are routine in nature, performed for most patients or are components of another procedure (see also ACS 0016 *General procedure guidelines*). Most importantly, the resources used to perform these procedures are often reflected in the diagnosis or in an associated procedure. That is, for a particular diagnosis or procedure there is a standard treatment that is unnecessary to code.

...

The procedures listed below are normally not coded:

...

8. **Drug treatment/pharmacotherapy/prescription of drugs** (e.g. total parental nutrition (TPN))

   Exception(s): code following the guidelines in:

   - ACS 0044 *Pharmacotherapy*
   - ACS 0534 *Specific interventions related to mental health care services*
   - ACS 0943 *Thrombolytic therapy*
   - ACS 1316 *Cement spacer/beads*
   - ACS 1500 *Diagnosis sequencing in obstetric episodes of care*
   - ACS 1511 *Termination of pregnancy (abortion)*
   - ACS 1615 *Specific diseases and interventions related to the sick neonate*

Note: this query has been sent to IHPA for their consideration (February 2022).

Query ID 04-0222: Assignment of laparoscopy code

Query: Please advise what procedure code(s) should be assigned for the following scenario:

Patient admitted with adenocarcinoma of the rectosigmoid junction. The patient also has abdominal adhesions.

A laparoscopic high anterior resection of the rectum and laparoscopic division of adhesions was performed under GA (ASA 19).

Should 32024-00 [935] *High anterior resection of rectum* be assigned with an additional laparoscopy procedure code (30390-00 [984] Laparoscopy) or does the inclusion of 30393-00 [986] *Laparoscopic division of abdominal adhesions* negate the need for assigning the laparoscopy code (30390-00 [984] *Laparoscopy*) immediately after 32024-00 [935]?

Option 1:

32024-00 [935]	*High anterior resection of rectum*
30393-00 [986]	*Laparoscopic division of abdominal adhesions*
92514-19 [1910]	*General anaesthesia, ASA 19*

Option 2:

32024-00 [935]	*High anterior resection of rectum*
30390-00 [984]	*Laparoscopy*
30393-00 [986]	*Laparoscopic division of abdominal adhesions*
92514-19 [1910]	*General anaesthesia, ASA 19*

Response: CCAQ agreed that in the scenario provided, an additional code for the laparoscopy (30390-00 [984]) is not required, as the laparoscopic component of the procedure is captured in 30393-00 [986] *Laparoscopic division of abdominal adhesions*.

The procedure codes to assign for the scenario provided are (Option 1):

32024-00 [935]	*High anterior resection of rectum*
30393-00 [986]	*Laparoscopic division of abdominal adhesions*
92514-19 [1910]	*General anaesthesia, ASA 19*

Query ID 05-0222: Panendoscopy with inspection of larynx

Query: Please advise what procedure code(s) should be assigned in the following scenario:

Procedure: Fibreoptic laryngoscopy and upper GI endoscopy

Indication: Dysphagia & regurgitation

Under IV sedation & analgesia the gastroscope was introduced to the third part of the duodenum. The supraglottic, glottis and subglottic components of the larynx appeared normal. Vocal cords appeared normal.

At the OGJ there was evidence of moderate reflux. Barrett's oesophagus was noted. Antral gastritis was noted. Moderate duodenitis? H Pylori.

Suggested codes:

Option A:	30473-00 [1005]	*Panendoscopy to duodenum*
Option B:	30473-00 [1005]	*Panendoscopy to duodenum*, and
	41764-03 [520]	*Fibreoptic laryngoscopy*

Option C: Other codes?

Response: CCAQ agreed that in the scenario provided, both the laryngoscopy and gastroscopy procedures should be coded, with the following codes assigned:

30473-00 [1005]	*Panendoscopy to duodenum*, and
41764-03 [520]	*Fibreoptic laryngoscopy*

Query ID 06-0222: Retrograde drilling of osteochondritis dissecans (OCD) knee lesion

Query: What procedure code should be assigned for retrograde drilling of the knee (medial femoral condyle) to treat osteochondritis dissecans? Neither chondroplasty nor arthroscopy has been documented on the procedure report.

Procedure report: After a team timeout, administration of anaesthetic and sterile prep and drape, a 1cm incision was made over the medial aspect of the distal femur (at the junction of the condyle) and 1.6mm K wires advanced into the OCD lesion 12 times. II shots were saved with each set of 4 passes. The procedure was repeated on the right side. The wounds were washed and closed with Monocryl.

Looking at the ACHI alphabetic index using 'Drilling' as the lead term, the only sub-term available is 'with chondroplasty', an essential modifier:

Drilling/bone/knee/with/chondroplasty 49558-01 [1520]

49558-01 [1520] *Arthroscopic chondroplasty of knee*

Research indicates that OCD is a pathologic lesion affecting articular cartilage and subchondral bone with one of the operative techniques being subchondral drilling with a K-wire or drill with the expected outcome of formation of fibrocartilagenous tissue

(https://www.orthobullets.com/knee-and-sports/3028/osteochondritis-dissecans).

Using our knowledge of medical terminology (chondr/o = cartilage + plasty = repair) and our clinical knowledge that drilling of the femoral condyle refers to drilling of bone and cartilage to promote the development of healthy cartilage, we have used the lead term Chondroplasty in the ACHI alphabetic index to assign 49503-02 [1520] *Chondroplasty of knee*.

Response: CCAQ agreed that this is a documentation issue, as the clinician has used the term drilling, not chondroplasty. CCAQ agreed that a documentation query should be raised and if chondroplasty is confirmed, follow the ACHI index using the lead term Chondroplasty to assign a code.

Note: ICD-10-AM/ACHI/ACS 12th Edition contains updates to the musculoskeletal system. The ACHI updates are intended to address issues relating to the classification of musculoskeletal (orthopaedic) surgery.

Query ID 07-0222: Intraoperative bent K wire

Query: Please advise if a mechanical complication should be coded for a bent K-wire in the following scenario:

Patient presents with a trimalleolar fracture of the right ankle. Right ankle ORIF was performed. Post fracture reduction, the clinician had documented on the operation report "ankle very unstable and dislocating – II (Image Intensifier) showed medial malleolus had displaced and K wire bent therefore removed". There was no documentation of any injury sustained to the patient from the bent wire.

Is this considered a procedural complication as it did not cause any injury to the patient, and it was managed as part of the fracture reduction procedure?

Response: CCAQ agreed that as there was no injury to the patient as a consequence of the bent K-wire, it would not be considered a procedural complication. Therefore, it would not be appropriate to assign a mechanical complication code.

Query ID 08-0222: Pharmacotherapy for IV administration of Infliximab

Query: Please advise what ACHI code is to be assigned for same day IV administration of Infliximab?

A recent data quality activity has identified that there are admitted episodes of care where code 96199-04 [1920] Intravenous administration of pharmacological agent, antidote has been assigned for intravenous administration of Infliximab.

Response: Infliximab is a humanised monoclonal antibody but is classified as an immunomodifier (MIMS | Quick Search (mimsonline.com.au)).

CCAQ agreed that the correct code for same day intravenous administration of Infliximab is 96199-19 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent.*

Query ID 03-0621: Obesity meeting ACS 0002

Query: Can CCAQ please advise if the use of a Hovermat, or other bariatric equipment, is considered increased care for surgical patients or is it considered "routine care" for the obese patient?

i.e., Patient having surgical procedure, documentation of "Hovermat used due to obesity", would the obesity then meet ACS 0002?

Response: CCAQ agreed that the use of a Hovermat for obese surgical patients would be considered routine care, therefore would not meet the criteria in ACS 0002 Additional diagnoses/Increased clinical care.

November 2021

Query ID 02-1121: Gastroscopy with insertion of Nasojejunal (NJ) Tube

Query: Can CCAQ please advise what is the correct ACHI code for insertion of a nasojejunal (NJ) tube via gastroscopy?

Response: CCAQ noted there is currently one query (Ref Q3747, submitted 1/10/21) and one public submission (Ref P511, submitted 14/4/21) with IHPA.

Advice from CCAQ is for facilities to continue with their current practice to maintain data consistency until IHPA provide a response to existing submissions.

CCAQ will not be submitting an additional query to IHPA at this stage but will await IHPA's response to existing jurisdictional queries.

Query ID 03-1121: ieMR usage

Query: Can an ieMR site use clinical information from another site's ieMR, as we have access to view these, regardless of whether the site is within its district or not?

For example, a patient is admitted and discharged from Hospital A (ieMR site). The patient is subsequently admitted to Hospital B (ieMR site).

Can Hospital B refer to hospital A's episode of care clinical notes, pathology results or other clinical information on ieMR?

Can the information from Hospital A's episode of care be used for coding in Hospital B's episode of care?

Response: CCAQ agreed that it is acceptable to utilise documentation from outside the current episode of care for the purpose of adding specificity or for clarification of already documented conditions, in line with **ACS 0010 Clinical Documentation and General Abstraction Guidelines**.

Query ID 04-1121: F90 excludes note with mood disorders (F30 – F39)

Query: Can CCAQ please provide advice as to the code(s) that would be assigned for the below scenario.

Patient admitted with Major Depression and ADHD. During the episode of care the patient is actively treated for ADHD (change in the medication). As per ICD-10-AM Tabular, F90 has an

excludes note with mood disorders (F30 – F39): F90 Hyperkinetic disorders Excludes: anxiety disorders (F41.-) mood [affective] disorders (F30–F39) pervasive developmental disorders (F84.-) schizophrenia (F20.-)

Response: CCAQ note the Conventions used in the tabular list of diseases/Instructional notes/terms/Excludes notes state: "*Excludes notes are listed at the chapter, block category and code levels in the Tabular List. Some are a guide to redirect users from an incorrect code to a correct code (see Example 18), and some support mortality coding* (see Example 19).*"

**mortality coding is single condition coding*

In the scenario provided, there are two conditions that both meet criteria for coding, major depression and ADHD. Following the Conventions used in the tabular list of diseases/multiple condition coding, both conditions should be coded to fully describe the episode of care: MULTIPLE CONDITION CODING In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care. This does not mean multiple codes are assigned to describe a single condition (unless otherwise instructed).

September 2021

Query ID 01-0921: PD selection for maintenance patients awaiting home modifications

Query: Can we please confirm the correct principal diagnosis selection for maintenance patients who are awaiting home modifications before they can be discharged home? Eg installation of ramp or bathroom equipment. We had previously been assigning Z59.1 Inadequate housing however this is repeatedly flagging on HQI / EVA with the following edit:

Principal diagnosis code Z591 is an unexpected code for Care type 11 Maintenance episodes of care.

Response: CCAQ agreed there was nothing precluding the use of Z59.1 *Inadequate housing* as principal diagnosis in the scenario provided. The validation impacting assignment of Z59.1 is informed by **ACS 2105 Long term/nursing home type inpatients** and **ACS 2117 Non-acute care** and is a warning, not a fatal error.

It was noted that there is neither an excludes note at chapter level (Chapter 21 Factors influencing health status and contact with health services (Z00–Z99)) or at block level (Z55-Z65) to preclude the use of code Z59.1.

It was also noted that **ACS 0050 Unacceptable principal diagnosis codes** states "A number of codes from Chapter 21 Factors influencing health status and contact with health services (Z00–Z99) have been flagged as unacceptable principal diagnoses, however it should be noted that there are many other codes from this chapter that will rarely be appropriate to assign as a principal diagnosis in an admitted episode of care".

An alternate code that may be considered as principal diagnosis for the scenario given is Z76.8 *Persons encountering health services in other specified* circumstances, with Z59.1 *Inadequate housing* assigned as an additional diagnosis, following the ICD-10-AM index:

Encounter with health service (for) Z76.9

- administrative purpose only Z02.9

- - specified reason NEC Z02.8

- specified NEC Z76.8

Query ID 02-0921: Use of documentation in Anaesthesia Record

Query: Would documentation by the Anaesthetist in the 'Medication Comments' section of the anaesthetic record such as 'Metaraminol for hypotension' be considered valid documentation for clinical coding?

I'm aware of **ACS 0010 Clinical documentation and general abstraction guidelines** which states "documentation of the indication for a drug on the medication chart must be qualified within the body of the current episode of care".

The ‘medication comments’ section (as described above) sits within the ‘Anaesthesia Printed Record’ (ieMR). Is there a requirement for separate documentation outside of the ‘Anaesthesia Printed Record’ to assign the appropriate codes?

Response: The anaesthetic record forms a part of the health care record within the episode of care, in paper-based, electronic and hybrid heath care records.

Provided the documentation is recorded by the clinician (i.e., anaesthetist), and there is documentation of a condition and treatment is linked to the condition (i.e., the condition meets criteria for coding as per **ACS 0002 Additional diagnosis**), it is acceptable to code from the anaesthetic record and does not need to be qualified elsewhere.

If the anaesthetic record shows that a medication (i.e., Metaraminol) was given and blood pressure was outside the normal range but without documentation of hypotension, or without a link made between the condition and the treatment, a documentation query may be appropriate to seek clarification.

Query ID 03-0921: Perineural Diverticula of Thoracic Spine

Query: The query sought advice on the correct diagnosis code to assign for a perineural diverticula of thoracic spine.

The scenario was an admission where an epidural blood patch of thoracic spine was performed with indication documented "perineural diverticuli". Using diverticula as a lead search term there is no appropriate sub-term available.

Research indicates spinal diverticulae are also known as cysts www.ncbi.nlm.nih.gov/pmc/articles/PMC5507759/

The alphabetic index cyst > spinal meninges - codes to G96.1 *Disorders of meninges, not elsewhere classified*.

Is this the correct code for spinal diverticuli?

Response: CCAQ agreed there is no index pathway for Diverticula/perineural and recommend seeking clarification from the clinician on what is meant by the term “perineural diverticula” to adequately classify the diagnosis.

Query ID 04-0921: Cystic Fibrosis bronchiectasis and organism

Query: The query sought advice for a scenario where the patient is admitted with "Acute pulmonary exacerbation of cystic fibrosis". Patient has a medical history of chronic Pseudomonas aeruginosa infection. Sputum this admission cultured P.aeruginosa. Management included insertion of PICC and IV antibiotics (Ceftazidime and Tobramycin).

Question 1: For the above scenario, is it correct coding practice to add an Additional Diagnosis code of B96.5 Pseudomonas (aeruginosa) as the cause of diseases classified to other chapters?

Question 2: Documentation of "exacerbation of CF bronchiectasis - MRSA". Does this documentation enable assignment of an Additional Diagnosis code of B95.6 Staphylococcus aureus as the cause of diseases classified to other chapters?

Response: For an acute pulmonary exacerbation of cystic fibrosis with a specific organism(s) identified as the causative agent(s), assign a code for the cystic fibrosis with an additional code from category B95-B97 to indicate the association of the organism with the current exacerbation (Q1). The significance of the organism may need to be clarified with the clinician if not adequately documented.

There are several examples within the classification where an organism code (B95-B97) is assigned in addition to a code for a condition that is not classified as an infection, to indicate the association between a condition and an organism:

ACS 1122 *Helicobacter pylori*

Q2802 Paediatric Autoimmune Neuropsychiatric Disorders (PANDAS)

TN196 Poststreptococcal glomerulonephritis

Note ACS 0112 *Infection with drug resistant microorganisms*, which contains classification advice to assign first a code for an infection, relates to the "coding of antibiotic or antimicrobial drug resistant organisms that have caused an infection in the patient". ACS 0112 does not preclude the assignment of an organism code in other scenarios.

CCAQ also agreed that B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters* could be assigned as an additional diagnosis in the scenario provided (Q2), provided there is evidence that MRSA was a current infection. The documentation "exacerbation of CF bronchiectasis – MRSA" indicates a relationship between the CF/bronchiectasis and MRSA. If the MRSA was a colonisation, rather than an infection, it may be more appropriate to assign a carrier status code (i.e., Z22.3 *Carrier of other specified bacterial diseases*).

Query ID 05-0921: Dehydration and Diarrhoea

Query: Can CCAQ please confirm the codes that would be assigned, and which would be the principal diagnosis for the below scenario?

Patient is admitted with dehydration and diarrhoea. There is no documentation of gastroenteritis.

Response: Unspecified diarrhoea is indexed to A09.9 *Other gastroenteritis and colitis of unspecified origin*.

Category A09 is annotated with the symbol ∇ **,** denoting that an ACS applies to all codes within the category (see Conventions used in the tabular list of diseases/Special signs/annotations).

Therefore, for documentation of both dehydration and diarrhoea (where both conditions were treated), assign the following codes, sequenced in accordance with **ACS 1120 Dehydration with gastroenteritis**:

PDX A09.9 *Other gastroenteritis and colitis of unspecified origin*

ADX E86 *Volume depletion*

Query ID 06-0921: DRG Allocation Sheets

Query: Can CCAQ please provide advice as to whether DRG Allocation Sheets are part of the clinical record and if they can be used to assign/validate diagnoses and procedures?

Response: DRG allocation sheets should be treated in a similar way to a discharge summary – they should be signed and designated by the clinician and all documentation on the DRG allocation sheet should be verified within the episode notes and meet criteria for coding (ACS 0001, 0002 or another ACS/Coding Rule/convention) before assigning a code.

Conditions or procedures that are documented on a DRG Allocation Sheet but cannot be verified within the episode notes should not be coded.

ACS 0010 Clinical Documentation and General Abstraction Guidelines states:

> **ROLES AND RESPONSIBILITIES IN THE DOCUMENTATION AND ABSTRACTION PROCESS**
>
> It is not the role of a clinical coder (or clinical documentation improvement specialist (CDIS)) to diagnose. Clinical documentation of accurate diagnoses is the responsibility of the clinician. Clear and accurate clinical documentation is critical to the continuity and quality of patient care and patient safety, and is the legal record of a patient's episode of care.
>
> The listing of clinical concepts (eg diseases and interventions) on the front sheet and/or the discharge summary (or equivalent) for an episode of care is the responsibility of the clinician. These responsibilities include identifying and documenting the principal diagnosis, and listing all additional diagnoses and interventions performed during the episode of care. Each diagnostic statement and intervention must be as informative as possible in order for the clinical coder to classify the clinical concept to the most specific ICD-10-AM or ACHI code.
>
> Before classifying any documented clinical concept, the clinical coder must verify information on the front sheet and/or the discharge summary (or equivalent) by reviewing pertinent documents/data within the body of the current episode of care.

August 2021

Query ID 01-0821: Application of Biodegradable Temporising Matrix (BTM)

Query: What procedure code is assigned for application of a Biodegradable Temporizing Matrix (BTM)?

Response: Biodegradable Temporizing Matrix (BTM) is a man-made synthetic polymer used for temporary wound closure and to assist in generation of new tissue.

https://polynovo.com/novosorb-btm/

BTM is a product similar to Biobrane and Integra, which are both classified to 90672-00 [1640] *Synthetic skin graft* and 90672-01 [1640] *Synthetic skin graft to burn.*

Where Biodegradable Temporizing Matrix (BTM) has been used, assign either:

90672-00 [1640] *Synthetic skin graft*

or

90672-01 [1640] *Synthetic skin graft to burn*

by following the index pathways:

For skin:

Dressing/synthetic

Graft/skin/synthetic

For burns:

Dressing/synthetic/for burn

Graft/skin/synthetic/for burn

Query ID 02-0821: Prominent Internal Fixation Device

Query: What diagnosis code is assigned where 'prominent fixation device' is documented as the indication for removal of an internal fixation device? There is no specific index pathway for 'prominent'.

Response: CCAQ agreed that 'prominent' could be considered synonymous with 'protrusion/protruded' and is therefore classified as a mechanical complication.

Follow the ICD-10-AM index:

Protrusion, protrusion/device, implant or graft (see also Complication(s)/by site and type/mechanical)/fixation, internal (orthopaedic) NEC to assign T84.2 *Mechanical complication of internal fixation device of other bones* or T84.1 *Mechanical complication of internal fixation device of bones of limb.*

Query ID 03-0821: Mechanical and osteolytic complication of Intervertebral disc prosthesis

Query: What is the correct procedural complication code to assign for a mechanical or osteolysis complication of a spinal intervertebral disc prosthesis?

Response: Vertebral disc replacement is a type of arthroplasty and can be an alternative to spinal fusion.

Osteolysis is a process of bone resorption in response to particulate debris and may be associated with implants and fixation devices.

For a mechanical complication of an intervertebral disc prosthesis, follow the ICD-10-AM index:

Complication/arthroplasty/mechanical to assign T84.0 *Mechanical complication of internal joint prosthesis*

For postprocedural osteolysis not documented as due to mechanical complication of a device, follow the ICD-10-AM index:

Osteolysis/postprocedural to assign M96.8 *Other intraoperative and postprocedural disorders of musculoskeletal system*

An additional code may be assigned to add specificity to the type of complication (as per ACS 1904). Follow the ICD-10-AM index:

Osteolysis/specified NEC to assign M89.58 *Osteolysis, other site*

Assign external cause codes as appropriate.

Note: a clinical documentation query may be required to clarify the nature of the complication.

Query ID 04-0821: Pregnancy complicated by respiratory (RTI) or respiratory syncytial virus (RSV)

Query: What diagnosis codes should be assigned for an admitted episode of care relating to pregnancy complicated by respiratory tract infection with respiratory syncytial virus confirmed as the causative agent?

Response: For pregnancy complicated by a respiratory tract infection with RSV confirmed as the causative agent, assign:

O99.5 *Diseases of the respiratory system in pregnancy, childbirth and the puerperium*

A code for the respiratory tract infection (J98.8, J22 or J06.9 depending on specific documentation)

B97.4 *Respiratory syncytial virus as the cause of diseases classified to other chapters*

following the index:

Pregnancy/complicated by/conditions in/J00-J99 O99.5

Infection/respiratory (tract) NEC

Infection/respiratory/syncytial virus, as cause of disease classified elsewhere B97.4

Note:

O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium* is assigned for conditions classified to A80-B09 and B25-B34 (ie Chapter 1 codes).

O98.8 *Other maternal infectious and parasitic diseases in pregnancy, childbirth and the puerperium* is assigned for conditions specifically indexed to that code (i.e. Pregnancy/complicated by/infections/specified NEC) and for conditions classified to the code ranges at Pregnancy/complicated by/conditions in (A00-A07, A09, A24-A49, A65-A79, B35-B49 and B65-B94).

The code ranges provided at *Pregnancy/complicated by/conditions in* can be used as a guide for the correct code assignment.

B97.4 *Respiratory syncytial virus as the cause of diseases classified to other chapters* is assigned to add specificity to the infection code (J98.8, J22 or J06.9) and does not need its own O 'cover' code.

Query ID 05-0821: CCF/APO with ischaemic cardiomyopathy

Query: Can a code for heart failure i.e. I50.0 *Congestive heart failure*, I50.1 *Left ventricular failure* or I50.9 *Heart failure, unspecified* be assigned in addition to I25.5 *Ischaemic cardiomyopathy*? Although block I50* does not have any excludes notes, Index Failure – Heart-Ischaemic leads to I25.5 *Ischaemic cardiomyopathy*.

ACS 0940 Ischaemic Heart Disease states that ischaemic cardiomyopathy can lead to heart failure and so they are two distinct conditions. We would want to code both conditions to fully translate clinical concepts into code.

Response: If both the heart failure and cardiomyopathy meet criteria for coding (ACS 0001, ACS 0002 or another specialty standard), assign codes for both conditions to fully describe the episode of care.

Note: The Conventions used in the Tabular List of diseases state:

In Australia, multiple condition coding (meaning that multiple conditions may be assigned in an episode of care) is used to provide the necessary specificity to fully describe the episode of care.

Query ID 06-0821: Postembolisation syndrome (PES)

Query: What codes should be assigned for Postembolisation syndrome (PES)?

Response: Post-embolisation syndrome (PES) is a common complication of transarterial embolisation and chemoembolisation, such as TACE (transarterial chemoembolisation) for liver lesions and uterine embolisation for management of fibroids. PES comprises a constellation of symptoms including pain, fever, nausea and vomiting. Onset is usually within the first 72 hours after embolization and is often self-limiting. It is thought that PES may be caused by tissue infarction and necrosis, leading to the release of breakdown products. (https://radiopaedia.org/articles/post-embolisation-syndrome-1).

CCAQ considers that PES meets the criteria to be coded as a postprocedural complication, as the relationship is inherent in the diagnosis (ACS 1904 Procedural complications/Overview – second dot point).

As the condition is not related to a prosthetic device, implant or graft and the symptoms are not specific to a body system, assign T81.89 *Other complications following a procedure, not elsewhere classified* following the ICD-10-AM Index:

Complication/postprocedural/specified NEC T81.89

Additional codes may be added to provide specificity to the condition (i.e., fever, nausea, vomiting) in accordance with ACS 1904 *Procedural complications* and Coding Rule TN1504 *ACS 1904 Procedural complications – additional code to add specificity.*

U91 *Syndrome, not elsewhere classified* may be assigned where it meets the criteria in ACS 0005 Syndromes.

Query ID 07-0821: Coding long term use of anticoagulant

Query: Can code Z86.72 *Personal history of thrombosis and embolism* be assigned with Z92.1 *Personal history of long term (current) use of anticoagulants*, when personal history of thrombus meets ACS 0002 for a patient who is on long term anticoagulants (meeting ACS 0002 and ACS 0303).

For example, a patient on Warfarin (long term) requires review by the Vascular team for their history of pulmonary embolus and deep vein thrombosis (DVT).

Response: For a patient on long term anticoagulant therapy and a personal history of thrombosis and embolism meeting ACS 0002, assign only Z92.1 *Personal history of long term (current) use of anticoagulants* following the excludes note at code Z86.72 *Personal history of thrombosis and embolism*:

Excludes: personal history of cerebrovascular thrombosis and embolism (Z86.71)

that with current:

- abnormal coagulation profile (R79.83)
- haemorrhagic disorder due to circulating anticoagulants (D68.3)
- long term use of anticoagulants without haemorrhagic disorder (Z92.1)

Query ID 09-0821: Terminology for dehydration

Query: The query sought advice on assigning a code for dehydration based on documentation of "clinically dry" with plan and administration of IVT (Intravenous therapy). We often see this terminology in clinical notes and have initiated clinical query with confirmation of dehydration. However, it will be helpful if we have a state or national level (if required) advice on this. An example of documentation is as following:

Clinically dry - Did not reach oral fluid target. Clinically dry. Needs to drink up. Aim to have 3L.

Plan: IVT 1L today.

Pt given 1L of fluid on same day.

Response: CCAQ agreed that 'clinically dry' is not synonymous with 'dehydration' and that in this instance a clinical documentation query should be submitted to clarify the diagnosis.

Query ID 10-0821: Insertion of Barrigel® prior to radiation therapy

Query: The query sought advice in the scenario where a Urologist uses Barrigel® as a treatment prior to radiation therapy. Documentation within the operation record describes this procedure - "Barrigel® deposition of tissue expander interprostatorectal plane".

Do we follow the ACHI Alphabetic Index > insertion > tissue expander > intraoperative and assign 45572-00 *Intraoperative insertion of tissue expander* which groups to an error DRG?

Or do you consider the VICC advice in Query 3530 'Insertion of Trace IT' to be more appropriate and therefore we are to follow the pathway > administration agent > prostate and assign 37218-01 *Administration of agent into prostate/periprostatic tissue (includes: SpaceOAR)* which groups to a prostate malignancy DRG.

Response: Barrigel® is a prostate spacer, injected between the rectum and prostate, and is used to protect healthy organs by minimising the side effects of prostate radiation therapy (https://barrigel.eu/).

For insertion of Barrigel®, assign 37218-01 [1160] *Administration of agent into prostate* by following the index:

Administration/specified site/periprostatic tissue (SpaceOAR) (spacing organs at risk) 37218-01 [1160]

July 2021

Query ID 01-0721: Dialysis and dialysis training

Query: The query sought advice where a patient is admitted for dialysis as well as training/education for future home dialysis. Should both 13100-00 [1060] *Haemodialysis* and 13104-00 [1063] *Education and training for home dialysis* be assigned for the admitted episode of care?

Most same-day admitted episodes of care for dialysis are auto-coded. Should facilities be capturing 13104-00 [1063] *Education and training for home dialysis* where this is provided, or is there other ways facilities can/are capturing information on those patients that are receiving education and training for dialysis during their dialysis admitted episode of care?

Response: CCAQ noted that Haemodialysis is routinely auto coded so this level of detail is not available for these cases. Some jurisdictions do check the peritoneal dialysis cases and add the education codes as required.

The suggested code is: 13104-00 (1063) *Education and training for home dialysis*.

Query ID 03-0721: Bone donation as part of elective joint replacement

Query: The query sought advice on whether Z52.2 *Bone donor* should be assigned where bone removed as part of an elective joint replacement (i.e. hip replacement) and is sent on the Queensland Bone Bank.

Related documentation: Statewide form SW243 Donor Declaration and Questionnaire.

Australian Coding Standard 0030 *Organ, tissue and cell procurement and transplantation* does not address this specific scenario.

Response: CCAQ agreed that the Z52.2 *Bone Donor* should be coded as the Additional Diagnosis in accordance with ACS 0030 *Organ, tissue and cell procurement and*. No ACHI code is required as the bone removal is a component of the joint replacement.

Query ID 04-0721: Coding E11.72 Type2 diabetes mellitus with features of insulin resistance

Query: The query sought advice on whether the BMI can be used to assign E11.72 when there is no documentation of a condition such as obesity, morbid obesity or overweight as per ACS 0401. T2DM and BMI of 29.5 is documented in the anaesthetic record.

The following coding rules around BMI would indicate to use a result the condition must be clearly documented or clinically significant:

Q2974 Coding from test results and findings on radiological reports

Q3482 Supplementary U code for obesity

Q3384 BMI from calculated EMR fields.

Response: CCAQ agreed that in this scenario (BMI has been assessed and documented by an Anaesthetist) on a background of Type 2 diabetes, the coding assignment of E11.72 *Type2 diabetes mellitus with features of insulin resistance* is appropriate (Diabetes with overweight (BMI ≥ 25 kg/m2 to ≤; 29.99 kg/m2)).

The BMI on its own does not meet ACS 0002 for Chapter coding assignment however in this scenario, the ACS 0401 Diabetes mellitus and intermediate hyperglycaemia is the reason that E11.72 can be captured. A 'U' code is not applicable as the range for this code is BMI ≥ 30.00 kg/m2.

Query ID 07-0721: Absence of Red Eye Reflex

Query: The query sought advice on coding assignment for Red Eye Reflex.

Three different codes have been considered:

- H57.8 *Other specified disorders of eye and adnexa*
- P96.89 *Other conditions originating in the perinatal period* along with Z03.79 *Observation for suspected disease or conditions, unspecified*
- *R68.8 Other specified general symptoms and signs derived independently from the retired VICC advice below.*

VICC advice which was retired on 30/06/2020 states:

"VICC considers that as red eye reflex is a clinical sign which has been investigated with no definitive diagnosis being made, a code could be assigned in accordance with ACS 1802 Signs and symptoms. VICC considers that the appropriate code to assign in this circumstance is R68.8 *Other specified general symptoms and signs following the index entry Abnormal/clinical findings NEC*."

Response: CCAQ agreed that in this scenario, in the absence of further clinical documentation for an eye diagnosis, R68.8 *Other specified general symptoms and signs* is the appropriate coding assignment. A clinical documentation query should be submitted to determine if there is an underlying eye disorder which can be coded.

June 2021

Query ID 02-0621: Pre-anaesthesia medication

Query: The query sought clarification for code assignment under ACS 0002, specifically with regards to pre-existing conditions and what is considered minor adjustment vs major variation to a plan of care as well as preoperative management.

Scenario:

A 75 year old high risk patient with multiple comorbidities presents with #NOF and is scheduled for theatre. The anaesthetist notes the patient has a co-morbidity of asthma and gives pre-medication salbutamol to "decrease the reactiveness of the patient's airway" whilst under anaesthetic. Operation proceeds without complications.

Can Asthma be coded in this instance?

The same patient also has chronic AF. The anaesthetist determines that blood pressure measurements at spaced out intervals may be unsafe and inserts an arterial line for invasive blood pressure monitoring.

Can AF be coded due to this intervention given that it is not routine patient care and is not required for every patient undergoing surgery.?

In both instances the anaesthetist makes a direct correlation between the condition and treatment/intervention.

Response: CCAQ agreed that in this scenario U83.3 *Asthma, without mention of chronic obstructive pulmonary disease* should be assigned.

CCAQ recommended that a clinical documentation query be submitted to establish a link between the AF and the procedure. If the link can be established, then it can be coded in line with ACS 0002 as the insertion of the arterial line is invasive and more than routine care.

Query ID 04-0621: Adhesions divided at Caesarean

Query: The query sought advice on National Coding Advice published in December 2019 to code adhesions divided during caesarean section to O655 *Labour and delivery affected by abnormality of maternal pelvic organs*.

That advice does not direct Clinical Coders to add an additional chapter code to specify the type of abnormality (the adhesions).

ACS 1500 DIAGNOSIS SEQUENCING IN OBSTETRIC EPISODES OF CARE advises to "*Assign a code from another chapter when it adds specificity to the Chapter 15 code, or as per any instructional notes.*"

Should an additional chapter code be assigned to specify the type of abnormality with O655 *Labour and delivery affected by abnormality of maternal pelvic organs* when adhesions are divided during caesarean section?

If an additional chapter code is assigned for the adhesions would the chapter code depend on the documentation?

N994 *Postprocedural pelvic peritoneal adhesions*

N736 *Female peritoneal adhesions*

K660 *Peritoneal adhesions*

Response: CCAQ advise to follow the coding rule and only code O65.5 *Labour and delivery affected by abnormality of maternal pelvic organs.*

Query ID 05-0621: Removal of intradural schwannoma

Query: The query sought confirmation of the correct procedure code for removal of schwannoma arising from spinal nerve roots during Laminectomy with excision of intraspinal lesion.

Response: CCAQ agreed that in this scenario the appropriate procedure code for removal of schwannoma is 40312-00 *Removal of spinal intradural lesion*.

Query ID 06-0621: 3D Modelling Implant

Query: The query sought advice on the appropriate ACHI code assignment to identify 3D modelling technology.

The facility's Plastics team have introduced 3D modelling to solve complicated surgical cases such as jawbone, skull & pectus reconstructions & tibial implantation using a 3D printed bone. Computer assisted image guidance is used to assess the patient's defect (in an outpatient setting) to get the 3D image of the patient's defect and these 3D images are sent to a lab in Singapore where the implants are made. A customised bioabsorbable implant is created in a lab, which is then implanted (bioabsorbable implant) as part of the reconstruction process.

We would like to identify the cases that involve the use of this 3D technology from the coded data.

Response: CCAQ agreed that within the current classifications the creation of the 3D model would not be coded as it did not occur within the admission time.

May 2021

Query ID 07-0521: Malignant Pleural Effusion in Lymphoma / Leukaemia

Query: The query sought advice on whether Pleural Effusion J90 is able to be coded as the PDx for patients with Lymphoma / Leukaemia when patients are admitted with malignant pleural effusion for insertion of ICC for drainage and the PDx on the Discharge Summary is listed as Malignant Pleural Effusion? These patients may re-present multiple times to have their effusions drained.

ACS0222 LYMPHOMA advises that lymphomas are classified to categories C81-C88 and are never classified as metastatic neoplasms.

In ACS0222 EXAMPLE 1 a patient with lymphoma was admitted for drainage of malignant ascites under GA and the malignant ascites was not coded.

In ACS0001 PRINCIPAL DIAGNOSIS Point 2. Coding the problem as the principal diagnosis EXAMPLE 4 Patient is admitted for drainage of ascites due to know underlying liver disease and the ascites is coded as the PDx with the liver disease coded as an ADx.

Response: CCAQ agreed that only the malignancy is to be coded.

Query ID 08-0521: Pharmacotherapy for neoplasm

Query: The query sought advice on the coding of pharmacotherapy for neoplasm and neoplasm related conditions.

The query relates to the coding of drugs if they are considered 'chemotherapeutic' when the drugs administered are not 'chemotherapy' such as paracetamol and steroids.

Coding rule Q3476 regarding the coding of oral chemotherapy was released by IHPA in December 2020.

The IHPA advice appears to conflict with the notes in the tabular at block 1920 *Administration of pharmacotherapy* and the advice in ACS 0044 PHARMACOTHERAPY. If the aim of the drugs is to stop the cancer or to treat a condition related to the malignancy, it is considered an antineoplastic drug as per the Pharmacotherapy ACS.

The IHPA advice regarding assigning code 96203-00 [1920] *Oral administration of pharmacological agent, antineoplastic agent,* however states that 'it was never intended that this code be assigned for agents that are not chemotherapeutic for example, Steroids...

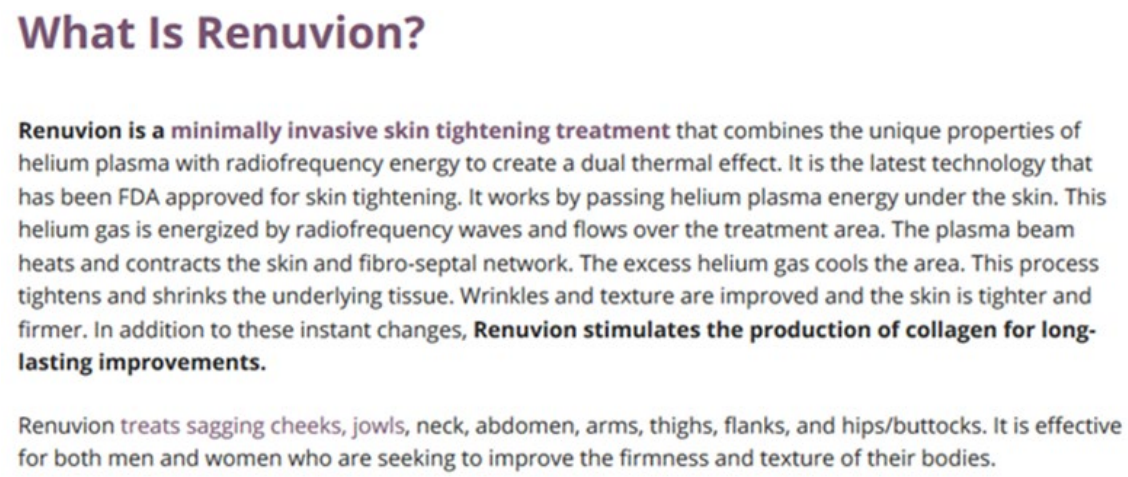
Response: CCAQ agreed any new National Coding Advice released by IHPA/ACE will supersede the ACS and Tabular. The new advice released in December 2020 specifies assignment of 96203-00 [1920] *Oral administration of pharmacological agent, antineoplastic agent* for oral chemotherapy only.

April 2021

Query ID 02-0421: Renuvion Skin Tightening

Query:

The query sought advice on what code(s) should be assigned for Renuvion Skin Tightening where performed with liposuction.



What Is Renuvion?

Renuvion is a minimally invasive skin tightening treatment that combines the unique properties of helium plasma with radiofrequency energy to create a dual thermal effect. It is the latest technology that has been FDA approved for skin tightening. It works by passing helium plasma energy under the skin. This helium gas is energized by radiofrequency waves and flows over the treatment area. The plasma beam heats and contracts the skin and fibro-septal network. The excess helium gas cools the area. This process tightens and shrinks the underlying tissue. Wrinkles and texture are improved and the skin is tighter and firmer. In addition to these instant changes, **Renuvion stimulates the production of collagen for long-lasting improvements.**

Renuvion treats sagging cheeks, jowls, neck, abdomen, arms, thighs, flanks, and hips/buttocks. It is effective for both men and women who are seeking to improve the firmness and texture of their bodies.

https://www.dermplasticsaz.com/blog/how-long-does-renuvion-skin-tightening-last/

Response: CCAQ agreed that based on current national advice, the best fit code for this procedure is 90676-00 *Other procedures on skin and subcutaneous tissue.* It was further noted that if the skin tightening is performed on different areas/lesions, it would be coded as many times as is performed.

Query ID 03-0421: Special screening examination for neoplasm of intestinal tract

Query:

The query sought advice on whether Z12.1 *Special screening examination for neoplasm of intestinal tract* can be assigned for the below scenario?

Scenario:

Patient is admitted for screening of neoplasm of intestinal tract due to family history of intestinal neoplasm. Via endoscopy with polypectomy, tubular adenoma of descending colon identified.

Response: CCAQ agreed that in this scenario the tubular adenoma is the Principal Diagnosis and that assignment of Z12.1 *Special screening examination for neoplasm of intestinal tract* is not required.

March 2021

Query ID 02-0321: Twin delivery pre-20 weeks

Query: The query sought advice as to which Z37 *Outcome of delivery* code should be assigned for the below scenario.

Scenario:

Pregnant patient admitted at 18 weeks gestation (twin pregnancy) in spontaneous labour. During the episode of care the patient delivers – one liveborn (but deceases soon after delivery) and one stillborn.

As the gestation is less than 20 weeks, which Z37 Outcome of delivery code should be assigned?

Response: CCAQ agreed that the appropriate coding assignment in this scenario is Z37.3 *Twins, one liveborn and one stillborn.*

Query ID 03-0321: Prophylactic hyperbaric interventions

Query: The query sought advice as to what diagnosis codes are to be assigned for the below scenario?

Related coding advice Ref No TN197, Q2620 and Q2687 all note to assign the condition necessitating the intervention as the principal diagnosis – but in this care there is no condition (pending prophylactic surgery).

Scenario:

Patient admitted for multiple same-day hyperbaric interventions episodes of care prior to surgical extraction of teeth as a prophylactic measure to prevent osteoradionecrosis on a background of personal history of laryngeal carcinoma for which they have had previous radiotherapy.

Response: CCAQ agreed that the best fit codes for the scenario provided are Z29.8 *Other specified prophylactic measures* with Z85.2 *Personal history of malignant neoplasm of other resp and intrathoracic organ* for the laryngeal carcinoma.

Query ID 04-0321: Principal Diagnosis queries

Query: The query sought clarification on ACS 0010 *Clinical Documentation and General Abstraction Guidelines*

"Before classifying any documented clinical concept, the clinical coder must verify information on the front sheet and/or the discharge summary (or equivalent) by reviewing pertinent documents/data within the body of the current episode of care."

"If, after following the above guidelines, the documentation within the health care record is inadequate for complete and accurate classification, the clinical coder should seek information from the clinician."

Question

1. If a query is to be done in the above scenario, why does in not contain the ACS0001 more specific definitions of a Principal Diagnosis relevant to the query as I have included in as numbered below?

Without these more specific definitions being included on the principal diagnosis query, the assignment of principal diagnosis based on ACS0001 is questionable due to the lack of knowledge by the MO of ACS0001 Principal Diagnosis multiple scenarios.

This may leave it open to revenue optimization by not adding context to Principal Diagnosis queries regarding the Principal Diagnosis definitions ACS0001.

Currently reference for Principal Diagnosis on discharge summaries and queries usually only relates to the following:

"The phrase **after study** in the definition means evaluation of findings to establish the condition that was chiefly responsible for occasioning the episode of care. The condition established after study may or may not confirm the admitting diagnosis."

To enhance the quality of Principal Diagnosis queries, would it be of benefit to link the query to each of the principal dx scenarios as per ACS0001 to which the diagnoses relate? Not only would data quality be improved better reflecting accurate casemix as per ACS, a better understanding of ACS 0001 would be gained from both the Medical Officers and HIMs and Clinical Coders.

2. In the case of a Principal Diagnosis Query, should the Principal Diagnosis options be listed from the earliest date to the latest date documented in the current episode to avoid the incidence of placing the diagnosis with the highest cost weight as the first option?

Response: CCAQ agreed the following:

Question 1: It is not feasible to verify documentation or provide clarification for every scenario and ultimately it is the responsibility of the coder to write ethical queries and provide the required detail and supporting information for the clinician to answer the scenario as per ACS 0010. The sentence noted from ACS 0010 does not apply to the clinical concept(s) for a principal diagnosis – it applies to all codes.

Question 2: The chronological ordering of the documentation was not a workable option as each presentation scenario is different and the initial diagnosis in the chart may not be the principal diagnosis documented by the clinician.

Query ID 05-0321: Kidney transplant donor workup – Iohexol clearance

Query: The query sought confirmation on how to code admissions for patients who are admitted same day for Iohexol plasma clearance as part of their kidney donor workup?

Our clinicians have confirmed that patients are admitted and given Iohexol 300 I/mL injectable solution (IV) and then have blood taken to check the GFR levels.

Info from Google:

"In clinical research setting, accurate and precise measurement of glomerular filtration rate (GFR) is essential to overcome the limitations of GFR estimation with equations, which are often unreliable.

In recent decades, a method for measuring GFR by plasma clearance of iohexol, a non-ionic radiocontrast agent, was developed."

Code options are:

Z00.5 Examination of potential donor of organ and tissue

96199-19 IV adm of pharmacological agent other unspec

+/- 13839-00 Collection of blood for diagnostic purposes

Other?

Response: CCAQ agreed the appropriate coding assignment in the scenario provided is Z00.5 *Examination of potential donor of organ and tissue* with 96199-19 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent.* CCAQ further agreed that the collection of blood does not meet ACS 0042 *Procedures normally not coded* requirements.

Query ID 06-0321: P21 Birth Asphyxia

Query: The tabular note at P21 states "This category is not to be used for low Apgar score without mention of asphyxia or other respiratory problems." however the index only gives the option of low Apgar "with asphyxia ".

Apgar(score)

- 0–3 at 1 minute, with asphyxia P21.0

- 4–7 at 1 minute, with asphyxia P21.1

- low, with asphyxia P21.9

Scenario:

Newborn documented as having no respiratory effort, Apgar 2. Resuscitation and ventilation <1hr required. Nil other respiratory problem documented.

Question:

Would "no respiratory effort" be classed as a respiratory problem?

If so, then whilst the ventilation should not be coded as per ACS 1615, would P21.0 meet ACS0002 due to the intervention as per the tabular note?

There is no includes or excludes note for TTN regarding P21* or vice versa therefore would it be correct in assigning P21* in this or other like scenarios if an Apgar was documented?

Response: CCAQ agreed that "no respiratory effort at birth" does not meet the criteria of a respiratory problem for coding without clinician confirmation. As this was a condition at birth requiring resuscitation (and resuscitation is not coded) - only the ongoing conditions after resuscitation can be coded. Therefore, if the condition meets AC S0001 or ACS 0002 (i.e., the condition extends beyond birth resuscitation) it would be appropriate to send a query to clarify/provide a more specific diagnosis.

February 2021

Query ID 01-0221: Documentation Queries

Query: The query sought advice regarding documentation queries. The Coding Standard states the following:

The completed query form is part of the documentation for the episode of care being classified.

Queries to clinicians regarding documentation issues can be undertaken:

- *manually (with the clinician answering the query on the form provided)*
- *electronically via a portal as part of the electronic health record*
- *verbally/conversation with a clinician*
- *via email/facsimile*
- *via telephone/telehealth conversation.*

Document the outcome of the query to the clinician on the query form and include:

- *an appropriately worded query*
- *the process undertaken to obtain the answer (eg email, verbal and telephone)*
- *the date the answer was obtained*
- *the name, designation and signature of the clinician consulted*
- *the name, designation and signature of the personnel who consulted with the clinician.*

Q1: Can you clarify if a clinician signature is required when a response is received via email or verbal conversation? Q2: Would the email response attached to the query or recorded verbal conversation without a clinician signature be sufficient for evidence of code assignment?

Response: CCAQ agreed that, providing the query is ethical in accordance with ACS 0010 *Clinical Documentation and General Abstraction Guidelines*, and the outcome is recorded appropriately, a clinician's signature would not be required for an email or verbal query. A copy of the email response should be included as part of query.

Query ID 02-0221: Subsequent NSTEMI

Query: The query sought coding advice on the following scenario:

Scenario: Patient admitted with subsequent NSTEMI after suffering a NSTEMI 2 week previously.

I22.8 *Subsequent myocardial infarction of other sites* is not inclusive of NSTEMI in the list provided

What would be the appropriate way to code?

I22.8 for *Subsequent myocardial infarction of other sites* (New NSTEMI) +

I21.4 for the *NSTEMI* diagnosed 2 weeks previously

or

I22.9 for *Subsequent myocardial infarction unspecified* +

I21.4 or the *NSTEMI* diagnosed 2 weeks previously

or just code the I21.4 *NSTEMI*

Response: CCAQ agreed the codes to assign in this scenario are I22.8 *Subsequent myocardial infarction of other sites* (new NSTEMI specified site) and I21.4 *Acute subendocardial myocardial infarction* for the NSTEMI diagnosed 2 weeks previously, as long as it meets ACS 0002 *Additional Diagnoses.*

Query ID 03-0221: Ocular Ischaemic Syndrome

Query: The query sought advice on what code(s) would be assigned for ocular ischaemic syndrome?

Patient admitted and treated for R) ocular ischaemic syndrome.

Response: CCAQ agreed that based on the information provided, the most appropriate code in this instance is U91 *Syndrome NEC* as per ACS 0005 *Syndromes* plus H57.8 *Other specified disorders of eye and adnexa*. Multiple manifestations may be coded if they are known, and a clinical documentation query should be sent to obtain further clarity (if required).

Query ID 04-0221: Nebulised Antineoplastic Agent

Query: The query sought advice on what code(s) is to be assigned for nebulised administration of antineoplastic drug?

Possible ACHI codes:

- 96205-00 *Other administration of pharmacological agent, antineoplastic agent*
- 92043-00 *Respiratory medication administered by nebuliser.*

Response: CCAQ agreed the best fit for this scenario is ACHI code 96205-00 *Other administration of pharmacological agent, antineoplastic agent.*

Query ID 05-0221: Coding from the Allied Health Assistant (AHA) documentation

Query: (1) We are seeking clarification that we can capture an allied health ACHI code when a patient is seen by an Allied Health Assistant (AHA) and not the Allied Health professional? For example: patient seen by a Nutrition Assistant working under the direct supervision of a dietitian.

(Please note: AHAs have been reclassified and are now recognised as “Clinical Assistants” and they have moved into the Health Professional stream. 100% of allied health assistants work

under the supervision and delegation of allied health professionals in QLD. This is governed by the AHPOQ AHA Framework)

(2) Can we code diagnoses from an AHA's documentation? For example: Nutrition Assistant has seen the patient and documented that they are Obesity class 1. Care plan and dietary advice given to the patient.

Please see previous CCAQ query for supporting evidence:

Query ID 02-1019: Lack of documentation in Rehabilitation area

Query: The query seeks confirmation of the appropriate coding practice for an Allied Health Practitioner (AHP) intervention when the notes are made in the patient record by the Allied Health Assistant (AHA) and not documented by the qualified AHP therapist. In the scenario provided, patients attending the Day Therapy Rehab unit are admitted as day rehab. Often the only documentation is from an AHA (e.g., Patient attended Speech Therapy Session or Patient attended Physiotherapy group circuit).

Question: As the qualified AHP therapist has not documented in the chart should we be coding the relevant AHP intervention based only on the AHA entry in the patient record? Is there a consistent statewide practice?

Response: CCAQ agreed that Allied Health Assistants (AHA) work within strict protocols under the supervision of the Allied Health Professional (AHP).

In relation to Question 1, CCAQ agreed that where the AHA is a member of the care team and working under the direction/supervision of the AHP then it is appropriate to assign the appropriate ACHI code from documentation completed by the AHA.

In relation to Question 2, CCAQ agreed the diagnosis could not be coded from the AHA documentation unless there is other supporting documentation within the medical record.

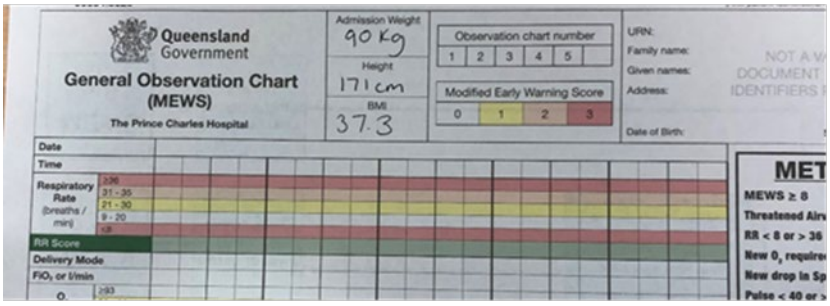
Query ID 06-0221: Obesity U code from MEWS Form

Query: The query sought advice on coding a supplementary code for obesity using the BMI that has been documented by a clinician (nurse) on the General Observation Chart (MEWS) or pre-anaesthetic form. Of note the MEWS is a not a screening tool but an observation chart.

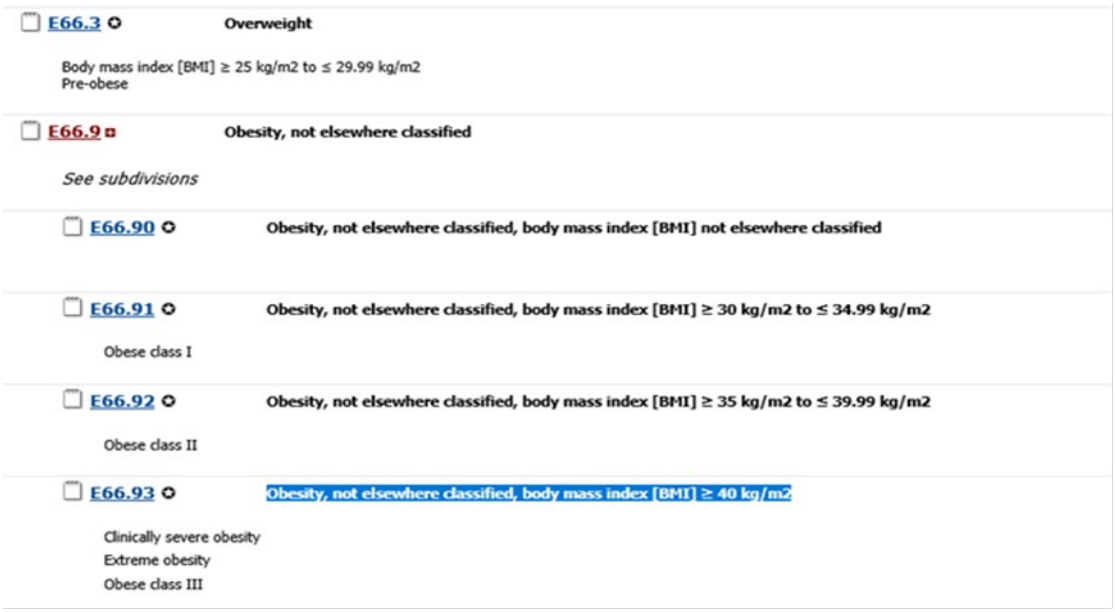
If a nursing staff member completed BMI and BMI category would this be considered appropriate to be counted for a supplementary U-code? We can code a supplementary code for obesity if nursing staff write “BMI 31 = Obesity” in progress notes? This is the same information duplicated if BMI is written on the MEWS form and therefore not good use of hospital resources.

This discussion is currently for a supplementary U-code. For obesity to be categorised as a complication that would require a documented intervention of what was done to treat this (E.g., If dietitian documented, an appropriate diet code or education). Of note: BMI is indexed in our classification.

General Observation Chart (MEWS)



- **WT (Kg) / HT (MT2) = BMI**
- **Located on MEWS form (nursing completed), chart entries**
- **BMI categories as per WHO**



Response: CCAQ agreed that the BMI captured on a MEWS general observation chart or pre-anaesthetic form cannot be used to assign a supplementary U code and that more supporting documentation is required. This is consistent with the National Coding Advice Ref No. Q3482.

Query ID 08-0221: T82.82 Excludes

Query: The query sought clarification on the scenario below. It is my opinion and the majority of hospitals that I have raised this with, that the excludes at T82.82 overrides ACS1904 and only a code for I80 or I26 with the relevant Y codes need to be assigned in the scenario of a DVT or PE following insertion of cardiac and vascular prosthetic devices, implants and grafts.

Many hospitals seem to be adding both codes resulting in double coding and assigning T82.82 with I80.X.

Contradiction T82.82 Excludes note vs ACS 1904

In the case of a DVT post op due to a cardiac or vascular implant or graft, which code is to be assigned as there is an excludes at T82.82 but it contradicts ACS 1904 as per below? Additionally, is it adequate to assign both to provide further specificity?

Excludes at T82.82

ÂµT82.82 Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts

Embolism and thrombosis of coronary artery and other vascular bypass grafts

Excludes: postprocedural:

- deep venous thrombosis (I80.-)
- pulmonary embolism (I26.-)

In this case T82.82 should not be assigned as per the excludes at T82.82 resulting in the principal diagnosis being I80.42. The correct DRG is therefore F63B.

Refer to the attachment of ICD10AM Coding Conventions for diagnosis assignments.

"An exclusion note is an instructional note/term which is to be adhered to when classifying conditions rather than using the Index in isolation."

Versus

ACS 1904 Complications classified to T80-T88:

T80-T88Complications of surgical and medical care, not elsewhere classified

As procedural complications may be classified to any of the above categories, the following rules apply:

Where a complication is related to a prosthetic device, implant or graft, assign T82-T85 Complications of prosthetic devices, implants and grafts, except where directed by an Includes note or the Alphabetic Index, for example:

- disruption of operation wound (T81.3)
- wound infection (superficial) (T81.4) (see also Postprocedural wound infection)
- foreign body accidentally left in body cavity or operation wound (T81.5)

Response: CCAQ agreed that it is correct to assign T82.82 *Embolism and thrombosis following insertion of cardiac and vascular prosthetic devices, implants and grafts* if a causal relationship between device and embolism or thrombosis has been clearly established. The ACE advice published on 18 December 2020 is appropriate and if there is a causal relationship then an additional chapter code is not required.

Query ID 09-0221: Internet Gaming Disorder

Query: The query sought advice on the scenario where a patient was admitted with additional diagnosis of internet gaming disorder/addiction disorder. It meets ACS0002 as it is documented by the clinician as the underlying cause for anorexia, nausea, and pressure area to spine from sitting at the computer chair.

The code that seemed closest was F63.8 using the pathway disorder, habit, other specified

Is this code appropriate or is there a better code?

Response: CCAQ noted that a code specifically for gaming disorder is proposed for inclusion in ICD-11-AM. In the interim the appropriate code to assign is F63.8 *Other habit and impulse disorders*.

Query ID 10-0221: Remote interrogation Implantable Cardiac Defibrillator

Query: The query sought advice on the best coded ICD code and/or ACHI code for inpatient that receives remote interrogation of their Implantable cardiac defibrillator via a specialist team at another hospital.

Response: CCAQ noted that the device is designed to be remotely interrogated by the clinician. CCAQ agreed the appropriate code to assign is Z45.0 *Adjustment and management of cardiac device* for remote interrogation with procedure code 11727-00 [1856] *Testing of cardiac defibrillator*.

December 2020

Query ID 03-1220: Abnormal Coagulation Profile

Query: The query sought advice on which code is applicable for the scenarios when patient is admitted for warfarin bridging pre-operatively and patient has abnormal INR during same admission.

a) Z92.1 *Personal history of long term (current) use of anticoagulants*

b) R79.83 *Abnormal coagulation profile*

As per ACS0303 ABNORMAL COAGULATION PROFILE DUE TO ANTICOAGULANTS Z92.1 *Personal history of long term (current) use of anticoagulants* is assigned as an additional diagnosis if a patient is on long term anticoagulants and:

- bridging anticoagulant therapy is administered prior to or following a planned procedure, **or**
- anticoagulant therapy is withheld because the patient has a medical condition that contraindicates the continued use of anticoagulants, **or**
- anticoagulant level monitoring is undertaken during an episode of care and the INR level is within the target therapeutic range (i.e., no supratherapeutic or subtherapeutic INR is documented).

Our understanding is that the INR will be abnormal for patients on warfarin undergoing bridging and then will have to aim for therapeutic INR post procedure. For such cases Z92.1 Personal history of long term (current) use of anticoagulants is applicable and R79.83 Abnormal coagulation profile while bridging is not valid.

Response: CCAQ agreed that the INR levels will be abnormal for patients on warfarin undergoing bridging therapy. Only one code can be assigned, and in this instance the appropriate code is Z92.1 *Personal history of long term (current) use of anticoagulants* as per ACS 0303 Abnormal coagulation profile due to anticoagulants.

November 2020

Query ID 01-1120: Closed to open reduction of dislocation

Query: The query sought advice on which ACHI procedure code(s) are assigned for reduction of the patella. Patient is admitted with a dislocated patella. In the operating room, patient undergoes planned closed reduction of dislocation of patella, but due to difficulties, the procedure progresses to open reduction of the dislocation.

Response: CCAQ noted the query does not state that the closed reduction was performed, only planned, with the procedure progressing to open reduction of the dislocation. CCAQ agreed that if the documentation states that only the open reduction is performed, the appropriate code to assign in this scenario is 47060-00 [1506] *Open reduction of dislocation of patella.*

Query ID 03-1120: UTI related to In-dwelling catheter (IDC)

Query: The query sought advice if N39.0 *Urinary tract infection, site not specified* is required to be assigned in addition to T83.5 *Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system* for IDC related UTI?

Codefinder provides two codes following this pathway:

-- UTI

-- UTI [urinary tract infection]

-- Complication [infection] of urinary device, graft or implant

-- Urinary (indwelling) catheter

-- Other/unspecified

-- No, or already coded

-- No, not required or external cause already coded

ICD-10-AM Diagnosis Codes

T835	Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system
N390	Urinary tract infection, site not specified

Points to consider:

IDC related infection can be local such as urethritis or may involve kidney(pyelonephritis) or bladder (cystitis) or systemic infection (IDC) and assigning N39.0 provides specificity to extent of the condition i.e., UTI NOS.

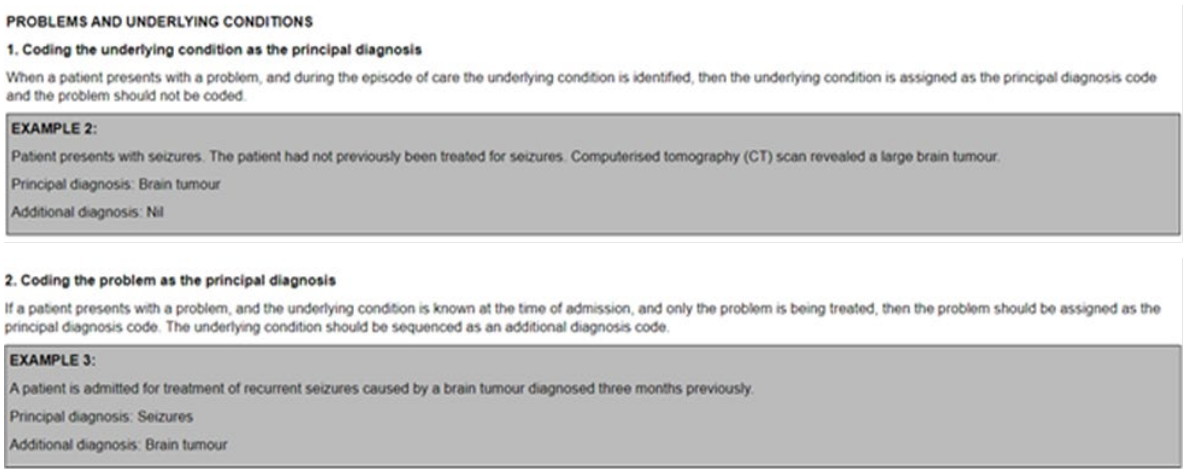
Response: CCAQ agreed the inclusion of N39.0 *Urinary tract infection, site not specified* with the T code is appropriate in this instance and would add specificity. The UTI is a condition and not a site, so the additional code is warranted.

Query ID 04-1120: Seizures with brain tumour

Reviewed 03/2021 – ADVICE UPDATED

Query: The query sought advice if code for seizures, R56.8 *Other and unspecified convulsions* can be assigned with brain tumours when they clearly meet ACS 0002 - for example treated with medication or intubated?

ACS 0001 Principal diagnosis:



PROBLEMS AND UNDERLYING CONDITIONS

1. Coding the underlying condition as the principal diagnosis

When a patient presents with a problem, and during the episode of care the underlying condition is identified, then the underlying condition is assigned as the principal diagnosis code and the problem should not be coded.

EXAMPLE 2:

Patient presents with seizures. The patient had not previously been treated for seizures. Computerised tomography (CT) scan revealed a large brain tumour.

Principal diagnosis: Brain tumour

Additional diagnosis: Nil

2. Coding the problem as the principal diagnosis

If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code.

EXAMPLE 3:

A patient is admitted for treatment of recurrent seizures caused by a brain tumour diagnosed three months previously.

Principal diagnosis: Seizures

Additional diagnosis: Brain tumour

Q1. Patient presented with seizures and diagnosed with brain tumour in this admission i.e., brain tumour is PDx. Can we assign code for seizures if patient is started on regular antiepileptics i.e., meet ACS 0002?

Q2. Patient presented with seizures with known diagnosis of brain tumour. Seizures deemed due to progression of brain disease/tumour and started on regular dexamethasone (for tumour associated oedema) as well as antiepileptics. Pdx documented on discharge summary is brain tumour. Thus, underlying cause and symptoms both have been treated. Can we assign R56.8 *Other and unspecified convulsions* in addition as seizures meet ACS 0002?

Response: CCAQ agreed that in both scenarios the Principal Diagnosis would be coded as brain tumour and that the seizures would be also coded as they meet ACS 0002 in their own right (i.e., they are being treated). Therefore:

Question 1: Principal Diagnosis brain tumour with the Additional Diagnosis of seizures (i.e., seizures meet ACS 0002 if anti-epileptics are commenced as anti-epileptics are not a treatment for the brain tumour).

Question 2: Principal Diagnosis brain tumour (as per discharge summary, progression of disease) with seizures as Additional Diagnosis due to specific treatment with anti-epileptics.

Query ID 06-1120: Complication of IDC

Query: The query sought advice on the appropriate code for the following scenario:

Traumatic haematuria in a delirious/dementia patient who has pulled out their own catheter.

Does this meet the definition of a complication of the IDC?

There is documentation of traumatic haematuria secondary to delirium and IDC on the discharge summary. There is no evidence of trauma to the urethra as such.

Should the codes include the haematuria with similar external cause codes as per the Victorian branch advice?

Victorian Advice

Self-induced urethral injury due to traumatic removal of a urinary catheter

Publication Date: December 2017

ICD 10 AM Edition: Tenth edition

Query Number: 3252

An elderly man was admitted to our hospital with haematuria, on a background of Parkinson's disease and dementia. The patient was a resident of a high-level care nursing home and normally had a permanent indwelling catheter (IDC). On admission it was determined that the haematuria was due to a urethral injury that was caused by the traumatic removal of the IDC by the patient without first deflating the balloon. The IDC was reinserted, and the patient monitored closely for further bleeding or blockage of the IDC. Once the medical staff were happy that the bleeding had stopped the patient was discharged back to his nursing home with instructions for the LMO to follow up the IDC as required.

Can the committee please advise how to code self-induced urethral injury due to traumatic removal of a urinary catheter?

Response: CCAQ agreed only the Haematuria can be coded in this instance as there was no documentation of any injury. In this instance, a documentation query should have been submitted to determine the cause of the haematuria. CCAQ further suggested that a Z code could be applied to reflect management of the device.

September 2020

Reviewed 06/2022 – ADVICE CURRENT

Query ID 02-0920: Dialysis post snake bite

Query: The query sought advice where a patent with a history of having been bitten by a taipan snake and had associated acute kidney failure (hospitalised). The patient is now on dialysis temporarily as a day only patient.

What diagnosis codes should be assigned for the same day dialysis episodes of care?

Response: CCAQ agreed that as the admission is for same day dialysis the principal diagnosis should be Z49.1 *Extracorporeal dialysis* as per the ICD-10-AM Index and ACS 1404 *Admission for kidney dialysis*. Coders may assign additional codes for specificity, where they meet criteria for coding.

Query ID 03-0920: Gram negative sepsis

Reviewed 06/2022 – ADVICE CURRENT (*updated for ICD-10-AM/ACHI/ACS 12th Edition)*

Query: The query sought advice on what criteria should be used for assigning A41.58 *Sepsis due to other Gram-negative organisms?*

The first results from pathology are often the Gram test (by phone) for Gram negative or Gram-positive bacteria. This is sometimes but not always documented. E.g., phone call from Infectious Diseases – blood culture results positive for Gram-negative organism, with no further classification available at this point. Later, the patient's blood culture comes back with the specific organism, but the coding pathway doesn't have every option, so unless you use the Gram-negative spell option you don't get there.

Does the Gram-negative characteristic of the bacteria need to be documented to assignA41.58, if the coder knows that an organism is a Gram-negative bacterium?

Scenario 1

Patient admitted with sepsis. Notes state that Infectious Diseases rang and initially said Gram-negative organism was identified and treatment was commenced based on that finding. Later, the culture comes back as Klebsiella Pneumoniae.

Scenario 2

Patient admitted with sepsis. No notes about the organism until Acinetobacter baumannii cultured in the blood and confirmed on the discharge summary.

Response: CCAQ agreed that the coder is adding specificity by including the organism.

Scenario 1: Klebsiella pneumoniae is a Gram-negative organism therefore A41.58 *Sepsis due to other Gram-negative organisms* is the most appropriate code, following the ICD-10-AM

index Sepsis/Klebsiella pneumonia (note this response has been updated for ICD-10-AM/ACHI/ACS 12th Edition).

Scenario 2: A41.58 *Sepsis due to other Gram-negative organisms* is the most appropriate code.

Query ID 06-0920: Kidney disease coding

Reviewed 06/2022 – ADVICE CURRENT (with updated code descriptions)

Query: The query sought clarification on how to code patients who have had their kidney transplant removed +/- native kidneys also removed.

Example 1:

End stage renal failure (ESRF) secondary to dysplastic kidneys with previous bilateral native nephrectomies. Previous kidney transplants x2 in 2001 complicated by rejection in 2002 and both removed in 2011.

Code options are:

a) N18.5 *Chronic kidney disease, stage 5* and Z90.5 *Acquired absence of kidney*

b) N18.5 *Chronic kidney disease, stage 5* and Q61.40 *Renal dysplasia, unspecified*

c) N18.5 *Chronic kidney disease, stage 5* and Z94.0 *Kidney transplant status*

d) Other?

Example 2:

ESRF secondary to chronic focal and segmental glomerular lesions (FSGS). Pt had a transplant in 2005 which was subsequently removed in 2010 due to chronic rejection. Native kidneys are still present.

Code options are:

a) N18.5 *Chronic kidney disease, stage 5* and N03.1 *Chronic nephritic syndrome, focal and segmental glomerular lesions*

b) N18.5 *Chronic kidney disease, stage 5* and Z94.0 *Kidney transplant status*

c) N18.5 *Chronic kidney disease, stage 5* and Z90.5 *Acquired absence of kidney*

d) Other?

Response: CCAQ agreed that in line with ACS 1438 *Chronic Kidney Disease*, it was appropriate to assign the underlying cause if known (as in this scenario) and assign a code for the transplant status if the patient has had a transplant (regardless if removed).

Example 1:

N18.5 *Chronic kidney disease, stage 5*

Q61.40 *Renal dysplasia, unspecified*

Z94.0 *Kidney transplant status*

Z90.5 *Acquired absence of kidney*

Example 2:

N18.5 *Chronic kidney disease, stage 5*

N03.1 *Chronic nephritic syndrome, focal and segmental glomerular lesions*

Z94.0 *Kidney transplant status*

Z90.5 *Acquired absence of kidney*

Query ID 07-0920: Meniscus transplant

Reviewed 06/2022 – ADVICE CURRENT

Query:

The query sought guidance on a suitable code for a meniscal transplant. The patient had right knee lateral meniscal transplant, distal femur varising osteotomy and iliac crest bone graft.

A Google search states: "A meniscal transplant replaces the damaged meniscus with donor cartilage. Healthy cartilage tissue is taken from a cadaver (human donor) and frozen. This tissue is called an allograft."

Is this proposed code suitable? It is noted that in the proposed code autologous is a non-essential modifier.

14203-01 [1906] *Direct living tissue implantation*

The pathway to this code is:

Transplant, transplantation / cartilage (autologous) (chondrocytes) (matrix-induced)

Response: CCAQ agreed that 14203-01 [1906] *Direct living tissue implantation* is the most appropriate code in this scenario.

Query ID 08-0920: Effects of other external causes

Query:

The query sought advice on whether a code in the range T75.- can be assigned with a code in the range T20-T31, against the Tabular excludes note where T75.- *Effects of other external causes* Excludes: burns (electric) (T20–T31)?

For example, a patient is admitted for shock from electric current, atrial fibrillation as an effect of the electric current (which required cardioversion, and patient had no known history of atrial fibrillation), and partial thickness burn of right hand involving less than 10% body surface associated with the electric current.

Response: CCAQ agreed that both T codes can be used. In the scenarios with multiple manifestations of electric current, the excludes notes can be overridden by the need to add specificity, and a code in the range of T75.- *Effects of other external causes* can be assigned with a code in the range of Burns (T20 - T31) in order to code all the manifestations / effects of electric current.

August 2020

Query ID 04-0820: Oral nutritional support

Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice as to the coding of 96096-00 [1871] *Oral nutritional support*.

ACS 0042 *Procedures normally not coded* notes:

Procedures normally not coded are only assigned if:

- cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 *Anaesthesia*)
- they are the principal reason for admission in same-day episodes of care. This includes patients who are admitted the day before or discharged on the day after a procedure because a same-day admission is not possible or practicable for them (e.g. elderly patients, those who live in remote locations)
- another specialty standard directs they should be assigned. In such cases, the specialty standard overrides this list and the stated code is assigned.

  13. Nasogastric intubation, aspiration and feeding

  Exception(s): nasogastric feeding in neonates (96202-07 [1920]) (see ACS 1615 *Specific diseases and interventions related to the sick neonate*)

Can 96096-00 [1871] *Oral nutritional support* be assigned for overnight episodes of care – including when relating to Dietician review?

Response: CCAQ agreed that oral nutritional support should not be coded unless it is the reason for admission in a day only episode of care, or the oral nutritional support was performed under anaesthetic – noting that both scenarios would be unusual. The dietician code should reflect the nutritional support.

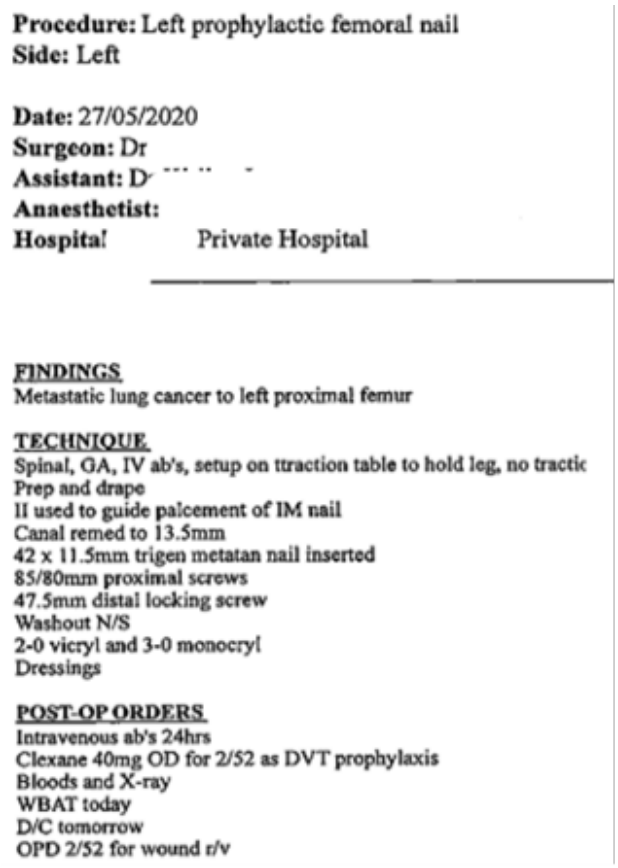
Query ID 06-0820: Prophylactic internal fixation

Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice on which diagnosis code is assigned when a patient presents for 'Prophylactic Internal Fixation of bone' with documentation of underlying neoplastic disease of bone (see Operation Report below).

National Coding Advice TN565 – ACS 2114 *Prophylactic Surgery* (Eighth Edition Education Workshop FAQs – Part 1) advises to assign the neoplastic bone disease as the principal diagnosis however this advice was retired 30th June 2019.

After reviewing 11th Edition ACS 2114 Prophylactic Surgery and ACS 0236 Neoplasm Coding and Sequencing it is unclear if Z40.8 (prophylactic fixation without fracture present) or C79.5 (underlying neoplasm) should be assigned?



Procedure: Left prophylactic femoral nail
Side: Left

Date: 27/05/2020
Surgeon: Dr
Assistant: D
Anaesthetist:
Hospital Private Hospital

FINDINGS
Metastatic lung cancer to left proximal femur

TECHNIQUE
Spinal, GA, IV ab's, setup on ttraction table to hold leg, no tractic
Prep and drape
II used to guide palcement of IM nail
Canal remed to 13.5mm
42 x 11.5mm trigen metatan nail inserted
85/80mm proximal screws
47.5mm distal locking screw
Washout N/S
2-0 vicryl and 3-0 monocryl
Dressings

POST-OP ORDERS
Intravenous ab's 24hrs
Clexane 40mg OD for 2/52 as DVT prophylaxis
Bloods and X-ray
WBAT today
D/C tomorrow
OPD 2/52 for wound r/v

Response: CCAQ agreed that the findings in the operation report clearly state metastatic cancer and therefore should be assigned as the principal diagnosis in this instance.

Query ID 08-0820: Underlying cause of CKD in kidney transplant patients

Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice on whether it is necessary to code the underlying cause / disease of chronic kidney disease (CKD) when a patient has had a renal transplant. There was a previous query sent to ACCD in 2015 with advice not to code the underlying cause of CKD when patient has had a transplant unless the condition has recurred in the transplanted kidney. This advice has been retired in June 2019 and we are unsure why. Can we please confirm if this previous advice still stands?

Points to note:

- ACS 1438 *Chronic Kidney Disease* advises us to 'assign a code for the underlying cause of CKD, e.g. IGA nephropathy.'
- The 'code also' note at N18 states 'use additional code to identify the underlying disease.'

- ACS 1438 states that 'patients who have had their end stage kidney disease treated with kidney replacement therapy, either in the form of dialysis or transplant, are still considered to have CKD.'
- ACS 1438 also states for patients who have received a kidney transplant, assign Z94.0 *Kidney transplant status* together with N18.3 *Chronic kidney disease, stage 3* or higher, as indicated by an eGFR/GFR level where CKD meets the criteria for code assignment (see ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*).

Response: CCAQ agreed that where CKD meets the criteria for code assignment in a patient that has had a renal transplant as per ACS 1438 *Chronic Kidney Disease/Kidney replacement therapy*, it is appropriate to assign a code for the underlying cause of the chronic kidney disease, following the "*Use additional code to identify underlying disease*" instruction at N18 *Chronic kidney disease*.

July 2020

Query ID 01-0720: Intravenous antibiotic infusion bottle change

Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice on the correct diagnosis and procedure codes to be assigned where a patient is admitted (same-day episode of care) for intravenous antibiotic infusion bottle change for treatment of infected total knee replacement?

Option 1

Z45.1 *Adjustment and management of drug delivery device*

96199-02 *Intravenous administration of pharmacological agent, anti-infective agent*

96209-02 *Loading of drug delivery device, anti-infective agent*

Option 2

Z45.1 *Adjustment and management of drug delivery device*

96209-02 *Loading of drug delivery device, anti-infective agent*

Option 3

T84.5 *Infection and inflammatory reaction due to internal joint prosthesis*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.23 *Health service area, not specified as this facility*

96199-02 *Intravenous administration of pharmacological agent, anti-infective agent*

96209-02 *Loading of drug delivery device, anti-infective agent*

Option 4

T84.5 *Infection and inflammatory reaction due to internal joint prosthesis*

Y83.1 *Surgical operation with implant of artificial internal device*

Y92.23 *Health service area, not specified as this facility*

96209-02 *Loading of drug delivery device, anti-infective agent*

Response: CCAQ advised the correct coding assignment in this scenario was per Option 2:

Z45.1 *Adjustment and management of drug delivery device*

96209-02 *Loading of drug delivery device, anti-infective agent*

The query refers to a bottle change only so there is no requirement to code the infection or IV administration of drugs.

Query ID 04-0720: Coding abandoned procedures

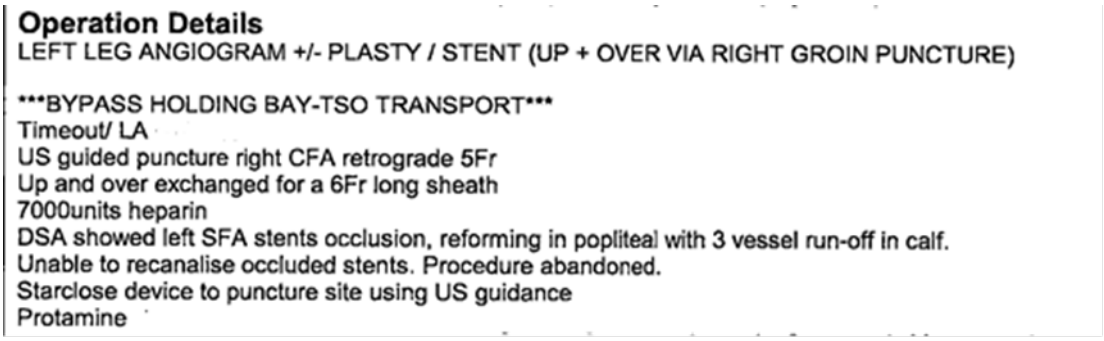
Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice on whether a procedure should be coded for the following scenario:

Patient was admitted for a left leg angiogram + stent and plasty, however the procedure was abandoned and only the DSA was completed. The procedure was performed under a local anaesthetic and overnight stay.

As the DSA was the extent to which the procedure was conducted after original procedure intent was abandoned, can the DSA alone still be coded as per ACS0019? Does this standard override ACS0042?

If the procedure is not coded, then the theatre time, resources and extent of procedure will not be captured.



Operation Details
LEFT LEG ANGIOGRAM +/- PLASTY / STENT (UP + OVER VIA RIGHT GROIN PUNCTURE)

BYPASS HOLDING BAY-TSO TRANSPORT
Timeout/ LA
US guided puncture right CFA retrograde 5Fr
Up and over exchanged for a 6Fr long sheath
7000units heparin
DSA showed left SFA stents occlusion, reforming in popliteal with 3 vessel run-off in calf.
Unable to recanalise occluded stents. Procedure abandoned.
Starclose device to puncture site using US guidance
Protamine

Response: CCAQ advised that the DSA (Digital Subtraction Angiography) procedure can still be coded in line with ACS0019 *Intervention abandoned, interrupted or not completed*.

Query ID 05-0720: Coding Breast Cancer scenarios

Reviewed 06/2022 – ADVICE CURRENT (code descriptions updated)

Query: The query sought advice on how to code the following scenarios:

1. Patient admitted with breast cancer (invasive ductal carcinoma) in both breasts. The morphology and site codes are the same -
Site: malignant neoplasm of upper inner quadrant of the left breast and right breast
Morphology: Infiltrating duct carcinoma.

2. Patient admitted with breast cancer (invasive ductal carcinoma) in both breasts. The morphology is the same however the sites are different -
Site: malignant neoplasm of upper inner quadrant of left breast and Malignant neoplasm of lower-outer quadrant of right breast
Morphology: infiltrating duct carcinoma for both lesions.

Options:

a) C50.2 *Malignant neoplasm of upper-inner quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS* and C50.5 *Malignant neoplasm of lower-outer quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS*,
   OR
b) *C50.8 Malignant neoplasm, overlapping lesion of breast* with M8500/3 *Infiltrating duct carcinoma NOS*

3. Patient admitted with breast cancer in both breasts. The morphology is different in both breasts however the sites are the same -
Site: malignant neoplasm of upper inner quadrant of left breast
Morphology: infiltrating duct carcinoma in the left breast and lobular carcinoma in the right breast lesion.

Options:

a) C50.2 Malignant *neoplasm of upper-inner quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS* and M8520/3 *Lobular carcinoma NOS*,
   OR
b) C50.2 *Malignant neoplasm of upper-inner quadrant of breast* with M8520/3 *Lobular carcinoma NOS*, OR
c) C50.2 Malignant *neoplasm of upper-inner quadrant of breast* with M8522/3 *Infiltrating duct and lobular carcinoma*

4. Patient admitted with breast cancer in both breasts. The morphology is different in both breasts however the sites are the same -
Site: neoplasm of upper inner quadrant of the left breast and in the right breast
Morphology: left breast - Infiltrating duct carcinoma and right breast - lobular carcinoma in situ.

Options:

a) C50.2 Malignant neoplasm *of upper-inner quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS* and D05.0 *Lobular carcinoma in situ of breast* with M8520/2 *Lobular carcinoma in situ NOS*,
   OR
b) only code C50.2 *Malignant neoplasm of upper-inner quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS*

5. Patient admitted with breast cancer in both breasts. The morphology is different in both breasts however the sites are the same -
Site: neoplasm of upper inner quadrant of the left breast and in the right breast
Morphology: left breast - lobular carcinoma and right breast - ductal carcinoma in situ.

Options:

a) Only code C50.2 *Malignant neoplasm of upper-inner quadrant of breast* with M8522/*3 Infiltrating duct and lobular carcinoma*

b) C50.2 *Malignant* neoplasm *of upper-inner quadrant of breast* with M8520/3 Lobular carcinoma NOS and D05.1 Intraductal carcinoma in situ of breast with M8500/*2 Intraductal carcinoma, noninfiltrating NOS*
c) Only code C50.2 Malignant *neoplasm of upper-inner quadrant of breast* with M8520/3 *Lobular carcinoma NOS*

Response: CCAQ advised the appropriate coding assignment for each scenario as follows:

Q1. Patient admitted with breast cancer (invasive ductal carcinoma) in both breasts – morphology and site codes are the same.

A: C50.2 *Malignant neoplasm of upper-inner quadrant of breast* with M8500/3 *Infiltrating duct carcinoma NOS.*

Q2. Patient admitted with breast cancer (invasive ductal carcinoma) in both breasts – morphology is the same, however the sites are different.

A: C50.2 *Malignant neoplasm of upper-inner quadrant of breast*, C50.5 *Malignant neoplasm of lower-outer quadrant of breast*, M8500/3 *Infiltrating duct carcinoma NOS* (ensuring that the morphology code is repeated after the first neoplasm code if one of the neoplasm codes is the principal diagnosis, as per QHAPDC morphology code sequencing requirements).

Q3. Patient admitted with breast cancer in both breasts - morphology is different in both breasts however the sites are the same.

A: C50.2 *Malignant neoplasm of upper-inner quadrant of breast*, M8500/3 *Infiltrating duct carcinoma NOS*, M8520/3 *Lobular carcinoma NOS.*

Q4. Patient admitted with breast cancer in both breasts - morphology is different in both breasts however the sites are the same (left breast infiltrating duct carcinoma and right breast lobular carcinoma).

A: C50.2 *Malignant neoplasm of upper-inner quadrant of breast*, M8500/3 *Infiltrating duct carcinoma NOS* and D05.0 *Lobular carcinoma in situ of breast*, M8520/2 *Lobular carcinoma in situ NOS*

Q5. Patient admitted with breast cancer in both breasts - morphology is different in both breasts however the sites are the same (left breast - lobular carcinoma and right breast - ductal carcinoma in situ).

A: C50.2 *Malignant neoplasm of upper-inner quadrant of breast*, M8520/3 *Lobular carcinoma NOS* and D05.1 *Intraductal carcinoma in situ of breast*, M8500/2 *Intraductal carcinoma, noninfiltrating NOS.*

Query ID 06-0720: Guidelines on researching conditions

Reviewed 06/2022 – ADVICE CURRENT

Query: The query sought advice on advice on when it is appropriate to research a condition to code an episode and when it is inappropriate to use that research. Two examples were provided where a coder sought information about a condition in order to get to an ICD code or to get to the most appropriate code.

Example 1- Patient with a Cyclops lesion of the knee undergoes arthroscopic excision of lesion. Without further research the only pathway is lesion, joint, knee to M25.96

Research describes it as localised arthrofibrosis. This would give a pathway to M24.66

Example 2- patient having a colonoscopy for haematochezia

There is no pathway for haematochezia, but it is described in Mosby's Dictionary as "the passage of red blood through the rectum".

In example 1 we get a generic code without research; and in example 2 we would have to send a query to the doctor to assign a code at all because no pathway exists.

Guidance in the use of ICD-10-AM states "in order to classify accurately, it is essential to have a working knowledge of medical science."

We would like some guidance on when to use research to understand a condition and when is it inappropriate to use that information to guide code assignment?

Response: CCAQ noted that the query sought guidance on the use of research material to code an episode of care and was not specifically looking for coding advice on the examples provided.

CCAQ advised that the role of the coder is not to research to obtain a diagnosis if the documentation is lacking. Research is useful to understand a condition or seek clarity on a documented diagnosis, however the research results could not be used to code an episode of care. If in doubt, coders must send a query to the clinician to confirm any diagnosis that is not clearly stated in the documentation.

CCAQ advised that coding query responses from CCAQ may be used in appropriate scenarios but responses from other jurisdictions can only be used as a guide and are not applicable in Queensland. Research results should also be considered on a case-by-case basis and not used for code assignment. If there is any doubt a clinical query must be instigated.

June 2020

Query ID 02-0620: MBS Item numbers

Reviewed 05/2022 – ADVICE CURRENT

Query: The query sought advice on whether the MBS item number supplied by the clinician can inform code assignment and/or query generation. There are 2 current VICC queries relating to one part of this question (3499 *Use of MBS for further clarification of a procedure* & 3359 *Division of adhesions (MBS provided but undocumented)*).

While much great work has been done in the area of documentation improvement, many clinicians are of the opinion that their assignment/documentation of MBS verifies the procedure performed. For nationwide consistency we seek direction on the following to ensure coders are routinely assigning ACS compliant ACHI for all procedures performed by the clinician during an episode of care

1. If a clinician documents a MBS item number on an operation report indicating a certain procedural component was performed but there is no documentation of this component in the detail of the operation report, is it acceptable for the coder to generate a query in relation to the conflicting information to so the ACHI assigned accurately reflect the all procedure/s performed?

   E.g., MBS 30378 (Description: *Laparotomy involving division of adhesions in conjunction with another intraabdominal procedure*) documented but adhesiolysis not documented in body of operation report. Query?

2. If a clinician documents a MBS item number on an operation report indicating they performed a certain procedure but when documenting the same procedure in the body of the operation report the terminology used by the clinician does not initiate a pathway for a code assignment, can the coder use the MBS item number descriptor to confirm the procedure performed and assign ACHI without query?

   E.g., dense adhesions, colon dissected off surrounding tissue (MBS 30378 - Description: *Laparotomy involving division of adhesions in conjunction with another intraabdominal procedure - documented*). Assign code?

3. If a clinician documents a MBS item number on an operation report indicating they performed a certain procedure that provides additional specificity to a component of the procedure documented on the operation report, can the coder use the MBS descriptor information to assign more specific ACHI without query?

   E.g., first stage flap repair documented on operation & 45003 documented (Description: *Single stage local myocutaneous flap repair*). Able to assign the code for myocutaneous without query?

4. If a clinician documents a MBS item number on an operation report that conflicts with information in the body of the procedure report, is it acceptable for the coder to generate a query due to conflicting documentation to confirm what procedures were performed?

E.g., colonoscopy with biopsy documented on the procedure report but MBS 32229 (*Removal of one or more polyps during colonoscopy)* plus path suggestive of polypectomy. Query?

5. If a clinician does not document a MBS item number on the operation report but later supplies the MBS item via phone & this MBS recorded in the patient administration software, if there is a conflict with the operation report documentation and this MBS supplied, can the coder raise a clinician query to ensure the ACHI assigned accurately reflects the actual procedure/s performed even if the MBS is not documented in the patient record?

   E.g., A surgeon cannot document 31355 *Malignant Tumour of Soft Tissue* until histological proof of malignancy has been obtained. If supply of this information (although not documented in the record) conflicts with record documentation. Query?

Response: CCAQ advised that MBS items are not to be used to support assignment of the ACHI code and if the documentation is deficient then a clinical query is to be generated. It was also advised that the clinical query should highlight a potential quality and safety issue if only the MBS item number is documented.

Query ID 03-0620: Bilateral procedures in the same region

Reviewed 05/2022 – ADVICE AMENDED

Query: The query sought advice on whether resection of ingrown toenail done medially and laterally through two separate incisions is coded twice or does the ingrowing toenail refer to one lesion and therefore the procedure is coded once. Not all nail resections are done on medial and lateral sides. The Doctor documents this as “bilateral”.

Response: CCAQ advised that the procedure should be coded once only, following ACS 0020 *Bilateral/multiple procedures*. Medial and lateral resection of an ingrown nail on a single toe would be considered one lesion.

Query ID 04-0620: Arterial occlusion secondary to intra-arterial drug injection

Reviewed 05/2022 – ADVICE CURRENT

Query: The query relates to coding advice "Ischaemic Fingers" (Ref TN200) published 15 June 2009 and seeks advice on the correct diagnosis codes to assign for an admission to treat arterial occlusion/ischaemia following previous intra-arterial drug injection?

Scenario:

The patient presented to hospital for amputation of an ischaemic thumb secondary to intra-articular injection of methamphetamine and subsequent occlusion of the radial artery. The patient injected methamphetamine into the radial artery 6 weeks ago.

Does the following Coding Rule, published in June 2009, apply to subsequent admissions for management of arterial complications from intra-arterial drug injection, or does it relate only to the initial episode of care to which the injury/poisoning relates?

ACCD Coding Rule Published 15 June 2009

Ischaemic fingers

Q:

Ischaemic fingers due to occlusion of blood vessel secondary to injecting crushed benzodiazepine tablets into the ulnar artery. What is the correct code assignment for the above scenario?

A:

The correct codes to assign for this scenario are:

T42.4 *Poisoning by antiepileptic, sedative-hypnotic and ant parkinsonism drugs, Benzodiazepines*

I77.8 *Other specified disorders of arteries and arterioles*

and the appropriate external cause of injury codes.

Assign a more specific code if the type of blood vessel occlusion is specified e.g. I74.2 *Embolism and thrombosis of arteries of upper extremities for thrombosis of ulnar artery*.

If the advice above relates to the initial episode of care only, please advise on the appropriate diagnosis codes to assign for the scenario above.

Our suggested codes are:

I77.8 *Other specified disorders of arteries and arterioles* (or a more specific code for the type of occlusion if documented)

T92.8 *Sequelae of other specified injuries of upper limb*

OR

T96 *Sequelae of poisoning by drugs, medicaments and biological substances*

Along with appropriate external cause codes.

Response: CCAQ Committee members agreed that in this scenario the condition was still acute and current and therefore not a *sequelae*, regardless of the time difference between the injury occurrence and presentation. As such, CCAQ supported the application of the coding rule from June 2009.

Suggested codes for the scenario provided were:

T43.61 *Psychostimulants with potential for use disorder, methylamphetamine*

X61 *Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, anti-parkinsonism and psychotropic drugs, not elsewhere classified*

I77.8 *Other specified disorders of arteries and arterioles* (or further specified condition e.g., thrombosis if documented) plus other manifestations of the injury documented/treated

A *sequalae* code can be used for a subsequent episode of care following the initial episode of care treatment.

May 2020

Query ID 02-0420: NUSS Bar malpositioning

Reviewed 05/2022 – ADVICE CURRENT

Query: The query sought advice on the diagnosis code to be assigned when a patient presents with malpositioning of a NUSS bar (originally inserted to treat Pectus Carinatum) that requires removal and/or revision?

The example operation report documents the indication for surgery 'bar slipped up' with Operation Description 'Redo reverse NUSS'. Procedure details 'Left and right thoracotomy x 2, new bar over ribs, 2 x end plate with Ticron'.

T84.2 *Mechanical complication of internal fixation device of other bones*? or

T84.3 *Mechanical complication of other bone devices, implants and grafts*? Or

T85.61 *Mechanical complication of respiratory prosthetic devices, implants and grafts*?

Response: CCAQ agreed the appropriate code to assign for the malpositioning of the NUSS bar is T84.2 *Mechanical complication of internal fixation device of other bones* as it is an internal fixation device used to reshape the chest.

Query ID 03-0520: Definition of Birth Episode and Assignment of prematurity code

Reviewed 05/2022 – ADVICE AMENDED

Query: The query sought guidance on the definition of 'birth episode' and the assignment of prematurity codes after the birth episode.

1) Definition of birth episode

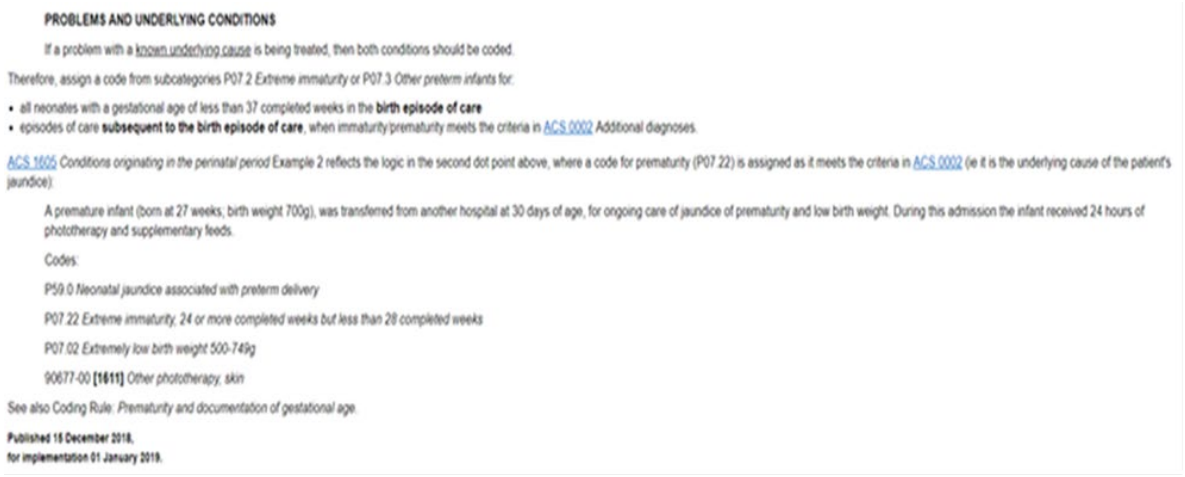
2) After birth, if a patient is transferred to another facility is this still considered the birth episode of care regardless of patient age?

3) When to assign the premature/preterm code? If preterm patient is discharged from hospital after the birth episode of care, then re-admitted shortly after discharge with no perinatal conditions, and >28days old, can we assign the prematurity code based on gestational age for example: Ex 35 weeks?

Example:

A 5-week-old preterm baby presenting with likely viral illness. The child went into cardiac arrest and is resuscitated after 25 mins and then transferred to our facility where multi-organ failure and death occur. Clear documentation of Ex 35 weeks (Corrected age 40 weeks plus 5 days at the time of admission) with no underlying perinatal or congenital conditions. Patient passed away during the admission.

ACS 1618 has been retired. National Coding Advice published December 2018 Assignment of additional diagnosis codes for prematurity should be revised as per NCA below.



PROBLEMS AND UNDERLYING CONDITIONS

If a problem with a known underlying cause is being treated, then both conditions should be coded.

Therefore, assign a code from subcategories P07.2 *Extreme immaturity* or P07.3 *Other preterm infants* for:

- all neonates with a gestational age of less than 37 completed weeks in the **birth episode of care**
- episodes of care **subsequent to the birth episode of care**, when immaturity/prematurity meets the criteria in ACS 0002 Additional diagnoses.

ACS 1605 *Conditions originating in the perinatal period* Example 2 reflects the logic in the second dot point above, where a code for prematurity (P07.22) is assigned as it meets the criteria in ACS 0002 (ie it is the underlying cause of the patient's jaundice):

A premature infant (born at 27 weeks, birth weight 700g), was transferred from another hospital at 30 days of age, for ongoing care of jaundice of prematurity and low birth weight. During this admission the infant received 24 hours of phototherapy and supplementary feeds.

Codes:

P59.0 *Neonatal jaundice associated with preterm delivery*

P07.22 *Extreme immaturity, 24 or more completed weeks but less than 28 completed weeks*

P07.02 *Extremely low birth weight 500-749g*

90677-00 **[1611]** *Other phototherapy, skin*

See also Coding Rule: *Prematurity and documentation of gestational age*.

Published 18 December 2018,
for implementation 01 January 2019.

Response: CCAQ agreed on the following:

Questions 1 and 2: The birth episode is the episode of care (for the baby) in which birth occurs. Subsequent episodes of care (including where the baby is transferred to another facility) are no longer considered the birth episode.

Question 3: A prematurity code cannot be applied to episodes of care after the birth episode unless the prematurity meets the criteria in ACS 0002 *Additional diagnoses* or is the primary reason for ongoing care in a subsequent admission (ACS 0001 *Principal diagnosis*).

Note: Coding Rule Ref Q3336 *Assignment of additional diagnosis codes for prematurity* referred to in the query was updated on 16/12/2019 and still applies.

Query ID 04-0520: Autologous blood patch pleurodesis

Reviewed 05/2022 – ADVICE CURRENT

Query: The query sought advice on correct coding for blood patch pleura/lung. Autologous blood patch pleurodesis is the instillation of the patient's own blood into the pleural space for the treatment of persistent prolonged air leaks, usually after pulmonary resections, in spontaneous pneumothorax patients or those with persistent air leaks or residual air space. Blood outside its own environment is an irritant, therefore chest physicians must watch closely for an allergic reaction.

The patient's own blood is taken from one of their peripheral veins and then, without mixing with heparin, is immediately instilled into the pleural cavity via an already placed chest tube. The procedure can be carried out at the patient's bedside in a surgical ward under strict aseptic conditions.

In the absence of a specific intervention code for blood patch pleura/lung, please advise if the following coding is correct or the most appropriate alternative -

38456-35 [558] *Other closed procedures on lung or pleura* - Note: code as many times as performed

92060-00 [1893] *Administration of autologous blood*

Response: CCAQ agreed the correct coding assignment is 38424-02 [556] *Pleurodesis* with the addition of 92060-00 [1893] *Administration of autologous blood*.

April 2020

Query ID 03-0420: Endometriosis of Uterosacral Ligament

Reviewed 04/2022 – ADVICE CURRENT

Query: The query sought guidance on coding endometriosis, where pathways are provided for 'broad ligament' and 'round ligament' but there is no pathway for 'uterosacral ligament' despite being one of the major ligaments to be affected by this condition (according to internet research) and the fact that (uterosacral) is a nonessential modifier in conjunction with (broad) and (round) in the relevant procedure code 35637-10 *Laparoscopic excision of lesion of pelvic cavity.*

Both broad ligament and round ligament options code to N80.3 *Endometriosis of pelvic peritoneum*.

Can coder's assume peritoneum/pelvis and follow pathway *endometriosis/peritoneal* to assign N80.3 or should endometriosis/specified site NEC be followed to assign N80.8?

Response: CCAQ agreed that assignment of N83.0 *Endometriosis of pelvic peritoneum* was appropriate as it is application of anatomy and the Clinical Coding Practice Framework, not an assumption; uterosacral ligaments are part of the pelvic peritoneum.

Query ID 04-0420: Bone Morphogenetic Protein (BMP) Pain

Reviewed 04/2022 – ADVICE CURRENT

Query: The query seeks guidance on coding assignment where documentation of 'BMP Pain' following Spinal Fusion surgery requires additional pain medication (e.g., Dexamethasone).

For example, patient was reviewed post spinal ALIF procedure due to excess pain. Diagnosis documented by Clinician "BMP associated pain" with a care plan "Plan: 4mg Dexamethasone orally bd for 5 days" (Dexamethasone was initiated during inpatient episode of care and continued post discharge).

There seems to be some confusion amongst coders if BMP Pain is regarded as Routine postoperative care (which includes prescribing analgesic medication for pain in the operative site) vs ACS 1904 Care beyond routine intraoperative/postoperative care (includes consultation/treatment by a clinician resulting in a change of management … treatment that delays discharge).

It is also noted ACS 1904 Procedural complications/Overview/dot point three "Conditions classified to T82–T85 for complications related to prosthetic devices, implants or grafts (eg mechanical complications, haematoma, pain, stenosis following insertion of prosthetic devices)".

Can the committee please advise if documentation of BMP Pain (meeting ACS 0002) meets ACS 1904 to assign T84.83 *Pain following insertion of internal orthopaedic prosthetic devices, implants and grafts*?

Response: CCAQ noted that coding for BMP would be dependent on the clinical documentation stating that it was either routine postoperative care (per ACS 0002) or care beyond routine intraoperative/postoperative care (per ACS 1904). It was agreed that for the scenario provided, the documentation meets ACS 1904 and T84.83 *Pain following insertion of internal orthopaedic prosthetic devices, implants and grafts* is the correct code to use.

Query ID 08-0420: Diabetic Foot Ulcer

Reviewed 04/2022 – ADVICE UPDATED

Query: The query seeks clarification of terminology where patient has type 2 diabetes mellitus and is admitted with a 'foot ulcer' for debridement. There are no other conditions to meet criteria for Diabetic Foot. However, the Anaesthetic Registrar has documented diabetic foot ulcer on the pre-anaesthetic assessment.

Is the documentation of 'diabetic foot ulcer' considered a 'diabetic foot'? Or is the description conveying that this is a Diabetic patient who also has a foot ulcer.

Response: CCAQ agreed that if diabetic foot is documented in the clinical record, E11.73 *Diabetes mellitus with foot ulcer due to multiple causes* should be assigned, following ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia/6. Diabetic foot.* If documentation is unclear, a documentation query should be submitted to the clinician.

February 2020

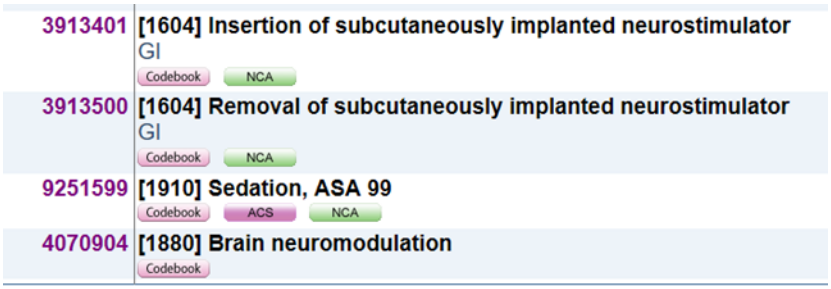
Query ID 04-0220: Deep Brain Stimulation

Reviewed 04/2022 – ADVICE UPDATED

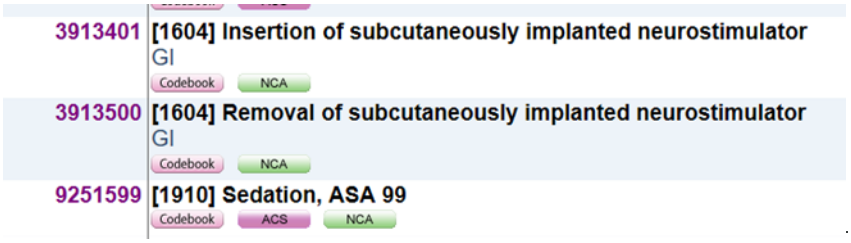
Query: This query seeks confirmation of the correct procedure codes for scenarios where patients come in for replacement of DBS generator due to flat battery. Is 40709-04 *Brain neuromodulation* also assigned if DBS activation is performed in conjunction with replacement?

Code options:

Option 1:



Option 2:



Response: CCAQ agreed that Option 2 lists the correct procedure codes for battery replacement. Members agreed that the addition of 40709-04 was not required as DBS was only necessary in order to change the battery. If DBS is performed in addition to replacement of the DBS generator, follow the 'code also' instruction for DBS.

Refer also to Coding Rule Ref: Q3227 *Re-positioning of neurostimulator wires/battery/IPG.*

Query ID 05-0220: Haematoma post endarterectomy

Reviewed 04/2022 – ADVICE CURRENT

Query: This query seeks advice on the correct coding assignment for post-operative haematoma at endarterectomy repaired with patch graft. For example, carotid endarterectomy repaired with Braun patch or common femoral endarterectomy repaired with as GSV patch.

1. As graft is not the main component of these procedures should the haematoma at post-operative site be coded as T81.0 *Haemorrhage and haematoma complicating a*

procedure, not elsewhere classified or T82.81 *Haemorrhage and haematoma following insertion of cardiac and vascular prosthetic devices, implants and grafts*?

2. What is the correct external cause in this case Y83.8 *Other surgical procedures* or Y83.2 *Surgical operation with anastomosis, bypass or graft*?

Response: CCAQ noted that as the haematoma in this scenario is associated with a graft it is appropriate to code T82.81 *Haemorrhage and haematoma following insertion of cardiac and vascular prosthetic devices, implants and grafts* as per pathway with Y83.2 *Surgical operation with anastomosis, bypass or graft* as the external cause code. This is also in line with national coding advice published on 15 September 2018.

December 2019

Query ID 01-1219: Exposure to tobacco smoke

Reviewed 03/2022 – ADVICE UPDATED

Query: The query seeks advice on whether the diagnosis code Z58.7 *Exposure to tobacco smoke* can be assigned for newborns in the birth episode of care.

Response: CCAQ agreed that if clinician documentation clearly states that the newborn is affected by secondhand smoke (passive) then Z58.7 *Exposure to tobacco smoke* may be assigned.

Query ID 03-1219: Graft

Reviewed 03/2022 – ADVICE CURRENT

Query: This query seeks confirmation of the coding pathway for removal of an infected AVF with embolectomy and patch repair of the brachial artery. The coding pathway for the patch graft leads to 33548-00 Patch graft of artery using autologous material, with only one other option being 'using synthetic material', nothing for xenograft or heterograft. The graft is not autologous and not synthetic either. Is this pathway correct? Does the classification need to be updated?

Response: CCAQ agreed that the correct pathway is to 33548-00 *Patch graft of artery* however it was noted that this did not cover the use of xenograft/heterograft tissue. Members agreed that a request for an additional code for xenograft/heterografts (or material NEC) should be submitted to the Australian Classification Exchange (ACE) via public submission.

Query ID 04-1219: Meconium aspiration syndrome

Reviewed 04/2022 – ADVICE UPDATED

Query: This query seeks clarification of ACS 1613 *Massive Aspiration Syndrome* which advises to code P22.1 *Transient tachypnoea of newborn* (TTN) when supplemental oxygen is required for less than 24 hours.

In the scenario provided, the baby was born in a rural facility and diagnosed with meconium aspiration syndrome and required transfer to another facility for admission to their special care nursery. The baby did not receive 24 hours supplemental oxygen prior to transfer. The same situation would occur if the baby died within 24 hours (standard advises to code TTN only). Should the Standard be updated to cover these two scenarios?

Response: CCAQ agreed that if the documentation states meconium aspiration syndrome and supplemental oxygen was required for <24 hours, assign P22.1 *Transient tachypnoea of newborn* as directed by ACS 1613 *Massive Aspiration Syndrome*.

Query ID 05-1219: Termination of pregnancy (TOP)

Reviewed 03/2022 – ADVICE CURRENT

Query: This query seeks advice as to the principal diagnosis (PD) coding for staged termination of pregnancy over 3 separate episodes of care?

Facility is a same-day facility that cannot admit overnight.

Episode 1 – Patient admitted and discharged same day for initiation of staged termination (PD Z32.2 *Initiation of medical abortion*).

Episode 2 – Patient re-admitted and discharged same-day for next stage of termination but further ripening of cervix required (Can the PD be Z32.2?)

Episode 3 – Patient re-admitted and discharged same-day for completion of termination (PD O04 *Medical abortion*).

On each of the days the patient is given light sedation so must be admitted depending on procedures performed.

Response: CCAQ agreed that Z32.2 *Initiation of medical abortion* can be coded for Episode 1 and Episode 2 with the *Duration of Pregnancy* code O09.-.

For Episode 3, code O04.- *Medical abortion with fourth character* .5-9 with the *Duration of Pregnancy* code O09.-.

Query ID 06-1219: U91 Syndrome

Reviewed 03/2022 – ADVICE CURRENT

Query: This query seeks clarification of the application of the new U91 Syndrome code for clinical diagnosis such as red man syndrome or refeeding syndrome.

ACS 0005 SYNDROMES

A syndrome is a group of signs and symptoms resulting from a common cause, or appearing in combination, to present a clear picture of a disease or inherited abnormality (Mosby 2009).

Many rare syndromes are not classified in ICD-10-AM to one single code. Clinical coders may need to research and/or seek clinical clarification to determine the manifestations of unclassified syndromes, to assist with code assignment.

CLASSIFICATION

Where there is no single ICD-10-AM code to classify all the elements of a syndrome, assign:

- codes for the manifestations that are relevant for the patient, and meet the criteria in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*

and

- U91 *Syndrome, not elsewhere classified*, as an additional diagnosis to flag that the manifestations are related to a syndrome.

As per the standard where there is no single code to classify all elements of a syndrome code the manifestations + the U91 code. Regarding the refeeding syndrome, do we code all the treated electrolyte imbalances + the U91?

Response: CCAQ agreed the correct approach was to code out the manifestations for any syndrome that meet ACS 0001 and ACS 0002 and code the U91 syndrome code as an additional diagnosis code to identify that there is a syndrome attached to these manifestations.

CCAQ noted this query related to all syndromes in general, not specifically red man or refeeding syndromes.

November 2019

Query ID 01-1119: Aspiration Pneumonia

Reviewed 04/2022 – ADVICE UPDATED

Query: The query seeks advice on the appropriate coding for aspiration pneumonia secondary to intubation for the purpose of respiratory support (CVS) and aspiration not further specified. Does the Coding Rule Ref No: Q3202 *COPD with aspiration pneumonia/Mendelson's syndrome* refer to the aspiration due to anaesthesia only or is intubation included as a component when anaesthesia is also provided?

1) How do you code aspirational pneumonia secondary to CVS intubation when this is performed with sedation for the purpose of intubation for respiratory support only in a non-operative setting?

2) How do you code aspirational pneumonia secondary to CVS intubation when performed with sedation/GA as operative anaesthesia?

3) How do you code aspiration that is not documented as Aspiration Pneumonia?

Response: CCAQ agreed that for Questions 1 and 2, the correct coding assignment is J69.0 *Pneumonitis due to food and vomit* with appropriate external cause codes in accordance with the "use additional external cause code" note at category J69.

For question 3, CCAQ agreed that for aspiration not documented as aspiration pneumonia, the coding assignment is T17.9 *Foreign body in respiratory tract* with appropriate external cause codes.

Query ID 04-0919: Loop recorder

Reviewed 04/2022 – ADVICE UPDATED

(Note: query submitted to ACE seeking further clarification)

Query: The query seeks advice on which diagnosis codes would apply for a patient who had a recent cerebral infarction and is now admitted same day for insertion of loop recorder to exclude cardio-embolic source and/or subclinical AF.

Response: CCAQ concluded that in the absence of AF history or cerebral infarction documented, the loop recorder was inserted for observation only and agreed Z03.5 *Observation for other suspected cardiovascular diseases* with Z86.71 *Personal History of cerebrovascular disease* is the appropriate coding assignment in this scenario.

Query ID 03-1119: Nerve Blocks

Reviewed 02/2022 – ADVICE CURRENT

Query:

This query seeks clarification that regional blocks and continuing infusion (if applicable) are coded when performed in theatre once the procedure has stopped? The block is placed and the indication for the regional is documented as "Post op Analgesia". According to the response in Q3223 (Published 15 March 2018) if the reason is "postprocedural analgesia" (as documented by the anaesthetist) then these are not coded? Otherwise, why ask if it is used for "operative anaesthesia or postprocedural analgesia? Is this coded regardless of the reason because it is initiated in theatre?

Response: CCAQ agreed that the term 'postprocedural analgesia' encompasses only those procedures which provide ongoing postprocedural analgesia via continuous infusion AND were initiated in the operating suite, theatre or recovery.

Therefore, if there was continuous infusion and it was initiated in the theatre (which includes recovery) it can be coded. The assignment is dependent on the intent of the nerve block as per ACS 0031 *Anaesthesia*.

Query ID 04-1119: Resistance to Anti-biotics

Reviewed 02/2022 – ADVICE UPDATED

Query:

This query seeks clarification on the appropriate process to query clinicians for confirmation of drug resistance as per ACS 0112 Infection with Drug Resistant Microorganisms. The Infectious Diseases (ID) team within the facility have expressed concerns regarding the coding practice of sending queries for all pathology results demonstrating resistance 'R' to antibiotics.

Clinician comments include 'Most bacteria will be resistant to certain antibiotics because they inherently are but are not classified as resistant organisms. For instance, Moraxella is often ampicillin resistant but is not thus a resistant organism.'

Further to this, ID highlighted some infective organisms are resistant to antibiotics which is intrinsic in nature for that pathogen. However, if the pathogen acquires unexpected resistance to the antibiotics and antibiotics are changed then it should be clarified from the clinician if resistance is not specifically documented within the progress notes.

Based on the above comments, please advise when it is appropriate to write a query for resistance to antibiotics for the following scenarios:

1. When the pathology results demonstrate the resistance of the infective organism to antibiotic, and documentation of resistance is not available in the progress notes (no change to antibiotics based on the pathology results)

2. Based on pathology results the selection of antibiotic that is sensitive to the pathogen acknowledges and avoids those that are resistant and thus influences the correctly chosen antibiotic, however the wording 'resistance' is not documented in the progress notes.

3. When the Clinician changes the antibiotics due to the resistance of the infective organism, for example:

a) Patient is already receiving antibiotic that was resistant on pathology, once the pathology results become available the antibiotics are changed

b) Patient has been on treatment that is sensitive and due to mutation of pathogen the resistant developed so the change in antibiotics.

Response: CCAQ agreed that a clinical documentation query may be written where there is documentation of an infection and the pathology report indicates the causative organism is resistant to an antibiotic(s), in accordance with **ACS 0010 Clinical Documentation and General Abstraction Guidelines**.
If the clinician confirms resistance, the appropriate resistance code(s) should be assigned, as per **ACS 0112 Infection with Drug Resistant Microorganisms.**

Query ID 05-1119: Ventilatory Support

Reviewed 02/2022 – ADVICE CURRENT

Query: This query relates to ACS 1006 *Ventilatory Support* and seeks advice on the correct ventilation procedure codes and what the ventilation hours would be for the following scenarios:

1. A patient with COPD is ventilated through an endotracheal tube for 23 hrs. At 23 hours, the patient is extubated to non-invasive ventilation via facemask, and is then progressively weaned off non-invasive ventilation over the following 85 hours.

2. A patient with a neuro-muscular disorder is ventilated through an endotracheal tube for 24 hours after an overdose. They are extubated once the side-effects of the overdose drugs have worn off but fail due to their underlying neuro-muscular disorder. After a further 24 hours ventilation through an endotracheal tube, they are extubated to non- invasive ventilation via facemask to facilitate weaning of ventilation over five days. The alternative weaning approach would require a tracheostomy and weaning of ventilation over that same five-day period, but with the additional risks and costs associated with a tracheostomy.

a) Please advise how to code if the patient is extubated to non- invasive ventilation via facemask.

b) Please advise how to code if the patient has a tracheostomy and is weaned off ventilation via that tracheostomy

3. A patient with COPD is intubated in ED to facilitate investigations. They are transferred to ICU and ventilated through an endotracheal tube for 48 hrs. At 48hrs they are extubated to room air. The following day the patient deteriorates with an exacerbation of COPD and is started on non-invasive ventilation via a facemask, requiring 2 days of non-invasive ventilation.

4. A patient with morbid obesity has been ventilated through an endotracheal tube for 36 hrs. They are extubated to high flow nasal prongs with a flow rate of 60lpm (exceeding ward capabilities) and then weaned off high flow over the following 72 hours.

Response: CCAQ agreed that the specific scenarios be coded as follows:

Scenario 1:

13882-00 [569] *Management of continuous ventilatory support <= 24 hours*

92209-01 [570] *Management of non-invasive ventilatory support >24 and < 96 hours*

Scenario 2:

a) 13882-01 [569] *Management of continuous ventilatory support >24 hours and < 96 hours*

92209-03 [570] *Management of non-invasive ventilatory support >= 96 hours*

b) if tracheostomy is performed for weaning and weaning is performed by a trachea shield or collar, include the weaning in the duration of the CVS up to a maximum of 24 hours following the cessation.

Scenario 3:

13882-01 [569] *Management of continuous ventilatory support >24 hours and < 96 hours*

92209-01 [570] *Management of non-invasive ventilatory support >24 hours and <96 hours*

Scenario 4:

13882-01 [569] *Management of continuous ventilatory support >24 hours and < 96 hours*

92209-01 [570] *Management of non-invasive ventilatory support >24 and < 96 hours*

October 2019

Query ID 02-1019: Lack of documentation in Rehabilitation area

Reviewed 02/2021 – ADVICE CURRENT

Query: The query seeks confirmation of the appropriate coding practice for an Allied Health Practitioner (AHP) intervention when the notes are made in the patient record by the Allied Health Assistant (AHA) and not documented by the qualified AHP therapist. In the scenario provided, patients attending the Day Therapy Rehab unit are admitted as day rehab. Often the only documentation is from an AHA (e.g., Patient attended Speech Therapy Session or Patient attended Physiotherapy group circuit).

Question: As the qualified AHP therapist has not documented in the chart should we be coding the relevant AHP intervention based only on the AHA entry in the patient record? Is there a consistent statewide practice?

Response: CCAQ agreed that where the AHA is a member of the care team and working under the direction/supervision of the AHP then it is appropriate to assign the appropriate ACHI code from documentation completed by the AHA.

Query ID 04-1019: Coding from Alcohol Withdrawal Score

Reviewed 02/2022 – ADVICE CURRENT

Query: This query seeks advice on assignment of F10.3 *Mental and behavioural disorders due to use of alcohol – withdrawal state* and F10.4 *Mental and behavioural disorders due to use of alcohol – withdrawal state with delirium* based on the patient's Alcohol Withdrawal Scale (AWS) score. The AWS is requested by clinicians and usually performed by nurses for patients who have a history of excessive alcohol consumption (dependence, intoxication, frequent use etc.) and are at risk of withdrawal. Most of these patients receive thiamine for prophylaxis against Wernicke's encephalopathy and nurses will administer Diazepam (routinely charted as PRN by clinician) based on the AWS score.

Response: CCAQ agreed that F10.3 *Mental and behavioural disorders due to use of alcohol – withdrawal state* and F10.4 *Mental and behavioural disorders due to use of alcohol – withdrawal state with delirium* should only be assigned where the clinician has documented withdrawal state in the patient chart. If in doubt, a clinical documentation query should be submitted.

Query ID 05-1019: COF assignment of hypoglycaemia with Diabetes Mellitus

Reviewed 09/2020 - ADVICE UPDATED

Query: This query seeks advice on the correct Condition Onset Flag (COF) assignment for codes E1-.64 Diabetes mellitus with hypoglycaemia in cases when patient is known to have recurrent hypoglycaemia and has episodes of hypoglycaemia during admission however is not hypoglycaemic at time of admission. For example, documentation – "T1DM patient with hypoglycemics unawareness and history of recurrent hypoglycaemia managed by endocrine team and frequent BSL monitoring".

1. Should the COF be 1(QLD) – a previously existing condition that is exacerbated during the current episode of admitted patient care OR COF2(QLD) – for combination codes where a diagnosis within the code meets the criteria of COF 1(QLD2), and is not represented by another code with a COF 1(QLD2) value, then assign COF 1(QLD2) to the combination code?
2. What will be the correct COF for code E1-.64 when the patient also has documented poor control/unstable diabetes and H/O erratic BSLs?

Response: CCAQ agreed that in both scenarios, where the hypoglycaemia is the reason for admission, then COF 1 (QLD) should be assigned. Members further noted that a COF 1 is generally assigned where there is any doubt around the condition being present on admission.

The Condition Onset Flag should be present on admission.

Documentation in the example given states that the hypoglycaemia is a recurrent problem/pre-existing.

If in doubt or the condition is stated as chronic or pre-existing, then assign COF 1 present on admission.

COF 2 would only be assigned if the patient did NOT have documentation of current poor control and frequent episodes of hypoglycaemia at home.

September 2019

Query ID 02-0919: Impella device

Reviewed 07/2023 – ADVICE CURRENT

Query: The query seeks advice regarding the ACHI code for the use of the Impella.

Response: CCAQ agreed that until an ACHI code is created, the only available code is 38615-00 [608] *Insertion of left ventricular assist device.*
A procedure code from block [667] *Cardiac catheterisation* might also be assigned if the Impella device is used in conjunction with a cardiac catheterisation procedure.

Note: this query has been sent to IHACPA for clarification (February 2022)

Query ID 03-0919: Electric current scenarios

Reviewed 07/2023 – ADVICE CURRENT

Query: The query seeks advice on coding a scenario which includes multiple effects of electrocution including burns. Please note that category T75* excludes burns.

T75 Effects of other external causes

adverse effects NEC (T78.-)
burns (electric) (T20–T31

An electrician admitted to cardiology after sustaining electric shock from drilling into copper wire next to electrical mains wire. Electric shock through right hand; left hand was also touching the electric mains box. Presented with new Atrial fibrillation (no known H/O AF) as an effect of the electric current and partial thickness burn of right hand involving less than 10% body surface associated with the electric current.

Impression:
Likely new AF secondary to Electrocution requiring cardioversion
Burn over hypothenar eminence- deep partial thickness burn @ exit wound

Principal diagnosis on EDS - Electrocution AF

What are the correct diagnosis and external cause codes for this scenario?

Response: CCAQ agreed that the following codes could be assigned:

T75.4*Effects of electric current*

W86 *Exposure to other specified electric current*

Y92.9 *Unspecified place of occurrence*

U73.08 *Other specified work for income*

I48.9 *Atrial fibrillation and atrial flutter, unspecified*

T23.2 *Partial thickness burn of wrist and hand*

T31.00 *Burns involving less than 10% of body surface*

W86 *Exposure to other specified electric current*

Y92.9 *Unspecified place of occurrence*

U73.08 *Other specified work for income*

Query ID 06-0919: Retirement of Coding Rule C2907 – *Procedures performed in radiology departments*

Reviewed 07/2023 – ADVICE UPDATED

Query: The query seeks advice on the retired Coding Rule Q2907 *Procedures performed in radiology departments* and whether the advice is still applicable.

Response: CCAQ agreed that the QHAPDC Manual should be referenced for guidelines relating to procedures performed in privately owned/offsite radiology departments, specifically sections:

4.7.2 Procedures performed by a private health provider (Non-hospital) and

4.7.11 Recording of procedures performed by private health providers (Non-hospital)

Refer also to ACS 0029 *Coding of contracted procedures.*

June 2019

Query ID 01-0619: External cause code - anastomosis

Reviewed 07/2023 – ADVICE CURRENT

Query: The query seeks confirmation of the assignment of external cause code from category Y83* for post-op complications when the related surgical operation can be categorised to both Y83.2 *Surgical operation with anastomosis, bypass or graft* and Y83.6 *Removal of other organ (partial)(total)*. For example, Haematoma following Laparoscopic ultralow anterior resection, hand-sewn colo-anal anastomosis - both resection/ removal of organ (intestine) and anastomosis is performed. As opposed to appendicectomy when only surgical removal of organ (appendix) is performed without anastomosis.

Response: CCAQ agreed it was acceptable to use both Y83.2 and Y83.6 for anastomosis performed during organ removal. The coding standard ACS 2001 states that more than one external cause code may be assigned if required to classify the clinical concept. In this scenario, members agreed that just one external cause code, Y83.2 *Surgical operation with anastomosis, bypass or graft* should be assigned as it is more specific to the type of procedure performed and the complication condition.

Query ID 04-0619: Phacoemulsification with anterior vitrectomy

Reviewed 07/2023 – ADVICE UPDATED

Query: The query seeks confirmation of the correct procedure code assignment where a patient has had anterior vitrectomy performed for a complication during phacoemulsification of cataract with insertion of intraocular lens. Patient was booked for right phacoemulsification with intraocular lens (IOL) for cataract.

The procedure in this scenario was - right complicated phacoemulsification of lens and insertion of intraocular lens and mechanical vitrectomy by anterior approach.

The query provided two ACHI index options and sought advice on the correct index pathways to use:

Option 1:

Extraction/lens (crystalline) NEC/with removal of vitreous (vitrectomy) *and*

Insertion/lens, intraocular

Option 2:

Phacoemulsification *and*

Insertion/lens, intraocular *and*

Vitrectomy (anterior or limbal approach)

Response: In this scenario, CCAQ agreed with Option 1 as the pathway included "with removal of vitreous". ACHI codes 42731-01 [200] *Extraction of crystalline lens with removal of vitreous* and 42701-00 [193] *Insertion of intraocular lens* should be assigned.

Query ID 06-0619: Seat Belt Sign

Reviewed 07/2023 – ADVICE CURRENT

Query: The query seeks confirmation of the correct coding assignment for abdominal seat belt sign / seat belt injury without mention of abrasion / contusion or any other specific injury description?

For example:

Restrained driver of vehicle T boned to rear driver side door at approx. 80kph

c/o R) scapula pain, seat belt sign to LIF and R) side of neck.

Plan: CT Neck Thorax Abd.

No abdominal pain documented with CT NAD

In this case Unspecified injury of neck and Unspecified injury of shoulder and upper arm can be assigned for neck and scapula pain due to trauma.

What will be the correct code to assign for abdominal seat belt sign or seat belt injury (unable to seek further clarification from clinician)?

Response: CCAQ agreed that ordinarily further clarification should be sought from the clinician to rule out any further injury. CCAQ noted that in this scenario, the coder was unable to seek further clarification from the clinician therefore they would code S39.9 *Unspecified injury of abdomen, lower back and pelvis* as there cannot be an assumption of contusion.

April 2019

Query ID 02-0419: Castrate resistant prostate cancer

Reviewed 06/2023 – ADVICE UPDATED

Query: The query seeks confirmation the terms “castrate resistant prostate cancer" and "androgen-independent prostate cancer" can be used synonymously and assigned Z07 *Resistance to antineoplastic drugs* as per the recent Coding Rule Hormone Resistance in Prostate Cancer issued December 2018.

Response: CCAQ agreed that the terms “castrate resistant prostate cancer" and "androgen-independent prostate cancer" can be used synonymously to assign Z07 *Resistance to antineoplastic drugs.*

Note: Coding Rule Q3324 Hormone resistance in prostate cancer was retired on 1/7/2022.

February 2019

Query ID 01-0219: Cardiac sarcoidosis

Reviewed 06/2023 – ADVICE CURRENT

Query: This query relates to a patient diagnosed with probable cardiac sarcoidosis and proceeded to insertion of a cardiac defibrillator. Cardiac MRI performed and result "in keeping with myocardial sarcoid". The index entries under sarcoid and sarcoidosis are inconsistent, so the query seeks:

1. Correct code to assign for cardiac sarcoidosis?
2. Correct code to assign for myocardial sarcoid?
3. Are the terms 'sarcoid' and 'sarcoidosis' interchangeable?
4. Does myocarditis need to be documented in order to assign D86.8 *Sarcoidosis of other and combined sites* and I41.8 *Myocarditis in other diseases classified elsewhere*?

Response:

1. CCAQ agreed the correct coding for cardiac sarcoidosis is D86.8 *Sarcoidosis of other and combined sites*
2. CCAQ agreed the correct coding for myocardial sarcoid is D86.8 *Sarcoidosis of other and combined sites*
3. CCAQ agreed 'sarcoid' and 'sarcoidosis' are not the same in medical terms, however noted that the ICD-10-AM classifies them as interchangeable.
4. CCAQ agreed that D86.8† *Sarcoidosis of other and combined sites* and I41.8* *Myocarditis in other diseases classified elsewhere* can only be assigned if the documentation states myocarditis.

November 2018

Query ID 02-1118: Drainage of submandibular abscess

Reviewed 05/2023 – ADVICE CURRENT

Query: This query seeks the appropriate coding for the incision and drainage of a submandibular abscess.

Response: CCAQ are seeking further advice from IHACPA. In the interim, things to consider when assigning a code are the clinical documentation, anatomical position and the surgical approach.

October 2018

Query ID 01-1018: Posterior arm removal for shoulder dystocia

Reviewed 05/2023 – ADVICE UPDATED

Query: This query seeks to clarify if this procedure is to be coded as an assisted delivery when the McRoberts Manoeuvre is not performed.

Response: CCAQ agreed that posterior arm removal for shoulder dystocia should be coded as an assisted delivery.
Assign O83 *Other assisted single delivery*, 90477-02 [1339] *Assisted vertex delivery* and 90477-00 [1343] *Other procedures to assist delivery*. Refer also to ACS 1505 *Delivery and assisted delivery codes.*

September 2018

Query ID 03-0918: Gallstone pancreatitis

Reviewed 05/2023 – ADVICE UPDATED

Query: This query relates to assigning one or two codes to the following three scenarios where the diagnosis is gallstone pancreatitis and investigations provide further information.
Scenario 1: Gallstone Pancreatitis – Lap Chole – Histo: gall stones in gall bladder, no cholecystitis
Scenario 2: Gallstone Pancreatitis – Lap Chole – Histo: chronic cholecystitis
Scenario 3: Biliary Pancreatitis – ERCP, sphincterotomy & extraction of obstructing bile duct stone.

Response: CCAQ agreed that the following codes should be assigned for each scenario:
Scenario 1 – assign K85.1 *Biliary acute pancreatitis*
Scenario 2 – assign K85.1 *Biliary acute pancreatitis* and refer to ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* to determine whether a code can be assigned for the chronic cholecystitis
Scenario 3 – assign K85.1 *Biliary acute pancreatitis* and K80.51 *Calculus of bile duct without cholangitis or cholecystitis, with obstruction.*

July 2018

Query ID 01-0718: Intervention of beyond routine and cholecystectomy

Reviewed 05/2023 – ADVICE UPDATED

Query: This query relates to interventions beyond routine and cholecystectomy. The following questions were asked:

Q1a: What interventions would be considered beyond routine when there is mention of bleeding and/or a capsular tear during cholecystectomy, and therefore potentially qualify coding an intraoperative haemorrhage and /or liver injury code?

Q1b: Is diathermy a routine intervention used during surgery to achieve haemostasis and as such bleeding and/or a capsular tear would not be coded as a procedure complication?

Q1c: If Flowseal or Surgiseal is used, would this then qualify coding a complication if there is mention of bleeding or capsular tear? Or does the use of Surgiseal and Flowseal not automatically qualify coding a complication unless there is clear documentation of a 'liver injury', significant capsular tear and/or bleeding that is clearly documented as being significant and beyond normal?

Q2: If Flowseal or Surgiseal qualifies coding as an intervention beyond routine during a cholecystectomy, could CCAQ advise what procedure code to assign?

Q3: If it is advised that diathermy is beyond routine intervention during a cholecystectomy, could CCAQ advise if a procedure code is required to be assigned for diathermy of liver and the correct code to assign?

Response: CCAQ agreed that these queries could not be definitively answered. The coder must be led by the documentation. If the documentation is insufficient or unclear, a clinical documentation query may be required.

Refer also to Coding Rules Q3240 *Control of bleeding during ERCP* and Q3460 *Diathermy for control of haemorrhage due to minor liver laceration*, which provide advice on ACHI code assignment for similar scenarios.

Query ID 02-0718: Labour and delivery affected by unusually large fetus – condition onset flag (COF)

Reviewed 05/2023 – ADVICE CURRENT

Query: This query relates to which condition onset code and code should be assigned in association with the delivery of an unusually large fetus.

Response: CCAQ agreed condition onset flag = 1 (Qld) should be assigned with O66.2 *Labour and delivery affected by unusually large fetus* or O36.6 *Maternal care for excessive fetal growth*, depending on the documentation.

Refer to ACS 0048 Condition onset flag.

June 2018

Query ID 03-0618: Condition onset flag (COF)

Reviewed 04/2023 – ADVICE UPDATED

Query: This query relates to the condition onset flag (COF) assignment for the following two scenarios:

Scenario 1:
Patient with a history of gout with a flare up 9 days after admission not documented as having been precipitated by any hospital care.

Scenario 2: Patient with an attack of shingles with a re-occurrence 18 days after admission not documented as having be precipitated by any hospital care. Doctor notes previous flare-ups.

Response: CCAQ agreed that Qld condition onset flag 1 (present on admission) is to be assigned for both scenarios as the conditions were pre-existing.

Refer to ACS 0048 *Condition onset flag*, which states that a condition considered to be present on admission (Qld COF 1) includes "a previously existing condition that is exacerbated during the current episode of admitted patient care (e.g., atrial fibrillation, unstable angina)".

Query ID 04-0618: Pressure Injury

Reviewed 04/2023 – ADVICE UPDATED

Query: This query relates to whether pressure injuries need to meet ACS 0002 *Additional diagnoses* before they can be coded.

Response: CCAQ agreed that while typically pressure injuries will have a care/treatment plan implemented, a pressure injury still needs to meet the criteria in ACS 0002 *Additional diagnoses* before assigning a code.

Query ID 07-0618: Aspiration of uterine isthmocele

Reviewed 04/2023 – ADVICE CURRENT

Query: This query relates to the correct diagnosis and procedure code assignment of aspirated uterine isthmocele.

The treating doctor confirmed that the uterine isthmocele was a definite consequence of previous caesarean section (2012) and clinically this one was quite large. The treating doctor explained that at the site of the caesarean section scar an isthmocele can form in a divot or weakness in the wall which collects with mucous and fluid which in turn fills up the uterine cavity. The treating doctor drained the isthmocele (approx. 3-4mls of fluid) using an embryo

transfer catheter attached to a syringe, placed catheter into uterus and aspirated fluid collection under ultrasound vision. No scope was used.

Response: CCAQ agreed on the following code assignment as per the ICD-10-AM Index Complication/caesarean section wound NEC:
O90.8 *Other complications of the puerperium, not elsewhere classified*
N85.8 *Other specified noninflammatory disorders of uterus*
90436-00 [1273] *Other procedures on uterus*

May 2018

Query ID 05-0518: Complications of SPC

Reviewed 05/2023 – ADVICE UPDATED

Query: This query relates to the correct code assignment for complications of a suprapubic catheter (SPC).
If a patient has a UTI secondary to an SPC would the correct codes be:

N99.52 *Infection of stoma of urinary tract*
Y83.36 *Cystostomy as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*
Y92.23 *Place of occurrence, health service area, not specified as this facility*
N39.0 *Urinary tract infection, site not specified*
Or
T83.5 *Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system*
Y83.36 *Cystostomy as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*
Y92.23 *Place of occurrence, health service area, not specified as this facility*
N39.0 *Urinary tract infection, site not specified*

Response: CCAQ agreed that for a UTI secondary to an SPC, the following codes should be assigned:

N99.52 *Infection of stoma of urinary tract*
N39.0 *Urinary tract infection, site not specified*
Y83.36 *Cystostomy as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*
Y92.23 *Place of occurrence, health service area, not specified as this facility*

Query ID 06-0518: Diastasis of recti abdominal muscle in pregnancy or delivery

Reviewed 04/2023 – ADVICE UPDATED

Query: This query relates to when code O71.82 *Diastasis of recti abdominal muscle in pregnancy or delivery* is considered a condition that meets ACS 0002 *Additional diagnoses*, and the diagnosis code should be assigned.

Scenario 1: An admitted obstetric patient (post-delivery) is assessed by a physiotherapist and the separation of the rectus abdominus is assessed as being 1 cm. The clinical notes include "Recti abdominus 1cm, management discussed with patient".

Scenario 2: An admitted obstetric patient (post caesarean delivery) is assessed by a physiotherapist and the separation of the rectus abdominus is assessed as being 4 cm. The clinical notes include "Recti abdominus 4 cm, brace and Tubigrip fitted. Exercises recommended".

Response: CCAQ agreed that diastasis recti, diastasis of the rectus abdominus muscles or DRAM needs to be documented and the condition must meet the criteria in ACS 0002 *Additional diagnoses* to assign O71.82 *Diastasis of recti abdominal muscle in pregnancy or delivery*. Ambiguous or insufficient documentation should be clarified with the clinician.

Refer to ACS 0002 *Additional diagnoses/Examples illustrating additional diagnosis criteria (Example 12)* where DRAM is used to illustrate increased clinical care criteria.

Query ID 09-0518: Stiffness following TKJR

Reviewed 05/2023 – ADVICE UPDATED

Query: This query relates to the correct coding sequence for the below scenario:
Patient readmitted for 'postop stiffness following total knee joint replacement (TKJR)' and admitted for elective manipulation under anaesthesia.

Response: CCAQ agreed that for the scenario provided, the terms 'post op' and 'following' may refer only to the timing of the event and does not meet the criteria in ACS 1904 *Procedural complications* to code as a postoperative complication.
Assign M25.66 *Stiffness of joint, not elsewhere classified, lower leg* with Z96.65 *Presence of knee implant* to indicate the presence of the joint prosthesis.

Query ID 11-0518: Manual removal of placenta (MROP) definition

Reviewed 04/2023 – ADVICE UPDATED

Query: This query relates to what constitutes the definition of a manual removal of placenta (MROP).

Example: Sheared cord, requiring intervention to remove the placenta.
It was coded as MROP, and the Senior Registrar was queried for a 'retained' placenta.
The clinician's response was:
"This was not a manual removal of placenta or a retained placenta. A manual removal of placenta involves having to insert a hand into the uterine cavity."

In this example, should the intervention be coded as:
O83 *Other assisted single delivery* and 90482-00 [1345] *Manual removal of placenta* OR
O83 *Other assisted single delivery* and 90477-00 [1343] *Other procedures to assist delivery.*

Response: CCAQ agreed with the clinician's response and for the scenario provided advise to assign O83 *Other assisted single delivery* and 90477-00 [1343] *Other procedures to assist delivery*. Refer also to ACS 1505 *Delivery and assisted delivery codes*.

March 2018

Query ID 01-0318: Hysteroscopy

Reviewed 04/2023 – ADVICE CURRENT

Query: This query relates to whether the hysteroscopy procedure code should be assigned once or twice for the below scenario:

> Female patient admitted with excessive and frequent menstruation with regular cycle for dilation and curettage and hysteroscopy as a same-day procedure. In theatre after general anaesthesia given, the clinician performs a hysteroscopy with polypectomy. The dilation and curettage is then undertaken. Then another hysteroscopy examination in then performed to re-check the uterus. The patient has nil complications and is discharged later that day.

Response: CCAQ agreed that the hysteroscopy procedure code should only be assigned once as per ACS 0020 *Bilateral/multiple procedures/Multiple procedures – classification point 2* "the same procedure repeated during a visit to theatre involving one entry point/approach and similar/same lesions".

Query ID 05-0318: Coding between episodes of care

Reviewed 04/2023 – ADVICE UPDATED

Query: This query requests clarification from a coding perspective on what constitutes a coding episode of care (EOC) when the formal admission may have several episodes of care within that formal admission. Can a condition documented in a subsequent EOC be used to code a diagnosis in the first EOC? Is every EOC considered an admission in its own right therefore is only what is documented in that episode coded?

Example:

> Patient admitted with principal diagnosis of stroke with hemiplegia. Awaiting MRI. Each day, documentation states "awaiting MRI". On day 5 of admission patient snapped to Rehab with a principal diagnosis - stroke awaiting MRI. On Day 2 of the Rehab episode of care, MRI performed which showed cerebral infarction. Diagnosis now documented as cerebral infarct.

Can the cerebral infarction be coded as the principal diagnosis in the first episode of care? Or is the principal diagnosis in the first episode stroke and cerebral infarct can only be coded as the principal diagnosis in the second episode of care?

Response: CCAQ agreed that each episode of care is to be coded as an individual admission. The principal diagnosis in the first episode of care will be stroke, and in the second episode of care the principal diagnosis will be cerebral infarct, as the specificity was not known until the subsequent episode of care. Past episodes of care may be used in circumstances such as gaining specificity, however subsequent episodes cannot. Note the ACS Glossary provides a definition of 'episode of care'. Refer also to ACS 0010 *Clinical documentation and general abstraction guidelines* for guidelines on using information outside the current episode of care.

Query ID 07-0318: Pain management – femoral nerve block

Reviewed 03/2023 – ADVICE CURRENT

Query: Is an ACHI code for a nerve block for pain management assigned in the following scenario:
Patient admitted in DEM with a fractured neck of femur. Femoral nerve block administered (anaesthetic agent). Patient transferred to the orthopaedic ward and had surgery on day 2.
Is it correct to assign a code from block [63] for the femoral nerve block?

Response: CCAQ agreed that for a nerve block performed within the admission period, a code for the nerve block for pain management can be assigned. In the example provided, assign 18270-00 [63] *Administration of anaesthetic agent around femoral nerve* following the ACHI Index Administration/specified site/nerve/femoral (anaesthetic agent).

Query ID 08-0318: Coronary PTCA of multiple vessels

Reviewed 03/2023 – ADVICE CURRENT

Query: This query relates to procedure code assignment for the following scenarios and whether the procedures are individually coded or bundled together into one code.
Scenario 1) PTCA with a total of 3 stents inserted into 2 arteries: single stent to single artery (proximal LAD) and two stents to a single artery (proximal RCA & mid RCA)
Scenario 2) PTCA with a total of 4 stents inserted into 2 arteries: two stents to a single artery (proximal LAD & mid LAD) and two stents to a single artery (proximal RCA & mid RCA).

Response: CCAQ agreed that for each scenario, only one procedure code is assigned. Assign 38306-02 [671] *Percutaneous insertion of 2 or more transluminal stents into multiple coronary arteries* following the ACHI Index PTCA/with/stenting/multiple stents/multiple arteries.

Query ID 10-0318: Tissued IVC mid procedure

Reviewed 03/2023 – ADVICE CURRENT

Query: This query relates to whether the following scenario meets ACS 0002 *Additional diagnoses* and whether it is considered a procedural complication:
Scenario: Mid procedure patient's IVC tissued (post incision and drainage of abscesses but during packing) resulting in unanticipated pain. Explanation and counselling offered to patient post-operatively. Patient has a history of drug use resulting in difficult IV access.

Response: CCAQ agreed that management of the tissued IVC in this scenario would be considered routine post-operative care therefore not meeting the criteria in ACS 1904 *Procedural complications* to code as a postoperative complication.

December 2017

Query ID 01-1217: Endoscopic ultrasound guided drainage of pancreatic pseudocyst

Reviewed 03/2023 – ADVICE CURRENT

Query: This query relates to correct code assignment for the following:

Q.1. Endoscopic ultrasound (EUS) guided drainage of pancreatic pseudocyst using devices such as AXIOS and NAGI stents (procedure codes only).

Q.2. Endoscopic removal of AXIOS/NAGI stent (diagnosis and procedure codes).

Response:
Q1. CCAQ advise that for EUS guided drainage of a pancreatic pseudocyst using an AXIOS or NAGI stent, refer to Coding Rule Ref Q3214 *Endoscopic cystogastrostomy*.

Q2. For endoscopic removal of an AXIOS or NAGI stent assign:
Z45.89 *Adjustment and management of other implanted devices*
30491-04 [975] *Endoscopic removal of pancreatic stent*

Follow the ICD-10-AM Index: Management/implanted device NEC/specified NEC
Follow the ACHI Index: Removal/stent/pancreatic (endoscopic)

Query ID 04-1217: Insertion of multiple intrauterine devices (IUDs)

Reviewed 03/2023 – ADVICE CURRENT

Query: This query relates to coding procedures where multiple intrauterine devices (IUD) are being inserted.
Q.1. A female patient is admitted to have two Mirenas inserted for menorrhagia. Is 35503-00 [1260] *Insertion of intrauterine device [IUD]* assigned once or twice?

Q.2. A female patient had a replacement of existing Mirena (single) as well as having a second device inserted. Is 35506-00 [1260] *Replacement of intrauterine device* and 35503-00 [1260] *Insertion of intrauterine device [IUD]* assigned?

Response: CCAQ agreed on the following answer to each question:

Q.1. 35503-00 [1260] *Insertion of intrauterine device [IUD]* is to be assigned once, based on ACS 0020 *Bilateral/Multiple Procedures*/Multiple procedures Classification point 2. The same procedure repeated during a visit to theatre involving one entry point/approach and similar/same lesions.

Q.2. As per the above, only 35506-00 [1260] *Replacement of intrauterine device* is to be assigned.

Query ID 06-1217: Condition onset flag (COF) for J44.0

Reviewed 03/2023 – ADVICE CURRENT

Query: This query relates to the correct condition onset flag (COF) for J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection* in the following scenario:

Patient admitted for 15 days with fractured femur. Patient also has COPD and later in the admission develops a lower respiratory tract infection (no documentation of pneumonia).

Response: CCAQ advise that condition onset flag 2 (Qld) – not present on admission should be assigned, following ACS 0048 *Condition onset flag/Guide for use point 5*:

"For combination codes (see ACS 0015 Combination codes) where a diagnosis within the code meets the criteria of COF 2, and is not represented by another code with a COF 2 value, then assign COF 2 to the combination code (see Example 2)." (*CCAQ note – COF values amended for Qld*).

Query ID 07-1217: Subclinical hypothyroidism

Reviewed 03/2023 – ADVICE CURRENT

Query:

Q1. What is the correct code assignment for subclinical hypothyroidism not documented as iodine deficiency related?

Q2. Would you use the same code if the scenario was the same, except they choose not to treat the patient with medication?

Response:

Q1. For subclinical hypothyroidism not related to iodine deficiency, assign E03.9 *Hypothyroidism unspecified* following the Index Hypothyroidism (NOS).

Q2. Assign a code for subclinical hypothyroidism where it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

Query ID 09-1217: IVF and administration of intralipids

Reviewed 03/2023 – ADVICE UPDATED for 12th Edition

Query: What procedure code is assigned for a same day admission for intravenous intralipids for a patient undergoing IVF?

Response: CCAQ advise that for a same day admission for intravenous administration of intralipids, assign 96199-19 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent* following the ACHI Index Administration NEC – *code to block* [1920] *with extension* -19.

Query ID 10-1217: Parkinson's symptoms

Reviewed 03/2023 – ADVICE CURRENT

Query: Can G20 *Parkinson's disease* be assigned as an additional diagnosis in the following scenario:

Patient admitted for change of implantable pulse generator/deep brain stimulator. Following device replacement, the neurostimulator is reprogrammed to previous settings and the patient remains in hospital for 1-2 nights for neurological observation and monitoring of Parkinson's symptoms. The patient is reviewed by a neurologist on the day following the procedure and the neurostimulator settings are adjusted for symptom reduction.

Response: CCAQ advise that for the scenario provided, G20 *Parkinson's disease* can be assigned as an additional diagnosis as the condition meets ACS 0002 *Additional diagnoses*.

Query ID 11-1217: Anaemia secondary to myelofibrosis

Reviewed 03/2023 – ADVICE PENDING CLARIFICATION FROM IHACPA

Query: This query relates to anaemia secondary to myelofibrosis and the following questions were asked:

Q.1. What is the coding concept to be followed to ensure the correct principal diagnosis assignment?

Q.2. Would D47.4 *Osteomyelofibrosis* be coded as an additional diagnosis to the principal diagnosis D64.9 *Anaemia, unspecified*? When applying ACS 0001 *Principal diagnosis/problems and underlying conditions* and the underlying cause was diagnosed previously, does the underlying cause have to meet ACS 0002 *Additional diagnoses* to be coded?

Response: CCAQ agreed on the following for each question:

Q.1. The principal diagnosis is D64.9 *Anaemia, unspecified* because anaemia is a symptom of myelofibrosis and it is a condition in its own right and treated.

Q.2. D47.4 *Osteomyelofibrosis* is assigned as an additional diagnosis if documented as it meets ACS 0001 *Principal diagnosis/Problems and underlying conditions.*

November 2017

Query ID 05-1117: Resistance coding

Reviewed 12/2022 – ADVICE UPDATED

Query: This query relates to the coding of resistance. The query noted that resistance must be documented before it can be coded however it asked in cases where MRSA is documented, can resistance be assumed, and the pathology used for specificity. In the below scenario, is it correct to assign resistance to FLU and CFZ as we can assume MRSA in this scenario means 'multi'?

Scenario: Documented principal diagnosis – MRSA infection of THR. A joint aspiration was performed, pathology below.

MICROBIOLOGY 24/03

Specimen: Fluid - Femoral Joint

Gram Stain: Leucocytes 1+

Epithelials Nil

No organisms seen

Culture/sensitivities:

MRSA PEN (S) FLU (R) CFZ (R) DA (S)

Antibiotic Abbreviations Guide:

PEN Penicillin G

FLU Di(Flu)cloxacillin

CFZ Cefazolin

DA Clindamycin

Response: CCAQ agreed that ACS 0112 *Infection with drug resistant microorganisms* needs to be followed as there is clear direction on how resistance is to be coded depending on the documentation. 'M' in MRSA cannot be assumed to be 'multi' however it does indicate that there is a resistance therefore the pathology can be referred to for specificity as supported by ACS 0112. If in doubt, a query is to be submitted to the clinician to confirm.

Refer also to Coding Rule Ref No: TN1601 Twelfth edition FAQ: *Antimicrobial drug resistance*.

October 2017

Query ID 01-1017: Prevena Dressing

Reviewed 02/2023 – ADVICE CURRENT

Query: Is a Prevena™ dressing a vacuum dressing and should it be coded as such?

Response: CCAQ agreed that a Prevena™ dressing is a type of negative pressure dressing therefore it should be coded as a vacuum dressing.

Query ID 03-1017: Underlying cause of CKD when transplant fails

Reviewed 04/2023 – ADVICE UPDATED

Query: This query referred to Coding Rule Q2963 *Coding of underlying cause of CKD (chronic kidney disease) in a patient who has received a renal transplant* (retired 30 June 2019) which advises that when a patient has had a kidney transplant, it is no longer necessary to code the underlying cause of CKD unless the original disease (or a different disease) has recurred in the transplant kidney.

What diagnosis codes should be assigned in the following scenarios?

Scenario 1: End stage renal failure (ESRF) due to IgA nephropathy. Pt received a kidney transplant in 2007, which was removed in 2015 due to chronic rejection. Pt is on haemodialysis. Original kidneys still in situ.

Scenario 2: ESRF due to IgA nephropathy. Transplant failed in 2015 due to chronic rejection but transplanted kidney is still in situ. Original kidneys also in situ. Pt is on haemodialysis.

Response: CCAQ advise the following responses to each scenario.
Scenario 1:
The transplanted kidney was removed due to chronic rejection.
N18.5 *Chronic kidney disease, stage 5*
Z94.0 *Kidney transplant status*

Scenario 2:
The transplant failed due to chronic rejection.
N18.5 *Chronic kidney disease, stage 5*
Z94.0 *Kidney transplant status*

In both scenarios, the IgA nephropathy is not coded as it is not documented as the underlying cause of the current ESRF (transplant failure was due to chronic rejection).
Where the current ESRF is due to the original condition (e.g., IgA nephropathy), the original condition would be coded as the underlying cause of ESRF.
Kidney transplant status is coded in accordance with ACS 1438 *Chronic kidney disease.*

Query ID 04-1017: Spinal dural arteriovenous fistula

Reviewed 02/2023 – ADVICE CURRENT

Query: This query relates to the correct code assignment for a spinal dural arteriovenous (AV) fistula causing progressive paraplegia, requiring a T6/7 laminectomy and disconnection of a right T7 dural AV fistula. This particular case is not a congenital spinal dural arteriovenous fistula, it is acquired.

Response: CCAQ agreed that in the scenario given, assign I77.0 *Arteriovenous fistula, acquired* following the index Fistula/arteriovenous (acquired) (nonruptured).

Query ID 05-1017: Prophylactic immunotherapy

Reviewed 02/2023 – ADVICE CURRENT

Query: What condition onset flag (COF) should be used in reference to code *Z29.1 Prophylactic immunotherapy* as per ACS 1500 *Diagnosis sequencing in obstetric episodes of care*?

Response: CCAQ agreed that condition onset flag 1 (present on admission) should be assigned to code *Z29.1 Prophylactic immunotherapy* as it is present on admission. Refer to ACS 0048 *Condition onset flag*.

September 2017

Query ID 01-0917: Pap smear

Reviewed 02/2023 – ADVICE CURRENT

Query: Can Pap smears be coded when performed in conjunction with another procedure under general anaesthetic (GA), or should they only be coded if the GA was required specifically for the Pap smear?

Response: CCAQ agreed that as per ACS 0016 *General procedure guidelines*, a code can be assigned for a Pap smear if performed in conjunction with another procedure.

Query ID 03-0917: ACS 0042 Procedures normally not coded

Reviewed 02/2023 – ADVICE CURRENT

Query: This query requests clarification on whether the emphasis to the below statement from ACS 0042 Procedures normally not coded is to be placed on "required" or "anaesthesia":

"Procedures normally not coded are only assigned if:

- cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 Anaesthesia)"

Is the intent of this rule that procedures not normally coded, should be coded, if –

1. a general anaesthetic or sedation is required in order for that procedure to be performed, e.g., a child that requires an anaesthetic in order for an MRI to be performed without distress to the child and to obtain valid images?
   OR
2. a procedure in the list of procedures not normally coded, is done in conjunction with another procedure, under general or sedation anaesthetic e.g., routine transrectal ultrasound measurement (not biopsy) of prostate volume prior to ablation?

Response: CCAQ agreed that the emphasis on the statement "*Cerebral anaesthesia is required in order for the procedure to be performed (see ACS 0031 Anaesthesia)*" is to be placed on "required" as per:

1. a general anaesthetic or sedation is required in order for that procedure to be performed, e.g., a child that requires an anaesthetic in order for an MRI to be performed without distress to the child and to obtain valid images.

Query ID 04-0917: INR scenarios

Reviewed 02/2023 – ADVICE UPDATED

Query: This query requests for clarification on the following INR scenarios:

1. Does INR monitoring need to be documented in the clinical record or can we reference the laboratory results to ascertain if INR tests were done?

2. Can we please confirm if Z92.1 *Personal history of long term (current) use of anticoagulants* should be coded if patient is on Rivaroxaban / Xarelto if INR or Rivaroxaban levels are performed during admission? Or does Z92.1 only apply to warfarin / heparin / Clexane?

3. If patient is on rivaroxaban (Xarelto) or dabigatran (Pradaxa) and INR level is done, can we link the INR to monitoring of rivaroxaban and dabigatran? Product drug information indicates that these anticoagulants are not monitored with INR levels.

4. If rivaroxaban or dabigatran are stopped prior to a procedure and then restarted can we code Z92.1 *Personal history of long term (current) use of anticoagulants* to capture the adjustment of these medications during the admission?

5. If a patient's warfarin is stopped prior to admission i.e., stopped prior to admission when coming in for elective surgery, should we assign Z92.1 *Personal history of long term (current) use of anticoagulants* if no heparin or bridging therapy is required, and the INR was not supratherapeutic? Should Z92.1 be coded in this scenario? Or is it not coded if the INR test performed prior surgery was a routine INR test prior to major surgery e.g., cardiac surgery.

Response: CCAQ agreed on the following response for each INR scenario:

1. To meet ACS 0303 *Anticoagulant use and abnormal coagulation profile*, INR monitoring must be documented in the clinical record (refer also to ACS 0010 C*linical documentation and general abstraction guidelines/Test results and medication charts).*

2. ACS 0303 *Anticoagulant use and abnormal coagulation profile* applies to anticoagulant therapy and is not specific to any particular anticoagulant drug. Z92.1 *Personal history of long term (current) use of anticoagulants* may be assigned for any anticoagulant therapy, where the criteria in ACS 0303 is met.

3. Rivaroxaban (Xarelto) or dabigatran (Pradaxa) use is not generally monitored with INR levels. INR monitoring needs to be documented in the clinical record in order to meet ACS 0303.

4. Z92.1 *Personal history of long term (current) use of anticoagulants* should only be assigned where the criteria in ACS 0303 *Anticoagulant use and abnormal coagulation profile* is met.

5. Z92.1 *Personal history of long term (current) use of anticoagulants* should not be assigned in the scenario provided as the criteria for assignment of Z92.1 in ACS 0303 were not met.

Query ID 05-0917: Diabetes and radiculopathy

Reviewed 02/2023 – ADVICE AMENDED

Query: This query relates to whether 'truncal' radiculopathy includes lumbosacral radiculopathy and whether the term 'truncal' is a synonym for lumbosacral.

Response: CCAQ agreed that radiculopathy is the key term. In the ICD-10-AM Index at Diabetes, diabetic/with/radiculopathy, the terms thoracic and truncal are included in brackets. Terms listed in brackets in the index are non-essential modifiers. Therefore, for a patient that has diabetes with radiculopathy, regardless of the site, follow the index at Diabetes, diabetic/with/radiculopathy (thoracic) (truncal) and assign E1-.41 *Diabetes mellitus with diabetic mononeuropathy*.

Query ID 06-0917: Clipping colon

Reviewed 02/2023 – ADVICE CURRENT

Query: This query requests advice to the following scenarios and questions:

Scenario 1: 'Polypectomy was attempted with a saline, adrenaline and dye injection-lift technique using a hot snare. The polyp was removed intact. Resection and retrieval were complete. Three haemostatic clips were successfully placed. HaemoSpray to polypectomy site. Bleeding had stopped at the end of the procedure.'

Scenario 2: 'These polyps were removed with a cold snare. Resection and retrieval were complete. One haemostatic clip was successfully placed. Bleeding had stopped at the end of the procedure.'

Q1: Is 'bleeding had stopped at the end of the procedure' enough to assume the clipping was performed for controlling of haemorrhage?

Q2: What is the most appropriate procedure code for clipping post polypectomy? We currently would use the code 90308-00 [908] *Endoscopic destruction of lesion or tissue of large intestine*, following the index Control/haemorrhage/colon/endoscopic.

Scenario 3: '...The polyp was removed with a hot snare. Resection and retrieval were complete. One haemostatic clip was successfully placed. There was no bleeding during and at the end of the procedure'.

Q1: Can 90308-00 [908] *Endoscopic destruction of lesion or tissue of large intestine* be used for clipping post polypectomy when there is no mention of 'bleeding' in the procedure report? Should a procedure code be allocated at all if no bleeding has occurred?

Scenario 4: 'For placement of clips to mark site of excision of malignant rectal polyp prior to radiotherapy. Indication for Colonoscopy: Clips for planning. Post polypectomy scar was

noted in the distal rectum. Two haemostatic clips were successfully placed. This was done for marking'.

Q1: This seems to be similar to the intervention they do for insertion of fiducial markers for prostate cancer radiotherapy. What would be the most appropriate code for this procedure?

Response: CCAQ agreed on the following responses to the questions given for each scenario:

Scenarios 1 & 2:

Q1: Documentation of 'bleeding had stopped at the end of the procedure' is not sufficient to assume clipping was performed for control of haemorrhage. Clarification would be required from the clinician prior to assigning a code.

Q2: 90308-00 [908] *Endoscopic destruction of lesion or tissue of large intestine* is the correct code to assign for documentation of clipping for control of haemorrhage following the ACHI Index at Arrest/haemorrhage/intestine, large/endoscopic (closed).

Scenario 3:

Q1: 90308-00 [908] *Endoscopic destruction of lesion or tissue of large intestine* cannot be assigned for clipping post polypectomy when there is no mention of control of haemorrhage/bleeding in the procedure report.

Scenario 4:

Q1: The clips have been placed as a marker to indicate the site of a previous excision. The most appropriate code to assign in this scenario is 37217-01 [1800] *Implantation of fiducial markers* following the index Implant, implantation/fiducial marker(s) (fiducial seed) (fiducial marker) (gold fiducial marker) (Lipiodol) (radiopaque).

Query ID 07-0917: Asystole and ventricular standstill

Reviewed 02/2023 – ADVICE AMENDED

Query: This query relates to code assignment for a patient admitted with asystole or ventricular standstill and has had a permanent or temporary pacemaker inserted in this admission. The patient did not have any resuscitation performed.

Response: CCAQ agreed that a clinical documentation query should be submitted to determine the underlying cause of the asystole or ventricular standstill. Where clinical consultation is not possible, assign I46.9 *Cardiac arrest, unspecified* following the ICD-10-AM Index pathways Asystole (heart) (*see also Arrest/cardiac*) or Standstill/ventricular (*see also Arrest/cardiac*).

August 2017

Query ID 03-0817: Allied Health Interventions

Reviewed 12/2022 – ADVICE CURRENT

Query: This query relates to what constitutes an intervention by an Allied Health professional to meet the criteria for the allied health ACHI code to be assigned.
There are cases where a patient is off the ward at the time an allied health professional tries to see the patient and the allied health professional never gets to see the patient.
And in some cases, the allied health professional does not manage to see the patient, but their documentation indicates that they have reviewed the admission documentation, or provided advice to the treating team, or provided adaptive aids/splints etc. or initiates treatment (e.g., changes to diet while in hospital).

Response: CCAQ agreed that in cases where the only documentation from the allied health professional is that they attended the ward, and the patient was off the ward, then a code for allied health intervention is not to be coded. However, an allied health intervention should be assigned when the allied health professional does not manage to see the patient however their documentation indicates that they have reviewed the admission documentation, or provided advice to the treating team, or provided adaptive aids / splints etc., or initiates treatment (e.g., changes to diet while in hospital or any welfare support / arrangements by social workers etc.).

June 2017

Query ID 02-0617: Cancelled vs Abandoned Procedure

Reviewed 12/2022 – ADVICE UPDATED TO ALIGN WITH 12TH EDITION

Query: This query relates to when a patient is admitted for total knee replacement (TKR) for osteoarthritis, the patient is given a general anaesthetic and prepared for surgery but just prior to the operation starting a cardiac arrhythmia was noted. After a prolonged period, normal rhythm was re-established with medication. Surgeon decided not to proceed with TKR until after further cardiac investigations were completed.

Question 1: In this scenario, is this classed as a cancelled procedure (ACS 0011 *Intervention cancelled or not performed*) or an abandoned procedure (ACS 0019 *Intervention abandoned, interrupted or not completed*)? Would you code:
M17.1, I49.9, Z53.0, 92514-19
OR
M17.1, I49.9, 92514-19

Question 2: Is the VICC advice (*ACS 0011 Admission for surgery not performed* VICC Ref: 2773) Z53.0 Persons encountering health services for specific procedures, not carried out applicable because no knife skin, national advice?

Question 3: If Z53.0 *Procedure not carried out because of contraindication* is applicable for the above coding scenario as per example 5 of ACS 0011 and the patient stayed in hospital after the GA for cardiac monitoring/tests would I49.9 *Cardiac arrhythmia, unspecified* become the principal diagnosis? Would you code:
M17.1, I49.9, Z53.0, 92514-19
OR
I49.9, M17.1, Z53.0, 92514-19

Response: CCAQ advise that for the scenario provided, assign the following codes in accordance with ACS 0019 *Intervention abandoned, interrupted, or not completed*:

M17.1	*Other primary gonarthrosis*
Z53.3	*Procedure abandoned after initiation*
I49.9	*Cardiac arrhythmia, unspecified*
92514-99	*General anaesthesia, ASA 99*

Note VICC Query no: 2773 was retired 30/06/2017.

Query ID 05-0617: Preparatory care for dialysis and coding ESRF as additional diagnosis

Reviewed 12/2022 – ADVICE UPDATED WITH REFERENCE TO ACS

Query: This query relates to the correct code assignment for a patient that is admitted overnight for creation of an arteriovenous fistula (AVF) to commence haemodialysis. End stage renal failure (ESRF) is due to horseshoe kidney. Patient does not receive dialysis during the admission.

Are the correct diagnosis codes:
Option 1:
Z49.0 *Preparatory care for dialysis*
U87.1 *Chronic kidney disease, stage 3-5*

Option 2:
Z49.0 *Preparatory care for dialysis*
N18.5 *Chronic kidney disease, stage 5*
Q63.11 *Horseshoe kidney*

When following the Codefinder pathway 'creation of AV fistula, admission for' there is a prompt that asks if we should add an additional code to identify the associated condition.

Response: CCAQ agreed that in the scenario provided end stage renal failure and horseshoe kidney do not meet the criteria for coding in ACS 0002 *Additional diagnoses*. The correct code assignment for the scenario is:
Z49.0 *Preparatory care for dialysis*
U87.1 *Chronic kidney disease, stage 3-5*

Refer also to ACS 1438 *Chronic kidney disease/Classification dot point 8* and ACS 0003 *Supplementary codes for chronic conditions* (Example 4).

Query ID 07-0617: Neuropathic bladder and neurogenic bowel

Reviewed 12/2022 – ADVICE UPDATED WITH REFERENCE TO ACS

Query: This query relates to neuropathic bladder and neurogenic bowel in patients with acute spinal cord injuries, acute and chronic (traumatic/non traumatic) incomplete/complete paraplegia/quadriplegia.

Patients are seen in the spinal unit with acute spinal cord injuries resulting in paraplegia/quadriplegia and non-traumatic paraplegia/ quadriplegia that usually require long term rehabilitation. These patients have active management of neuropathic bladder and neurogenic bowel during their stay. Some patients require insertion of a suprapubic catheter to manage their neuropathic bladder.

Question 1: Should coders be assigning separate codes for neuropathic bladder and neurogenic bowel or is it inherent in these conditions?

a) Acute spinal injury
b) Acute paraplegia/quadriplegia - incomplete/complete
c) Chronic paraplegia/quadriplegia - incomplete/complete

Question 2: What are the correct codes for neurogenic bladder associated with spinal cord pathology including trauma?

Question 3: If an episode has a change in care type from rehabilitation to acute for insertion of an SPC, what is the correct principal diagnosis – the underlying condition (trauma or paraplegia/quadriplegia – non traumatic) or neurogenic bladder?

Response: CCAQ agreed on the following responses to each question:

Question 1: Neurogenic bladder and bowel should not be assumed to be inherent in spinal cord injuries and paraplegia and quadriplegia. Assign codes for neurogenic bladder and neurogenic bowel where they meet criteria for coding in ACS 0002 or another ACS/Coding Rule.

Question 2: Assign codes for neurogenic bladder and neurogenic bowel as per the ICD-10-AM Alphabetic index. Additional codes for the underlying cause (spinal cord pathology or trauma) can be assigned following the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*. See also ACS 0008 *Sequelae* and ACS 1912 *Sequelae of injuries, poisoning, toxic effects and other external causes*.

Question 3: The principal diagnosis should be assigned according to the documentation and by following the guidelines in ACS 0001.

May 2017

Query ID 05-0517: Coding drug resistance from EDS

Reviewed 12/2022 – ADVICE CURRENT

Query: This query relates to coding drug resistance from the electronic discharge summary (EDS) and whether it is appropriate for the clinician to copy and paste the pathology results into the summary when relevant and whether this is considered clinical documentation.

Response: CCAQ agreed that in this scenario, unless drug resistance is also documented in the progress notes, coding of drug resistance cannot be from documentation on the EDS alone. A clinical documentation query may need to be written to verify the documentation with the clinician prior to coding. Refer to ACS 0010 *Clinical Documentation and General Abstraction Guidelines* and Coding Rule Ref: TN1601 *Twelfth Edition FAQ: Antimicrobial drug resistance.*

Query ID 06-0517: Delayed Delivery

Reviewed 12/2022 – ADVICE CURRENT

Query: This query relates to how many hours/days after artificial rupture of membranes, spontaneous or unspecified rupture of membranes can/should O75.5 *Delayed delivery after artificial rupture of membranes* and O75.6 *Delayed delivery after spontaneous or unspecified rupture of membranes* be assigned. Please advise what would be considered delayed delivery.

Response: CCAQ agreed that delayed delivery cannot be assigned based on a period of time. The only way you can code delayed delivery is when it is documented as such. If in doubt a clinical documentation query should be written to confirm.

Query ID 08-0517: Radiologically Inserted Gastrostomy

Reviewed 12/2022 – ADVICE CURRENT

Query: This query asked whether there is a more appropriate procedure code for a radiologically inserted gastrostomy (RIG). 30481-00 [870] *Initial insertion of percutaneous endoscopic gastrostomy [PEG] tube* is being coded to capture the percutaneous approach even though it is not endoscopic. Can the ACCD consider a new ACHI procedure code for RIG?

Response: CCAQ agreed that 30481-00 [870] *Initial insertion of percutaneous endoscopic gastrostomy [PEG] tube* is the most appropriate code to use with the current classification. If your facility would like IHACPA to consider the creation of a new code, a Public Submission can be made to IHACPA requesting a new code for RIG.

April 2017

Query ID 06-0417: Atrial Fibrillation with RVR

Reviewed 11/2022 – ADVICE CURRENT

Query: Please can you advise if it is correct to add I47.2 *Ventricular tachycardia* as an additional diagnosis to code out the Atrial fibrillation with rapid ventricular response/rate?

Principal Diagnosis: Atrial Fibrillation with rapid ventricular response/rate

Index Rapid/heart (beat) R00.0 *Tachycardia, unspecified*. Category R00 Excludes – specified arrhythmias (I47–I49)
Documentation of "ventricular", therefore Index Tachycardia/ventricular I47.2

Response: CCAQ agreed that, in this scenario, the correct code assignment is I48.9 *Atrial fibrillation and atrial flutter, unspecified*. As the documented condition is not ventricular tachycardia, I47.2 would not be assigned.

Query ID 08-0417: Same day Admissions and pharmacotherapy

Reviewed 11/2022 – ADVICE UPDATED for 12th Edition changes

Query: Can CCAQ please provide advice in regards ACS 0042 *Procedures normally not coded* – Point 8. Drug treatment/pharmacotherapy?

The standard notes that drug treatment is normally not coded, except if:

- The substance is given as the principal treatment in same-day episode of care
- Drug treatment is specifically addressed in a coding standard (ACS 0206, ACS 0534, ACS 1500, ACS 1511, ACS 1615)

Scenario 1:
Patient is admitted as a same day episode of care every day for 7 days for intravenous (IV) antibiotics to treat septic arthritis.
Question: Is a procedure code to be assigned for the IV antibiotics (96199-02 [1920] *Intravenous administration of pharmacological agent, anti-infective agent*)?

Scenario 2:
Patient is admitted as a same day episode of care for IV fluids to treat dehydration.
Question: Is a procedure code to be assigned for the IV fluids (96199-19 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent*)?

Response: CCAQ agreed on the below responses to the given scenarios following ACS 0042 *Procedures normally not coded*:

Scenario 1: As the patient is being admitted for the purpose of the IV antibiotics, procedure code IV antibiotics (96199-02 [1920] *Intravenous administration of pharmacological agent, anti-infective agent*) is to be assigned.

Scenario 2: As the patient is being admitted for the purpose of IV fluids to treat dehydration, procedure code IV fluids (96199-19 [1920] *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent*) is to be assigned.

Query ID 09-0417: CVAD Dressing Change

Reviewed 11/2022 – ADVICE CURRENT

Query: Patient is admitted as a same-day episode of care for changing of central venous access device (CVAD) dressing.

The principal diagnosis assigned is PD Z45.81 Adjustment and management of venous catheter.

Can CCAQ please provide advice about what procedure code should be assigned for the CVAD dressing change?

Response: CCAQ agreed that 92058-01 [1922] *Maintenance (alone) of other catheter, implanted for administration of pharmacotherapy* is the correct procedure code assigned in this scenario as it includes dressing.

Query ID 11-0417: Dental Flaps

Reviewed 11/2022 – ADVICE CURRENT

Query: Can CCAQ please provide advice regarding how dental flaps should be coded?

The operation notes:

Surgical Release of 38 and 48
38, 48 elevated, closed with advancement flaps. (The item numbers documented are D324 x 2 plus 45200 x 2)

Front sheet of chart notes: Impaction / Non-functional 38, 48
Surgical release 38, 48 with flap repair

Block [458] *Surgical removal of tooth* notes:

Incision of mucosa and raising of mucoperiosteal flap to remove tooth, followed by suturing of the wound
Surgical extraction of tooth or tooth fragment.

Response: CCAQ suggest that the flap is inherent in the surgical removal of the tooth therefore 97232-00 [456] *Periodontal flap procedure, 1 to 8 teeth* is not required, as per the inclusion terms at Block [458] *Surgical removal of tooth*.

Query ID 12-0417: Intraoperative hypertension/ hypotension

Reviewed 11/2022 – ADVICE CURRENT

Query:
Question 1: What should be classed as intraoperative hypertension if it's been highlighted after the procedure and the patient was treated with clonidine recorded in the anaesthetic record?

Question 2: What should be classed as intraoperative hypotension if it's been highlighted and that after the procedure the patient was treated with ephedrine or clopiderol?

Response: The documentation of the conditions must meet ACS 0002 *Additional Diagnoses*. CCAQ agreed that a documentation query to the clinician is required to determine if the condition/s meet the definition of a procedural complication in accordance with ACS 1904 *Procedural complications* and what the direct cause is. The Coder is to then code as per the response.

Query ID 14-0417: External Fixation

Reviewed 11/2022 – ADVICE CURRENT

Query: What code should be assigned when a patient goes to theatre for External fixation of a fracture and there is mention of reduction performed during the external fixation? The index leads to reduction of the fracture code (e.g. Application – device- - external fixator NEC - - - with reduction of fracture – *see Reduction/fracture/by site*).

Please see below an example of an Ext fixation operation report with reduction.
Operation title: Left ankle Ext-Fix. Findings: talar body and tibial plafond fracture. Procedure technique: II used throughout the case. Two 35 x 5mm Schanz pins to proximal tibia. 5 x 50 mm Steinman pin to calcaneum, delta construct, pulled to length, reduction, alignment improved.

Is the index pathway correct? Should the closed reduction of fracture code be assigned if reduction is performed and not the External Fixation code? Or should the index pathway lead to coding the Application of external fixation device if an external fixator is applied in these types of cases where there is reduction of the fracture done in association with the external fixator?

Or is it possible to code both, the closed reduction code and the external fixator code? However, as there is an excludes note in the Tabular at the External fixation code: *excludes* that with reduction of fracture this option is not available in the Tabular or from the Index.

Response: CCAQ agreed that only the closed reduction code is to be assigned, following the Note at the beginning of Chapter 15 Procedures on musculoskeletal system (Blocks 1360-1580):

Closed reduction – involves correction of a dislocation/fracture without operative exposure and includes additional external fixation.

March 2017

Query ID 02-0317: Injection of Rose Bengal

Reviewed 11/2022 – ADVICE UPDATED

Query: What is the correct procedure code for codes PV10 injection (Rose Bengal) to Melanomas?

Rose Bengal is a novel injectable agent that has been evaluated as a rational treatment strategy for melanoma patients with recurrent unresectable local/regional metastases accessible for intralesional injection.

Operation Note:
PV10 injection to 2x in-transit melanomas
transit metastases of melanoma right leg
Technique time out. Sedation
LIGNOCAINE 1% 20mls
injection 0.7mls of PV10 into lesion 1 (see photos)
injection 2.8mls of PV10 into lesion 2
melolin/combine/crepe

Response: CCAQ agreed that 96200-00 [1920] *Subcutaneous administration of pharmacological agent, antineoplastic agent* should be assigned following the ACHI Index Administration/for neoplasm (antineoplastic) (chemotherapeutic) (prophylaxis) — *code to block [1920] with extension -00*.

Refer also to ACS 0206 *Pharmacotherapy for neoplasms.*

Query ID 03-0317: Coding additional code CKD with T86.1

Reviewed 11/2022 – ADVICE CURRENT

Query: Can we please confirm if an additional code for chronic kidney disease is to be assigned when T86.1 *Kidney transplant failure and rejection* is coded?

There is a code also note at Z94.0 *Kidney transplant status* that says to code also the stage of CKD, i.e., stage 3 or higher.

Example:
Patient admitted same day for plasma exchange for acute kidney transplant rejection.

Response: CCAQ agreed, following ACS 1438 *Chronic Kidney Disease*, the correct code assignment for the information provided is:

T86.1 *Kidney transplant failure and rejection*

Y83.02 *Kidney transplant*

Y92.2- *Health service area*

U87.1 *Chronic kidney disease, stage 3 to 5*

13750-00 [1892] *Therapeutic plasmapheresis*

Query ID 04-0317: Removal of ureteric stent following renal transplant

Reviewed 11/2022 – ADVICE CURRENT

Query: Can we please confirm whether renal transplant status, and therefore CKD stage 3 and higher, should be coded as additional diagnoses when patient is admitted same day for removal of ureteric stent following renal transplant?

Operation Title:

Flexible cystoscopy and removal of transplant stent

Findings:

AU - normal

PU - short, non-occlusive

Bladder - normal, UOs x 2, Tx stent in situ

Procedure:

Cystoscopy via 18Fr Olympus Flexible scope, removal of stent

Post-op:

Renal follow-up

Response: CCAQ agreed, with the information provided in the query, the correct code assignment is:

Z46.6 *Fitting and adjustment of urinary device*

U87.1 *Chronic kidney disease, stage 3-5*

36833-01 [1067] Endoscopic removal of ureteric stent

Query ID 05-0317: Hypoglycaemia

Reviewed 11/2022 – ADVICE UPDATED

Query: Can we please confirm whether diabetes with hypoglycaemia would be coded from nursing documentation of low BSL's?

For example

"BSL low at 3.3 - Jam on toast given with good effect up to 11.1".

Response: ACS 0401 Diabetes mellitus and intermediate hyperglycaemia/General classification rules for DM and IH Rule 3 states:

"The classification includes conditions (often termed 'complications') which occur commonly with DM or IH. These conditions may or may not have been a direct consequence of the metabolic disturbance and are indexed under Diabetes, with or Hyperglycaemia/intermediate/with. Always refer to these index entries to classify DM or IH."

Although there is an index pathway for Sugar/blood/low there is not an index pathway for Diabetes/with/low blood sugar level. Further, ACS 0010 *General abstraction guidelines/Test results and medication charts states*:

"Do not use test result values, descriptions, health risk screening (assessment) tools, medication charts, symbols and abbreviations from clinical documentation in isolation to assign diagnosis codes. For example:

- a test result that is not within the normal range does not necessarily mean that the patient has an abnormal condition. That test result may be normal for that particular patient

Therefore, CCAQ advise that E1-.64 *Diabetes mellitus with hypoglycaemia* should not be assigned based on documentation of low BSLs alone in a diabetic patient. A clinical documentation query may be submitted to clarify the diagnosis.

Query ID 06-0317: PICO Dressing

Reviewed 10/2022 – ADVICE CURRENT

Query: Can we please confirm if a PICO dressing is a vacuum dressing, and should it be coded as such?

Response: CCAQ agreed that a PICO dressing is the same as a VAC dressing and should be coded as one.

Query ID 10-0317: Obstetric Trauma

Reviewed 10/2022 – ADVICE CURRENT

Query: Is there an ACCD endorsed definition of "obstetric trauma"? Most pelvic injury pathways have this modifier. In absence of a definition, is a coder to assume all injuries in a delivery episode are obstetric trauma?

Response: There is no ACCD definition of an obstetric trauma. CCAQ agreed that obstetric trauma can only be coded if the trauma is specified as such. If the documentation is unclear, a Clinical Documentation Query should be done by the coder to confirm.

February 2017

Query ID 02-0217: MRI Fetal Brain

Reviewed 10/2022 – ADVICE UPDATED

Query: Due to changes in clinical care and interventional options, increased numbers and types of procedures are being performed on fetus in utero.

Scenario 1: Pregnant female patient (duration of pregnancy is 22 weeks) is admitted for MRI of fetal brain. The patient has a history of being cytomegalovirus (CMV) positive and as part of her antenatal care has had an amniocentesis and CMV immunoglobulin infusion. This admission is for MRI of fetal brain.

Should the assigned procedure code be 90901-06 [2015] *Magnetic resonance imaging of pelvis*, 90487-00 [1330] *Other intrauterine diagnostic procedure on fetus* or another procedure code?

Response: CCAQ agreed that 90901-08 [2015] *Magnetic resonance imaging of other site* is to be assigned for MRI of the fetal brain performed on a pregnant patient, where it meets the criteria in ACS 0042 *Procedures normally not coded.*

Query ID 10-0217: Subconjunctival Injection

Reviewed 10/2022 – ADVICE UPDATED

Query: Can we please confirm whether subconjunctival injection of steroids and / or antibiotics is to be coded in conjunction with ophthalmology procedures such as cataract extraction and corneal transplant?
Cataract extraction operation report:
Operation Surgical Procedure(s):
Phacoemulsification of cataract with intraocular lens implantation (Right)

Technique:

Surgical side marked
Paracentesis
Keratomy
IC viscoelastic
Anterior capsulorhexis
Phacoemulsification
Cortex extracted
Provisc in capsular bag
IOL in capsular bag
I/A, IC kefzol
AC reformed. IOP checked
Wound hydrated
Subconjuctival dexamethasone

topical betaseine and BSS wash
dressing and shield

Corneal transplant for keratoconus operation report:

Operation Surgical Procedure(s):
Penetrating keratoplasty (Left)

Technique

GA
betadine prep and drape
Cornea marked centrally
7.75mm corneal button excised with Baron Vacuum Trephine
Cornea sent for histology
8.0mm corneal donor harvested with hand-held trephine
graft sutured with 4 x 10/0 nylon cardinal sutures, 1 x 10/0 continuous, 1 x 11/0 continuous
cardinal sutures removed
Subconj celestone and cephazolin
peribulbar naropin 1% pad and shield

Response: CCAQ agreed that subconjunctival injection of steroids and/or antibiotics should not be coded with ophthalmology procedures such as cataract extraction and corneal transplant following ACS 0042 *Procedures normally not coded/Classification point 8 Drug treatment/pharmacotherapy/ prescription of drugs.*

Query ID 11-0217: Drug Induced Lupus Nephritis

Reviewed 10/2022 – ADVICE CURRENT

Query: What are the correct codes for end stage renal failure due to hydralazine induced lupus nephritis?

Response: CCAQ agreed on the following code assignment:

N18.5 *Chronic kidney disease, stage 5*
N08.5 *Glomerular disorders in systemic connective tissue disorders*
M32.1 *SLE with organ or system involvement*
M32.0 *Drug induced SLE*
Y52.5 *Other antihypertensive drugs, not elsewhere covered*
Y92.2- *Health service area*

November 2016

Query ID 07-1016: Koilocytosis and human papillomavirus

Reviewed 09/2022 – ADVICE CURRENT

Query: Should coders assume that a positive koilocytosis result documented in the microscopic section or summary of a histopathology report from a biopsy investigating potential cervical intraepithelial neoplasia, be coded to human papillomavirus (HPV) when HPV has not been documented in the same histopathology result or the episode notes?

Response: CCAQ agreed coders cannot assume that a positive koilocytosis result documented in a histopathology result can be coded to HPV. HPV must be documented. If in doubt, a documentation query could be raised with the clinician to confirm the diagnosis.

October 2016

Query ID 01-0916: Pregnancy Health Record documentation

Reviewed 09/2022 – ADVICE CURRENT

Query: Coding Rule Ref No: Q2895 *Coding from documentation in previous admissions (published 15/6/15, retired 30/6/19)* advised that previous admissions and correspondence cannot be used for code assignment, that conditions must be documented within the episode of care in to assign a code and including conditions in specialty standards that instruct certain conditions must be coded (HIV/AIDS, viral hepatitis and tobacco use). Does this advice also apply to obstetric patients in the delivery episode, and information from the Pregnancy Health Record?

For example, documentation on the Pregnancy Health Record states patient is an ex-smoker and has a chronic condition (such as asthma, epilepsy etc.), but neither of these are documented in the current episode of care. Can we code these conditions given that the Pregnancy Health Record relates to the pregnancy (and presumably delivery), or do they still need to be documented within the current episode of care, as per the Coding Rule?

Response: CCAQ agreed that the Pregnancy Health Record directly relates to the delivery episode of care therefore can be used to inform code assignment. However, coders should use supporting information in the clinical record to determine if chronic conditions documented within the Pregnancy Health Record are part of the patients' current health status prior to code assignment in the delivery episode. Given the pregnancy record relates to the entire pregnancy and will cover a period of approximately 9 months, care should also be taken when assigning codes for tobacco use (i.e., patient quits smoking during pregnancy).

Refer to ACS 0010 *Clinical documentation and general abstraction guidelines* (12th edition) for more information.

Query ID 07-0916: Urinary Incontinence and sacral nerve stimulator lead implantation

Reviewed 09/2022 – ADVICE CURRENT

Query: Could CCAQ please provide advice regarding the assignment of the principal diagnosis code that should be assigned for the below scenario?

Episode 1
Patient admitted with urinary incontinence for implantation of temporary sacral nerve stimulator leads and generator. The principal diagnosis for this episode of care is urinary incontinence.

Episode 2
Patient re-admitted for replacement of the temporary sacral nerve stimulator leads with permanent leads.

Should the principal diagnosis for the second episode of care be urinary incontinence or should it be Z46.6 *Fitting and adjustment of urinary device*?

Response: CCAQ agreed, in the scenario given, as the patient is coming in to have the permanent leads implanted and the temporary leads are removed, the principal diagnosis is urinary incontinence.

August 2016

Query ID 01-0716: 'Omit code' note at 42503-00 [160]

Reviewed 09/2022 – ADVICE CURRENT

Query: Is the 'omit code' note at 42503-00 [160] *Ophthalmological examination* meant to be interpreted as any other code within that ACHI chapter (and only that chapter)?

For instance, if an electroretinography and examination of the eyes is performed under a general anaesthetic, can we still code both 42503-00 [160] *Ophthalmological examination* and 11204-00 [1835] *Electroretinography [ERG]* because the code for the electroretinography sits outside of Chapter 3?

I note ACS 0022 *Examination under anaesthesia* states that "EUA should only be coded as a procedure when it is the only procedure being performed" but the examples provided are assigned codes from site-specific chapters, and not Chapter 19.

If a procedure is performed on one eye, for example 42809-00 [211] *Destruction procedures on retina, choroid or posterior chamber*, and an EUA of the other eye is performed, do we omit the code for the EUA based on ACS 0022, or add a code for the EUA as the procedure was performed on the other eye?

Response: CCAQ agreed on the following:

42503-00 [160] *Ophthalmological examination* should not be coded with 11204-00 [1835] *Electroretinography [ERG]* under general anaesthetic if performed on the same eye(s), as per the excludes note at 42503-00 [160] – "Excludes: that with any other procedure on the eye – omit code".

If a procedure is performed on one eye and an EUA is performed on the other eye, both procedures can be coded.

Query ID 02-0716: Ophthalmological examination

Reviewed 09/2022 – ADVICE CURRENT

Query: Is 42503-00 [160] *Ophthalmological examination* an inherently bilateral procedure and therefore coded only once if this is the procedure performed on both eyes? Or is it unilateral, requiring two codes?

Points to consider:
- Some patients only have one eye due to disease, injury, surgery etc. Is this relevant?
- Does the tabular note at 42503-00 [160] 'Excludes: that with any other procedure on the eye - omit code' only relate to procedures performed on the same eye?

- Is this still the appropriate code to use when an anophthalmic socket is examined?

Response: CCAQ agreed that 42503-00 [160] *Ophthalmological examination* reads that it is unilateral (singular). If the procedure is done bilaterally then 42503-00 [160] *Ophthalmological examination* should be assigned twice, following ACS 0020 *Bilateral/multiple procedures*. The 'omit code' instruction only applies to procedures performed on the same eye.

Members agreed that 42503-00 [160] *Ophthalmological examination* is the appropriate code to use when an anophthalmic socket is examined.

July 2016

Query ID 01-0616: ACS1615 and catheterisation/cannulation in a neonate

Reviewed 08/2022 – ADVICE CURRENT

Query: ACS 1615 *Specific diseases and interventions related to the sick neonate* includes a list of specific codes to be used for catheterisation/cannulation in a neonate.

Coding Rule Ref: Q2863 *Catheterisation and cannulation in neonates* also includes this list of procedures and advises 'where the site of the catheter is not specified and clinical confirmation cannot be sought, then a code for catheterisation cannot be assigned'. Code 13300-00 [738] *Catheterisation/Cannulation of other vein in neonate* is not on the list.

We have a baby that has had catheterisation of the vein in his foot, but it appears that we cannot assign 13300-00 [738], as it is not on the list of catheterisation/cannulation codes in ACS 1615.

Can we use 13300-00 [738] when another vein (apart from the scalp and umbilicus) has been clearly specified by the clinician but is not on the list of procedures in ACS 1615 or Coding Rule Ref Q2863?

Response: CCAQ agreed that the catheterisation of the vein in the foot of a neonate is not to be coded as it has not been identified as a site requiring code assignment in ACS 1615 *Specific diseases and interventions related to the sick neonate*.

Query ID 03-0616: Continuous ambulatory peritoneal dialysis while an inpatient

Reviewed 08/2022 – ADVICE CURRENT

Query: Can we please confirm if continuous ambulatory peritoneal dialysis (CAPD) should be coded for patients who are independent in managing their treatment? Patients are trained to perform this procedure at home and depending on the reason for admission can continue to perform dialysis themselves during their stay.

We have had confirmation from our renal doctors that the dialysate used during inpatient admissions is provided by the hospital. The nursing staff also fill out the Renal CAPD form for all peritoneal dialysis patients, regardless of who is performing the dialysis.

Response: CCAQ agreed that for patients managing their own CAPD treatment while an inpatient, this should be coded as there was evidence that resources were provided by the

hospital (for example the use of dialysate) and had observations performed by the nursing staff.

Query ID 04-0616: Auto-transplantation of kidney for operative access

Reviewed 08/2022 – ADVICE CURRENT

Query: Could CCAQ please provide advice regarding the procedure code(s) that should be assigned for the following scenario:

Patient undergoes a renal procedure where one kidney is temporarily (totally) removed from the patient so that the surgeon can have greater access to perform ongoing intervention(s) (surgical approach) before being replaced into the patient (same position, same operating room session).

Currently procedure codes 36503-01 [1058] *Autotransplantation of kidney* and 90350-00 [1059] *Other repair of kidney* are being assigned to capture the intervention.

Is the assignment of 36503-01 [1058] *Autotransplantation of kidney* the right procedure code to use?

Response: CCAQ agreed that 36503-01 [1058] *Autotransplantation of kidney* is the correct code to be used as per the ACHI Index Autotransplant, autotransplantation/kidney. Assignment of 90350-00 [1059] *Other repair of kidney* is not required.

Query ID 03-0716: Gastroenteritis in pregnancy

Reviewed 09/2022 – ADVICE CURRENT

Query: We occasionally have pregnant patients admitted with gastroenteritis and the index in the coding books (and Codefinder) sends us to O98.5 *Other viral diseases in pregnancy, childbirth and the puerperium* (viral gastroenteritis, conditions in A08) or O98.8 *Other maternal infectious and parasitic diseases in pregnancy, childbirth and the puerperium* (gastroenteritis unspecified, conditions in A09). These always come back as a fatal EVA error. There is also code O99.6 *Diseases of the digestive system in pregnancy, childbirth and the puerperium*. Should we be following the index and assigning O98.5 (and receive the fatal error) or should we be coding these to O99.6?

Response: CCAQ agreed that the index is to be followed and O98.5 *Other viral diseases complicating pregnancy, childbirth and the puerperium* or O98.8 *Other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium to be assigned.*

The fatal EVA errors are due to a national validation against these codes as they are of national interest. If this validation generates for the episode of care and the condition is

confirmed and supported by the clinical documentation within the episode of care, then formally notify the Statistical Services Branch (SSB). Please refer to the Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual for further details.

June 2016

Query ID 02-0416: Methadone program

Reviewed 08/2022 – ADVICE CURRENT

Query: This query relates to coding methadone/opioid dependence when a patient is on a methadone program.

If a patient is on a methadone program can and should a code for opioid dependence be assigned? i.e., if the admission notes do not state 'methadone/opioid dependence' and only state that the patient was on a methadone program and he/she required review by the drug and alcohol team or was reviewed by clinical staff and had their regular treatment/dose adjusted during their admission (so meeting ACS 0002 *Additional diagnoses*) can F11.2 *Mental and behavioural disorders due to use of opioids, dependence syndrome* be assigned?

If a patient is treated with certain medications coders should not assume that these patients have a certain diagnosis - it must be documented/queried/confirmed. However, isn't a methadone program a specific treatment for opioid dependence that warrants F11.2 being coded as it is correct to assume that these patients are opioid dependent?

A similar query was discussed at QCC previously (0206-15) where the committee agreed that it is correct to assign to 'F11.2 *Mental and behavioural disorders due to use of opioids, dependence syndrome*' for patients who are documented as being on a methadone program if it meets ACS 0002.

However, VICC Query 2988 *Methadone and opioid dependence* advises that opioid dependence must be documented and meet ACS 0002 to be coded as such.

Response: CCAQ agreed that documentation stating a patient is on a methadone program without documentation of the associated dependence is not sufficient to assign F11.2 *Mental and behavioural disorders due to use of opioids, dependence syndrome*. It is however good evidence for initiating a documentation query to confirm dependence for code assignment as per ACS 0002 *Additional diagnoses*.

April 2016

Query ID 04-0216: Overstitch procedure

Reviewed 08/2022 – ADVICE CURRENT

Query: I am looking for some information on how an OverStitch™ procedure should be coded.

OverStitch™ is an endoscopic suturing system which allows physicians to place full thickness sutures through a flexible endoscope. Our specialists are using this new technology for revisional bariatric procedures and repair of GI defects.

As there is no combination code for panendoscopy with repair, I am looking at using the normal panendoscopy code 30473-00 [1005] *Panendoscopy to duodenum* with an additional code of 90304-00 [887] *Other repair of stomach* if the overstitch is used on the stomach or an additional code of 30375-24 [901] *Suture of small intestine* or 30375-19 [901] *Other repair of small intestine* if a small intestine repair/suture is performed.

Response: CCAQ agreed that the OverStitch™ device is an endoscopic suturing system. Assign a code by following the index Suture/by site e.g., Suture/stomach.

Assign an additional code for the endoscopic component in accordance with ACS 0023 *Minimally invasive interventions*.

Query ID 07-0216: Insertion of TightRope® implant

Reviewed 08/2022 – ADVICE CURRENT

Query: Patient admitted for removal of screws right ankle and insertion of TightRope® implant.

Operation Report:
Compound scrub, upper thigh tourniquet 350mHg for 15 min, sandbag under hip
Old incision opened, x2 screws removed, 4mm drill bit by hand to inferior screw
Tightrope placed across ankle to act as internal splint from here
Check I-I, 3/0 nylon, 20ml Naropin

Is 47921-00 [1554] *Insertion of internal fixation device, not elsewhere classified* a suitable code for insertion of a TightRope® implant?

Response: CCAQ agreed with the code suggested for insertion of a TightRope® implant, based on the information provided in this scenario, using the pathway Insertion/fixation device/bone/orthopaedic (pin) (plate) (wire).

CCAQ members noted this advice should not be applied in all circumstances where insertion of a TightRope® implant is documented. CCAQ suggest first determining if this was a component of another internal fixation procedure or if the implant was used for stabilisation of the joint and assigning codes accordingly.

Query ID 08-0216: Principal diagnosis for bone marrow biopsy following transplant

Reviewed 08/2022 – ADVICE CURRENT

Query: Can the committee please clarify the principal diagnosis in the following scenario?

Same day admission for bone marrow biopsy for the indication "12 months post allograft for refractory cytopaenia with multilineage dysplasia".

The diagnosis on the pathology states "normocellular marrow with adequate trilineage haematopoiesis and no morphological evidence of relapsed myelodysplastic syndrome".

Should this be coded as a follow up admission?

Response: CCAQ agreed that a documentation query should be raised to determine if the neoplasm was a current or resolved condition. If resolved, assign the appropriate follow up code from Z08 *Follow-up examination after treatment for malignant neoplasms* as the principal diagnosis. If the condition was still current, assign a code for the condition as the principal diagnosis.

CCAQ also recommend assigning Z94.8 *Other transplanted organ and tissue status* as an additional diagnosis to indicate the transplant status.

Query ID 09-0316: Facial paralysis due to cerebrovascular accident

Reviewed 08/2022 – ADVICE CURRENT

Query: Is code G83.81 *Facial paralysis due to cerebrovascular accident* considered a combination code as per ACS 0015 *Combination codes* and coded alone or should an additional sequelae of stroke code be assigned?

As code G83.81 fully describes the condition and the cause coding the sequelae code would be surplus, wouldn't it?

Response: CCAQ considered it would add specificity to the coded data if a sequela code from category I69 *Sequelae of cerebrovascular disease* were assigned in addition to G83.81 *Facial paralysis due to cerebrovascular accident* to further identify the type of stroke.

Refer also to ACS 0604 *Cerebrovascular accident (CVA).*

February 2016

Query ID 06-1115: Percutaneous alcohol ablation of parathyroid

Reviewed 08/2022 – ADVICE CURRENT

Query: Can CCAQ please advise what the correct procedure code(s) are for percutaneous (ultrasound guided) alcohol/ethanol ablation of the parathyroid gland? This procedure is an alternative treatment for primary hyperparathyroidism in patients unsuitable for surgery (i.e., technically difficult, or risky).

Response: CCAQ recommend using code 90040-00 [117] *Other procedures on parathyroid gland* using index Procedure/parathyroid gland NEC.

October 2015

Query ID 03-1015: Intravenous saline in neonates

Reviewed 07/2022 – ADVICE CURRENT

Query: Should normal saline (0.9% sodium chloride) given intravenously to neonates be interpreted as an electrolyte infusion for the purposes of ACS 1615 *Specific diseases and interventions related to the sick neonate*?

Should saline with concentrations higher than 0.9% sodium chloride given intravenously to neonates be interpreted as an electrolyte infusion for the purposes of ACS 1615 *Specific diseases and interventions related to the sick neonate?* It would suggest it is not the intention of ACS 1615 to require the coding of normal saline, given its nature, but perhaps in concentrations above 0.9% it does?

Response: It is not the role of the clinical coder to determine if the saline infusion would be considered an electrolyte infusion based on the concentration of sodium chloride. Intravenous saline infusions are not coded, as per ACS 1615 *Specific diseases and interventions related to the sick neonate.*

If an indication for the IV saline has not been provided but concentration levels are indicative of treatment of a specific disorder, then this becomes a documentation issue and must be clarified with the treating clinician.

Query ID 05-1015: Ventilation using own device

Reviewed 07/2022 – ADVICE CURRENT

Query: 9-year-old patient normally receives continuous positive airway pressure (CPAP) treatment at home overnight due to obstructive sleep apnoea and is also receiving CPAP overnight using his own machine while he is in hospital.

ACS 1006 *Ventilatory support* at point 1e states "Do not code ventilation when the patient brings their own ventilator support devices (e.g., CPAP machine) into hospital and the patient operates the device". The patient is too young to operate the device, however the parents are generally operating the machine while the patient is in hospital, as the record states "Mum well versed in CPAP and caring for the mask fit and machine".

How should point 1e be applied in scenarios such as this where the patient is not operating their own device in hospital (e.g., because of young age, disability), but where the operation of that device is performed by persons other than hospital staff, such as parents or carers?

Is the extent to which hospital staff or other people are operating the devices relevant in determining whether it is to be coded?

Response: CCAQ agreed that the reference to 'patient' in ACS 1006 *Ventilatory support* classification point 1e:

"*Do not code ventilation when the patient brings their own ventilatory support devices (e.g. CPAP machine) into hospital and the patient operates the device.*"

would be considered inclusive of 'parent/carer'.

September 2015

Query ID 04-0815: Procedures not normally coded

Reviewed 07/2022 – ADVICE CURRENT

Query: Often in rural facilities patients are admitted over night for next day procedures such as aorto-bifemoral angiogram which is a Chapter 20 Imaging Services code. The bookings for these patients are usually "+/- stenting". Typically, no anaesthetic or sedation is given for the procedure.

As per ACS 0042 *Procedures not normally coded,* if such a procedure is the principal reason for admission, these procedures can be coded.

In the scenario where the imaging procedure is performed and then the patient proceeds to a procedure such as percutaneous transluminal balloon angioplasty with stenting, can the Chapter 20 code still be assigned?

Response: CCAQ agreed that where an aorto-bifemoral angiogram was the only procedure performed, assign a code for the procedure following ACS 0042 *Procedures normally not coded*, classification point 2:
Procedures normally not coded are only assigned if:
...

- *they are the principal reason for admission in same-day episodes of care. This includes patients who are admitted the day before or discharged on the day after a procedure because a same-day admission is not possible or practicable for them (e.g. elderly patients, those who live in remote locations).*

If angioplasty or stenting is performed at the same time as the angiogram, code only the angioplasty or stenting.

July 2015

Query ID 07-0715: Possible cardiac chest pain

Reviewed 07/2022 – ADVICE CURRENT

Query: Are the terms coronary and cardiac synonymous? Quite often clinicians are documenting 'possible cardiac chest pain'. Should this be coded as coronary pain I20.9 *Angina pectoris, unspecified*, R07.4 *Chest pain, unspecified* or R07.3 *Other chest pain* depending on the site? If a patient is treated for possible cardiac chest pain with a drug that is normally used for angina, do you code angina even though it is not documented?

Response: No, coronary and cardiac are not considered synonymous. Coronary refers to the heart vessels and cardiac refers to the heart.

For documentation of 'cardiac chest pain', assign code R07.4 *Chest pain, unspecified* following the index Pain/chest (there is no sub term for 'cardiac'). 'Cardiac chest pain' treated with angina medication may warrant a documentation query to clarify the diagnosis.

June 2015

Query ID 01-0515: Total hip replacement with grafting of acetabulum

Reviewed 07/2022 – ADVICE CURRENT

Query: There is no separate procedure code for total hip replacement with grafting of acetabulum. This had to be done due to a fracture of the inferior acetabulum on insertion of an uncemented cup during surgery.

Can this procedure be coded as:
49318-00 [1489] *Total arthroplasty of hip, unilateral*
49327-00 [1492] *Revision of total arthroplasty of hip with bone graft to acetabulum*.

Response: CCAQ agreed to assign only 49318-00 [1489] *Total arthroplasty of hip, unilateral* as this code includes bone grafting.

Query ID 09-0515: Lip tie

Reviewed 07/2022 – ADVICE CURRENT

Query: Could CCAQ please provide advice as to the correct diagnosis code to use for lip tie (either upper and/or lower)? Patient admitted with congenital lip tie and has a labial frenectomy performed.

Response: CCAQ agreed to assign code Q38.09 *Other congenital malformations of lips*, following the index pathway Anomaly/lip/specified NEC.

Query ID 01-0615: Stone and bile spill and ACS 0002 *Additional diagnoses*

Reviewed 07/2022 – ADVICE CURRENT

Query: Does stone retrieval and/or washout during a cholecystectomy qualify as meeting ACS 0002 *Additional diagnoses?* Coding Rule TN203 *Stones spilling from the gallbladder during cholecystectomy* (published 15/9/08, retired 1/7/17) states that an unintentional tear/rupture of gallbladder should only be assigned if it meets the criteria of an additional diagnosis.

Response: Coders would need to determine from the clinical documentation whether the stone or bile spillage significantly affected patient management, as per ACS 0002 *Additional diagnoses* in terms of requiring any of:
- commencement, alteration or adjustment of therapeutic treatment
- diagnostic interventions

- increased clinical care
- increased clinical care.

March 2015

Query ID 05-0315: Principal diagnosis selection for Geriatric Evaluation and Management care type (Qld)

Reviewed 07/2022 – ADVICE CURRENT

Query: As per the Queensland Hospital Admitted Patient Data Collection (QHAPDC) manual Geriatric Evaluation and Management (GEM) is a subacute episode of care. At our hospital we have been advised to code GEMs patients as per ACS 0001 *Principal diagnosis* rather than a Z code.

I would like to know how other facilities are coding these episodes. Are they treating them like acute episodes as per ACS 0001 *Principal diagnosis* or are they using Z codes for them?

Response: There are no QHAPDC and ACS rules around principal diagnosis selection for GEMS episodes of care therefore follow ACS 0001 *Principal diagnosis* and assign the condition that was chiefly responsible for occasioning the episode of care.

November 2014

Query ID 02-1114: Odynophagia

Reviewed 07/2022 – ADVICE CURRENT

Query: Can the CCAQ provide advice how to code odynophagia? This condition is not currently indexed in ICD-10-AM.

We have a case where odynophagia is documented as the reason for a radiologically inserted gastrostomy and nutritional support from speech pathologists, and so we believe this symptom is a condition in its own right. This is in the context of a cancer patient with severe mucositis.

Dorland's medical dictionary states that odynophagia is a dysphagia in which swallowing causes pain.

We would like to code odynophagia to R13 *Dysphagia* if the CCAQ agrees this is appropriate in cases where the criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses is met? We have been unable to find any published advice on this condition.

Response: CCAQ agreed to code odynophagia to R13 *Dysphagia*, following index pathway Problem/swallowing.

October 2014

Query ID 03-1014: Ocular surface squamous neoplasia (OSSN)

Reviewed 07/2022 – ADVICE CURRENT

Query: I have had a few histology results with OSSN, could you please advise of the correct code/s?

Histology: Right eye surface – stromal elastosis, corneal epithelial hyperplasia and mild atypia, no evidence of malignancy. Special stains and additional report to follow.

Response: CCAQ agreed, based on the clinical documentation provided, assign code H18.8 *Other specified disorders of cornea* following the index Disease/cornea/specified NEC H18.8.

NOTE: OSSN may involve other epithelial surfaces of the eye, e.g. conjunctiva, therefore this advice will not be applicable to all cases and codes should be assigned according to the epithelial site.

Query ID 04-1014: Nipple delay procedure

Reviewed 07/2022 – ADVICE CURRENT

Query: What is the correct code for a nipple delay procedure? This procedure is performed prior to a nipple sparing mastectomy. The operation report states dissection of sub-areolar tissue and nipple core biopsy (not published with this query).

Information regarding nipple delay procedure (from internet – source unknown):
Nipple delay is usually performed 7-21 days before the nipple-sparing mastectomy. The procedure involves severing the blood vessels and other breast tissue beneath the nipple so that it is no longer dependent on the underlying tissue for blood supply.
Over the next 1-3 weeks the nipple then becomes accustomed to getting its blood supply from the skin around it instead of the breast tissue underneath it. This improved blood supply makes the subsequent nipple sparing mastectomy safer and decreases the risk of nipple necrosis (tissue death) and wound healing complications. The procedure is combined with a subareolar biopsy to ensure there are no cancer cells involving the nipple. If the subareolar biopsy reveals malignancy, the nipple and areola are removed at the time of mastectomy.

Proposed codes:
90720-00 [1759] *Other procedures on breast*
31500-01 [1743] *Open biopsy of breast*

Response: CCAQ agreed the following codes should be assigned:
90720-00 [1759] *Other procedures on breast* and 31548-00 [1743] *Core biopsy of breast* by using the index pathways:
Procedure/breast NEC and Biopsy/breast/core.

June 2014

Query ID 03-0514: Principal diagnosis selection for insertion of a Port-a-cath and chemotherapy

Reviewed 07/2022 – ADVICE CURRENT

Query: Patient admitted to a surgical unit for insertion of a Port-a-cath under general anaesthetic. Before the patient is discharged the patient has their Port-a-cath flushed and chemotherapy is administered.

The question is which code should be the principal diagnosis: Z51.1 *Pharmacotherapy session for neoplasm* or Z45.2 *Adjustment and management of vascular access device* (see examples).

Z51.1 *Pharmacotherapy session for neoplasm*
Neoplasm codes
34528-02 [766] *Insertion of vascular access device*
92514-xx [1910] *General anaesthesia, ASA xx*
96199-00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*

OR

Z45.2 *Adjustment and management of vascular access device*
Neoplasm codes
34528-02 [766] *Insertion of vascular access device*
92514-xx [1910] *General anaesthesia, ASA xx*
96199-00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*

Rationale: Z45.2 *Adjustment and management of vascular access device* has an exclusion note (in red below):

Excludes: adjustment and management of vascular catheter without reservoir attached (Z45.81)
that for pharmacotherapy for neoplasm (Z51.1)

According to coding "rules and standards", Z51.1 *Pharmacotherapy session for neoplasm* should be assigned however this does not accurately reflect the intention of the visit.

Response: CCAQ agreed that in the case of same day admissions, the excludes note at Z45.2 *Adjustment and management of vascular access device* should be followed, therefore Z51.1 *Pharmacotherapy session for neoplasm* will be the principal diagnosis.

Refer also to ACS 0206 *Pharmacotherapy for neoplasms.*

May 2014

Query ID 02-0314: Principal diagnosis for insulin pump insertion

Reviewed 07/2022 – ADVICE CURRENT

Query: Can CCAQ confirm which code should be used for insertion of an insulin pump and upgrade of an insulin pump in both a day-only and overnight admission.

Does the most recent published advice Coding Rule Ref: Q2728 *Diagnosis code assignment for admission for insulin pump* 15/12/12 (note Coding Rule Q2728 was superseded by Coding Rule Q2903 *Diagnosis code assignment for admission for insulin pump* 15/6/2016) pertain to day admissions only? Please note the wording under Classification which states for 'fitting' of the device use Z45.1 *Adjustment and management of drug delivery device*.

As the patient is given insulin is that 'treating' the diabetes therefore in an overnight admission you would code the diabetes in the same way that you code cancer in a patient who has a PICC line inserted and is given chemotherapy during that admission.

Response: CCAQ agreed Z45.1 *Adjustment and management of drug delivery device* should be assigned as the principal diagnosis as per Coding Rule Q2903 *Diagnosis code assignment for admission for insulin pump* where the reason for admission is for insertion of insulin pump for both same day and overnight episodes of care. Refer also to ACS 0001 *Principal diagnosis*.

October 2013

Query ID 03-0913: Tongue biopsy

Reviewed 07/2022 – ADVICE CURRENT

Query: Patient admitted for biopsy of lesion of tongue.

Q 1. Please advise of the correct procedure codes for the following operation, as we are unsure if a procedure code for the tongue biopsy is required when a procedure code is being assigned for the laryngoscopy – as Laryngoscopy 'includes biopsy'.

Q 2. If the procedure only stated biopsy of tongue without specifying that the biopsy site was 'base of tongue' would the coding of this procedure be different?

Note – the DRG changes if a tongue biopsy procedure code is coded along with the laryngoscopy.

Operation Details:
'Rigid oesophagoscopy
Direct laryngoscopy – difficult view
Multiple biopsies Left tongue base including submucosal
Tumour visualised and biopsied directly.'

Response: Following the details of the operation report provided the CCAQ members agreed on the following:

Q1. Biopsy of the tongue would be coded as an additional code to correctly identify the biopsy site. Assign:
30075-19 [392] *Biopsy of tongue*
41849-00 [520] *Laryngoscopy*

Q.2. Again, biopsy of the tongue would be coded to correctly identify the biopsy site. It is irrelevant which area of the tongue is biopsied.
Assign:
30075-19 [392] *Biopsy of tongue*
41849-00 [520] *Laryngoscopy*

August 2013

Query ID 04-0713: Deletion of ACS 1408 *Human papillomavirus (HPV)*

Reviewed 07/2022 – ADVICE CURRENT

Query: Patient admitted for large loop excision of the transformation zone (LLETZ) for cervical intraepithelial neoplasia (CIN) 3 with histology showing HPV effect.

Previous ACS 1408 *Human papillomavirus* (HPV) was deleted for 7th Edition and there is currently no 'flag' in the classification for coders to know to assign an additional code of B97.7 *Papilloma virus as the cause of diseases classified to other chapters* when coding CIN 1, CIN 2 or CIN 3 and histology shows HPV effect.

There is a pathway prompt in 3M Codefinder to code B97.7 *Papilloma virus as the cause of diseases classified to other chapters* as an additional code but nothing in the coding index or tabular to remind coders to add this code.

Can consideration be given to an addition of a 'Use additional code' note for B97.7 at relevant Tabular N87, D06 etc.?

Response: The precedent for deleting standards appears to be when they are no longer relevant or there have been exclusions, inclusions, 'code also' notes added to codes and therefore the standard is not required. In this case, point two of ACS 1408 appears to not have a 'Use additional code' instruction added to the Tabular to replace what was directed in the standard.

CCAQ agreed that if there is a causative infectious agent that will add specificity it should be coded.
