ICD Coding Newsletter

Third quarter 2005-06

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Department of Human Services

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The ICD Coding Newsletter supports the clinical coding function performed in Victoria by providing relevant information to Health Information Managers, Clinical Coders, and their associates.

The newsletter, prepared by the Victorian ICD Coding Committee in conjunction with the Department of Human Services, seeks to:

- Ensure the standardisation of coding practice across the State
- Provide a forum for resolution of coding queries
- Address topical coding education issues, and
- Inform on national and state coding issues from the Victorian perspective.

The scope of the newsletter includes coding feature articles, selected coding queries and responses, and various information updates including feedback on the quality and uses of coded data (as reported to the Victorian Admitted Episodes Dataset).

If you have any mailing list changes or queries or comments regarding the ICD Coding Newsletter, contact the HDSS Help Desk:

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Coding features

AR-DRG Version 5.1

From 1 July 2006, funding for acute admitted care will be based on AR-DRG Version 5.1. The following information has been copied from the Commonwealth Department of Health and Ageing website for your information. This site can be accessed at the following URL.

http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-casemix-ardrg1.htm

AR-DRG version 5.1 was released in October 2004. It is a minor update to the classification and incorporates the fourth edition ICD-10-AM codes. The ADRG and DRG structure is unchanged from version 5.0.

The latest available morbidity and patient-level cost data was used to test recommendations for the development of AR-DRG Version 5.1. All recommendations were initially tested using morbidity and patient level cost data collected for the 2000/01 financial year. Morbidity data for financial years 2001/02 and 2002/03 later became available, and some recommendations were tested using this data.

Data for the financial years 2000/01 and 2001/02, which was coded using Second Edition ICD-10-AM codes, was mapped to Third Edition ICD-10-AM codes and grouped to AR-DRG Version 5.0 to test recommendations for the development of Version 5.1. Data for financial year 2002/03 data was coded using the Third Edition ICD-10-AM codes and grouped to AR-DRG Version 5.0 without mapping.

When AR-DRG Version 5.1 was finalised, it was tested using data that was forward mapped to Fourth Edition ICD-10-AM codes.

The CCCG was consulted during the testing of the recommendations. Each submission, with associated analysis reports and a Commonwealth response was presented to the CCCA and then presented to the State and Territory health departments for discussion and comment.

The specifications were released to the software developers on 30 April 2004. Development and testing of the developer's software was conducted during the period May 2004 to August 2004. The first acceptance certificates were issued to software developers on 16 September 2004.

Version 5.1 incorporates the Fourth Edition of ICD-10-AM within the basic structure of Version 5.0. The Adjacent DRG (ADRG) numbering sequence is the same as Version 5.0, which is no longer contiguous, and may not reflect the Surgical and Other hierarchies, in some MDCs. While details of each recommendation are described in AR-DRG Version 5.1 Recommendations, the major new features are summarised below:

- *Procedure code 35321-00 Transcatheter embolisation of blood vessels has been added to an additional eight MDCs. The current literature states that this procedure can be applied in virtually every vascular territory to arrest haemorrhage, to occlude abnormalities, to palliate neoplasm and to ablate tissue and this is supported by the clinical advice given by the CCCGs and CCCA;*

- *Babies with an admission birth weight between 100-399 grams will be grouped in Version 5.1 provided that they have been coded with any of the following diagnosis codes:*
    - *P07.01 Extremely low birth weight 499g or less;*
    - *P07.21 Extreme immaturity, less than 24 completed weeks; and*
    - *P07.22 Extreme immaturity, 24 or more completed weeks but less than 28 completed weeks;*

Previously they grouped to error DRG 960Z Ungroupable

- *20% of the public submissions received did not require action as the error reported was corrected in AR-DRG Version 5.0.*

Selected ICD-10-AM coding queries

#1978 Diabetes with peripheral vascular disease

Please confirm the coding of a patient who has type 2 diabetes, peripheral vascular disease, leg ulcer and cellulitis of the leg? Do we code:
E11.69 *Type 2 diabetes mellitus with other specified complication*
L97 *Ulcer of lower limb, not elsewhere classified*
L03.11 *Cellulitis of lower limb*
E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
I70.23 *Atherosclerosis of arteries of extremities with ulceration*
or
E11.51 *Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*
I70.23 *Atherosclerosis of arteries of extremities with ulceration*
L03.11 *Cellulitis of lower limb*

The correct codes to assign in this scenario depend on whether there is a documented relationship between the conditions.

If the ulcer is documented as related to the PVD, assign:
E1-.51 ***Diabetes mellitus with peripheral angiopathy, without gangrene***
I70.23 ***Atherosclerosis of arteries of extremities with ulceration***
L03.11 ***Cellulitis of lower limb***

If there is no documented relationship between the ulcer and the PVD, assign:
E1-.69 ***Diabetes mellitus with other specified complication***
L97 ***Ulcer of lower limb, not elsewhere classified***
E1-.51 ***Diabetes mellitus with peripheral angiopathy, without gangrene***
L03.11 ***Cellulitis of lower limb***

You will need to make your decision about the relationship between the peripheral vascular disease and the ulcer based on the available documentation, before you can select the appropriate diabetes code.

#2043 Anaphylactic reaction to food

A patient with a known allergy to peanuts presented with anaphylaxis after eating food in a restaurant that he did not know contained peanuts.

Previous advice in Coding Matters vol.4 no.1 in July 1997 and NCCH query Q732 (22/12/1998) both advised to code this to T78.0 *Anaphylactic shock due to adverse food reaction* and Y57.9 *Drug or medicament, unspecified.*

Is this direction still current, as Y57.9 appears to be an inappropriate code to use? It would be difficult to extract information on anaphylactic reactions to foods as opposed to medicinal substances while this code is being used for these cases.

This query was referred to the NCCH who provided the following advice:

> The NCCH has investigated this issue in depth on a number of occasions. The ICD-10-AM External Causes of Injury Index entry for 'Anaphylactic shock, anaphylaxis' classified to **Y57.9 *Drug or medicament, unspecified*** is consistent with ICD-10. There is no specific index entry or external cause code for anaphylactic shock 'due to food ingestion'.
>
> **X58 *Exposure to other specified factors*** or **X59 *Exposure to unspecified factor*** have previously been suggested as an alternative to Y57.9. As neither X58 nor X59 offer any more specificity in relation to the type of foodstuff consumed, the NCCH does not support the assignment of these codes as a long term option.
>
> The NCCH is unable to alter the above classification without approval from WHO Update Reference Committee (URC). A proposal was presented to WHO URC (by the Nordic Centre) in 2004 but following discussion with members of that committee was subsequently withdrawn for further research prior to resubmission. The NCCH will investigate the progress of this proposal, specifically in relation to the possibility of an expanded external cause code to indicate the type of food.
>
> In the meantime, where anaphylactic shock due to ingestion of food is documented, assign the following codes:
> **T78.0** ***Anaphylactic shock due to adverse food reaction***
> **Y57.9** ***Drug or medicament, unspecified***
> with appropriate place of occurrence code.

The VICC has requested that NCCH give consideration to an index entry for anaphylactic shock due to food ingestion for sixth edition.

#2052 Apheresis-platelet donor

Please advise on the correct coding of Apheresis.

We have been using Z51.81 *Apheresis* and 13755-00 [1892] *Donor haemapheresis*

This was referred to the NCCH who provided the following advice:

> The NCCH agrees that apheresis for procurement of any blood component should be assigned **Z51.81 *Apheresis***. This is consistent with the advice in query Q1375 (21/12/2000).
>
> The NCCH will consider changes to the table in **ACS 0030 *Organ procurement and transplantation*** for a future edition of the Australian Coding Standards.

#2063 Ivor-Lewis Oesophagectomy

Patient admitted with distal oesophageal cancer for Ivor-Lewis Oesophagectomy. Abdominal incision made and proximal stomach was resected and oesophagus mobilised, feeding jejunostomy inserted. Thoracotomy done, lung collapsed, oesophagus mobilised to the hiatus. Stomach was pulled up and anastomosed to the oesophagus. Drain tubes inserted and patient closed up. Pathology listed 5 cm of oesophagus and the proximal stomach received.

There appears to be a problem with the indexing of Ivor-Lewis procedures. If you look up Procedure, - Ivor Lewis, you are directed to 'see Oesophagectomy and Gastrectomy, total'. Oesophagectomy is then listed by the site of mobilisation being abdominal, thoracic, transthoracic and cervical. According to the surgeons who perform the above operation, there is no difference between thoracic and transthoracic. In the MBS schedule there is no mention of 'transthoracic' mobilisation. Could there be a review of the indexing and tabular of 'oesophagectomy'?

Our surgeon suggested code 30535-00 [860] *Oesophagectomy by abdominal and transthoracic mobilisation, with thoracic oesophagogastric anastomosis*, as it was 'closest' to the procedure performed.

In addition to the oesophagectomy component of the procedure we are also directed to see 'gastrectomy, total' yet all the procedures that I have coded have usually only involved a partial gastrectomy of the proximal stomach. On checking the coding of others, they are following the direction in the books and coding it to a total gastrectomy, could this be reviewed in the procedure index?

This query was referred to the NCCH who provided the following advice:

> Many procedures in ACHI are identified by eponyms, such as Ivor Lewis procedure. When eponyms are listed in the Alphabetic Index, the index usually gives a short description of the procedure or the site of the operation. In the example of Ivor Lewis procedure, the description listed in the index is 'oesophagectomy' and 'gastrectomy, total'. Coders must, however, confirm what procedures were actually performed for each case by referring to the operation report. In the case cited, a partial gastrectomy was performed instead of a total gastrectomy, therefore code assignment should reflect this.
>
> The NCCH will consider amendments to the indexing of Ivor Lewis procedure for a future edition.

In the meantime, based on the information provided and in the absence of a default code for oesophagectomy, the VICC recommends that you code the case cited as follows:

30536-00 [860] ***Oesophagectomy by abdominal and transthoracic mobilisation, with cervical oesophagogastric anastomosis***
30518-02 [875] ***Partial proximal gastrectomy with oesophagogastric anastomosis***

#2093 Abnormal limb movement

Patient had abnormal limb movements, due to a particular drug. Following the index Abnormal, movement, it takes me to a G code - disorder being a non-essential modifier. However, the correct code seems to be an R code. Should disorder be an essential modifier?

The VICC referred this query to the NCCH suggesting that NCCH alter the default to **R25.8** ***Other and unspecified abnormal involuntary movements***. The NCCH provided the following response:

> NCCH agrees that 'abnormal limb movement', not specified as a disorder, should be classified as:
> **R25.8** ***Other and unspecified abnormal involuntary movements***
>
> The indexing of 'Abnormal, movement' is consistent with ICD-10. NCCH will submit a proposal to WHO URC to amend the index.

#2101 ACS 0044 Chemotherapy

We are having difficulty applying ACS 0044 *Chemotherapy* for patients with neoplasms who are admitted to our same day oncology ward. In particular we are having difficulty determining what a 'neoplasm related condition' is.

Scenario 1:
Patient is admitted as a same day episode to our day oncology ward with dehydration and receives intravenous electrolytes. Patient has previously been diagnosed with breast cancer. Is the principal diagnosis Z51.1 *Pharmacotherapy session for neoplasm* or E86 *Volume depletion*? What is the correct procedure 96199-00 *Intravenous administration of pharmacological agent, antineoplastic agent* or 96199-08 *Intravenous administration of pharmacological agent, electrolyte*?

Scenario 2:
Patient admitted as a same day episode to our day oncology ward for IV erythropoietin to treat anaemia. Patient has previously been diagnosed with a neoplasm. Is the principal diagnosis Z51.1 *Pharmacotherapy session for neoplasm* or neoplasm code followed by D63.0 *Anaemia in neoplastic disease*? What is the correct procedure code to assign 96199-00 *Intravenous administration of pharmacological agent, antineoplastic agent* or 96199-09 *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent*?

Scenario 3:
If a patient who has a neoplasm is admitted to our day chemotherapy unit for electrolytes to treat nausea and vomiting, we don't know whether the nausea and vomiting are neoplasm related conditions or not. If the documentation does not support or rule that a condition is a 'neoplasm related condition', how should the episode be coded? Do we assume the condition is a neoplasm related condition or assume that it's not a neoplasm related condition?

A condition should not be assumed to be a neoplasm related condition unless documented as such or classified as such by coding convention, index entry or ACS.

The NCCH provided the following advice:

> NCCH suggests that a condition should not be assumed to be a neoplasm related condition unless documented or classified as such.
>
> Assign the following codes for the scenarios cited:
>
> 1. **E86 *Volume depletion*** (for the dehydration, as the principal diagnosis)
>   A code for the breast cancer (if the breast cancer is a comorbidity that has an affect on the episode of care as per **ACS 0002 *Additional Diagnoses***)-see also **ACS 0236 *Neoplasm Coding And Sequencing***
>   **96199-08 [1920] *Intravenous administration of pharmacological agent, electrolyte***
>   (as the principal treatment in same-day episodes of care)
>
> 2. The dagger (aetiology)/asterisk (manifestation) multiple code assignment for anaemia in neoplastic conditions indicates that the anaemia is a neoplasm related condition.
>   **Z51.1 *Pharmacotherapy session for neoplasm***
>   A neoplasm code (dagger)
>   **D63.0* *Anaemia in neoplastic disease***
>   **96199-00 [1920] *Intravenous administration of pharmacological agent, antineoplastic agent*** (as the principal treatment in same-day episodes of care)

3. **R11** ***Nausea and vomiting***
   A neoplasm code (if the neoplasm is a comorbidity that has an affect on the episode of care as per **ACS 0002** ***Additional Diagnoses***)-see also **ACS 0236** ***Neoplasm Coding And Sequencing***
   96199-08 [1920] ***Intravenous administration of pharmacological agent, electrolyte*** (as the principal treatment in same-day episodes of care).

#2102 Lumbar canal stenosis with sciatica

Question 1:
In coding intervertebral lumbar disc displacement and sciatica, we are able to code the dagger and asterisk combination of M51.1 *Lumbar and other intervertebral disc disorders with radiculopathy* and G55.1 *Nerve root and plexus compressions in intervertebral disc disorders.* However if you have lumbar canal stenosis with sciatica, you are not able to use this code combination:
Stenosis
-spinal
--with nerve root compression M48.0- and G55.3*

The tabular code descriptions of G55.1 and G55.3 are the same, but include a different range of dagger codes. If nerve root compression must be documented to use the extra code, why is this not the same for intervertebral disc displacement, or is the anomaly with the indexing of the spinal canal stenosis?

Question 2:
When could you use G55.3 *Nerve root and plexus compressions in other dorsopathies* with M45-M46 and M53-M54, as I can't find anything in the index that allows you to use this combination?

The VICC sought advice from NCCH when preparing this response:

Answer 1:
The VICC agrees that there is no index entry that allows you to use this combination for documentation of spinal stenosis with sciatica. As stated, there are other entries that index sciatica to nerve root and plexus compressions.

However, it is not possible to cover every documentation combination in the index. Coders can and should use clinical knowledge to find synonymous terms when the term documented in the record is not found in the index, to try to fully cover the diagnoses. Clinical literature refers to sciatica as neuropathy of sciatic nerve and lumbar radiculopathy, one of the causes is stated to be nerve compression. Using this knowledge the correct code assignment in this case, of lumbar canal stenosis with sciatica, would be:
Stenosis
-spinal
-- with nerve root compression M48.0- and G55.3*

Similar advice was provided in VICC #1922 Spinal cord compression secondary to neoplasm published in the May 2004 ICD Coding Newsletter.

Answer 2:
The NCCH is seeking advice on this issue from WHO URC.

#2107 Postprocedural abscess

If a patient has a postprocedural intra-abdominal or sub-phrenic abscess, these are currently included in T81.41 *Wound infection following a procedure.* These are quite significant infections, should they be moved to K91.8 *Other postprocedural disorders of digestive system, not elsewhere classified* as they are specifically of the gastrointestinal system?

The correct code to assign in this scenario is **T81.41** ***Wound infection following a procedure***. This is supported by **ACS 1904** ***Procedural complications*** and also by the index entries. Although the code title is 'wound infection' the code does include intra-abdominal and subphrenic abscesses as per the ‘includes’ note.

An additional code **K65.0** ***Acute peritonitis*** can be added to fully describe the medical statement.

It is important for coders to remember that ICD-10-AM is a statistical classification so there is not a specific code title for every condition and to follow the index entries and assign a code accordingly.

To have the classification changed, a public submission to the NCCH would be required.

#2117 Insertion of Miniaturo™ electrode

We have a number of patients admitted for insertion of an electrostimulation device into the para-urethral area known as Miniaturo™ electrode. This procedure is performed for severe interstitial cystitis. Currently we can find no code suitable for this procedure in ICD-10-AM. The surgeon is not assigning any MBS code currently for this procedure. It is performed in conjunction with a cystoscopy, biopsy and some diathermy. This procedure is performed in two stages, first placement of the electrode and second stage the implantation of the generator subcutaneously in the lower abdominal region. There is no code available for the placement of the electrode (1st stage), however it may be possible to assign: 90012-00[67] *Implantation of peripheral neurostimulator* for the placement of generator. This results in DRG 901Z in V5.0 and 4.2 of the grouper if no other procedures are performed. Please confirm the correct codes to be used for both stages of this procedure?

The VICC sought advice from the NCCH when preparing this response.

NCCH sought advice from a hospital where this procedure was performed as part of an international study. The hospital's code assignment for the procedure was determined following consultation with clinical/nursing staff involved with the study.

The MiniatURO device is inserted in a two step procedure. The procedure for both steps is almost identical. The first step is only temporary (the device is inserted and trialed for one day) and is performed using local anaesthetic.

The second step is more permanent, with the device being embedded in the pelvic floor muscles and performed using general anaesthetic.

Cystoscopy is performed with both steps.

The NCCH supports the following codes for each of the steps involved in insertion of the Miniaturo™:
90359-00 [1091] *Implantation of electronic bladder stimulator*
36812-00 [1089] *Cystoscopy*
a code for the anaesthesia, as appropriate.

#2124 Old myocardial infarct

This query relates to advice given in NCCH Q2078 [3/12/04] Old Myocardial Infarction and History of IHD. The original query related to the correct coding for a patient admitted with a cardiac condition where the clinician has documented a past history of MI or history of CABG, without documenting its relevance to the current episode of care.

NCCH advised 'That by applying the Clinical Coders Creed it would be appropriate to assign a code for old MI or History of CABG where this is documented in the clinical records of a patient admitted for treatment of a cardiac condition'.

This advice is contrary to advice provided in NCCH Q1386 (5/2/2001), namely that old MI can be coded if 'The treating clinician has documented that the old AMI is significant for the current episode of care'.

It is also contrary to advice provided in NCCH Q1711 (1/9/02) 'The intent of ACS 0940 Ischaemic Heart Disease is not for clinical coders to make assumptions as to whether there is a causal relationship between the old MI and the IHD, this information is rarely documented and clinical coders should not make this judgment'.

ACS 0940 also provides advice when old AMI can be coded.

I feel also that the application of the Clinical Coders Creed to this scenario exceeds the intention of the creed. The issue of ischaemic heart disease is complex and varied, with each case being different from the next. Without the necessary clinical documentation, as clinical coders it is not possible for us to know for which episode the old MI or history of CABG is relevant. To code history of MI or CABG because it is a 'cardiac condition' rather than because it is 'directly relevant to the current episode of care' (ACS 2112 *Personal History*) or meets ACS 0002 *Additional diagnoses* would seem to not be in keeping with correct coding practice.

This query was referred to the NCCH who provided the following advice:

> NCCH has received clinical advice that supports the following:
> When a patient is admitted for a cardiac condition, it is appropriate to assign a code for 'old MI' or 'history of CABGs' if this is documented in the patient's history. It would almost always be clinically relevant and affect the treatment of the cardiac condition for the current episode of care.
> A subsequent advice note has been added to NCCH queries 1386 & 1711.

The VICC note that this logic should not be applied in non-cardiac scenarios and that the VICC is working on a revision of **ACS 0002 *Additional diagnoses*** with the NCCH.

#2181 Coding and reporting of non-invasive ventilation (NIV) hours for newborns

I have two queries, one with relation to coding NIV for newborns and the other reporting hours of NIV for newborns when occurring in an SCN/NICU.

Some coders at our hospital and at other hospitals believe that allocating an NIV code for a newborn can only take place if the duration of ventilation is greater than one hour.

However ACS 1006 *Respiratory Support* states that codes for non-invasive ventilation should be assigned for neonates (age < 28 days), any duration. I interpret this as meaning we should allocate the appropriate NIV code even if it was administered for a short period of only two minutes.

In terms of reporting hours of ventilation section 3-77 of the current VAED Manual states that we are to round up to the nearest completed hour. Again, some coders believe that this only applies after 1 completed hour. I interpret this as meaning that if a newborn received two minutes of NIV in a SCN/NICU then we round up and report one hour of duration to the VAED.

Coders have been referring to Page 9 of the August 2002 ICD Coding Newsletter article which states 'Code the type of NIV for any duration greater than or equal to 1 hour, < 1 hour is rounded down to 0'.

Any duration of NIV can be coded for newborns according to **ACS 1006 *Respiratory Support*** except when given for resuscitation at birth as per NCCH Q1754 (01/12/2002).

Reporting of NIV hours to the VAED is now optional, so report hours if you choose to by following the instructions in the VAED manual page 3-77.

The advice in the article in the August 2002 ICD Coding Newsletter has been superceded by the VAED manual instructions. Reference to the article will be removed from the VAED manual.

#2196 Gastroscopy with pancreas biopsy

What codes should be assigned for gastroscopy with EUS (endoscopic ultrasound) and FNA (fine needle aspiration) of pancreas or mediastinal mass?

We think we should code out the aspiration of the pancreas/ mediastinal mass. There is no code for aspiration pancreas or mediastinal mass so we referred to 'biopsy' because the pathology of the aspiration includes cells. We have decided to code the following for the interim:

30473-00 [1005] *Panendoscopy to duodenum*
30075-16 [977] *Biopsy of pancreas*
55054-00 [1949] *Intra-operative ultrasound of other site*

The coding of the biopsy of pancreas or mediastinal mass severely affects the WIES/ DRG.

The Gastroenterologist who conducts these procedures at our site explained that the gastroscope is inserted with the needle attached to the end of the scope. The needle is injected through the gastrointestinal wall and the pancreas is biopsied.

The procedure has been coded appropriately. The decision to code this way is based upon advice published by the NCCH in query Q1042 (17/11/1999), which advises that aspiration biopsy, refers to the removal of cells for histological diagnosis.

It is correct to assign a code for the biopsy of the pancreas because the biopsy is not of the gastrointestinal tract. This code should be sequenced first. Therefore in your scenario code as follows:

30075-16 [977] ***Biopsy of pancreas***
30473-00 [1005] ***Panendoscopy to duodenum***
55054-00 [1949] ***Intra-operative ultrasound of other site***

#2203 Periodic Fever Unknown Origin

> In the index if you search under the lead term 'fever' and then select the essential modifier 'periodic' the code selected is E85.0 *Non-neuropathic heredofamilial amyloidosis*. When you go to the tabular this does not appear to be the correct code for the diagnosis.
>
> Is there an indent missing under Fever, periodic for 'Unknown Origin'?
>
> The clinician was adamant that the fever was periodic and not any other option.

Clinical research indicates that a range of conditions can cause periodic fever. Therefore following coding convention, the correct the default code is:
E85.0 ***Non-neuropathic heredofamilial amyloidosis***

Coders should be aware that the classification makes assumptions about the cause of some conditions.

This is supported in **ACS 0033** ***Conventions used in the tabular list of diseases*** which states:
'Data analysts should similarly be aware that some conditions assigned to an apparently specified category will not have been so specified on the record that was coded. When comparing trends over time and interpreting statistics, it is important to be aware that assumptions may change from one revision of the ICD to another. For example, before the Eighth Revision, an unqualified aortic aneurysm was assumed to be due to syphilis'.

#2204 Crohn's disease of the oesophagus

> A patient has been diagnosed with Crohn's disease of the oesophagus, a condition which the surgeon acknowledges is rare. The patient was admitted for dilatation of stricturing and findings were of a 'severely ulcerated oesophagus, with no features to suggest reflux disease'. In order to capture the specifics of the disease as well as the diagnosis I have coded the case as follows:
> K22.2 *Oesophageal obstruction*
> K22.1 *Ulcer of oesophagus*
> K22.8 *Other specified diseases of oesophagus*
> K50.8 *Other Crohn's disease*
> plus procedure codes.
>
> Am I able to use K50.8 *Other Crohn's disease* where the diagnosis refers to the oesophagus rather than the intestine?

K50.8 ***Other Crohn's disease*** is only indexed for Crohn's of small with large intestine or large with small intestine, neither of which are appropriate in this scenario; therefore the correct code to assign for Crohn's disease of esophagus is the default code:
K50.9 ***Crohn's disease, unspecified***

Based on the information provided in your query, the VICC has assumed that the Crohn's disease was diagnosed in a previous admission; therefore the codes would be assigned as follows:
K22.2 ***Oesophageal obstruction***
K50.9 ***Crohn's disease, unspecified***
and procedure codes.

A code for the ulceration of oesophagus is not required because it is a part of the Crohn's disease.

#2208 Principal diagnosis for cancelled chemotherapy

What code should be assigned as principal diagnosis for day chemotherapy admissions when chemotherapy is cancelled?

Coding Matters Vol. 12 No. 2 September 2005 contained instruction to code cancelled day chemotherapy for neoplasm to Z51.1 *Pharmacotherapy session for neoplasm*, appropriate neoplasm codes, Z53.0 *Procedure not carried out because of contraindication* and code for condition(s) resulting in cancellation of chemotherapy.

Previously in ICD Coding Newsletter February 2003 #1855 instructed coders that following ACS 0001 *Principal diagnosis,* chemotherapy would not meet definition of principal diagnosis, and therefore condition being treated (that resulted in cancellation of chemo) would be principal diagnosis.

The coding feature 'Admission for Chemotherapy' in ICD Coding Newsletter June 2002 advised that Z51.1 *Pharmacotherapy session for neoplasm* should be coded when the patient is treated with either antineoplastic or cytotoxic therapy.

ICD Coding Newsletter Aug 2000 #1537 instructed once again that if chemotherapy session is cancelled and no other treatment given, admission should be cancelled as it does not meet admission criteria, or if chemotherapy is cancelled for a condition that required further treatment this would become the principal diagnosis.

As per the coding feature titled 'Cancelled procedures' in the First quarter 2005-06 ICD Coding Newsletter, coders must first decide whether or not the admission is a legitimate admission according to the criteria discussed in the DHS Hospital Admission Policy.

If the admission is legitimate, then the codes must be assigned according to the instructions contained in ACS 0011 Admission for surgery not performed and this is reinforced in Coding Matters Volume 12, Number 2 September 2005.

If the admission is not legitimate, then the admission must not be reported to the VAED.

Please note that this advice supersedes previous advice published in the August 2000, June 2002 and February 2003 ICD Coding Newsletters.

The following scenarios are to assist coders in code assignment:
Scenario 1:
Same day patient admitted for chemotherapy, which is cancelled because of fever. Patient is separated same day. Assign the following codes:
Z51.1 ***Pharmacotherapy session for neoplasm***
Neoplasm code
Z53.0 ***Procedure not carried out because of contraindication***
R50.9 ***Fever, unspecified***

Scenario 2:
Intended same day patient admitted for chemotherapy, which is cancelled because of fever. Patient becomes a multi-day stay. Assign the following codes:
Neoplasm code
Z53.0 ***Procedure not carried out because of contraindication***
R50.9 ***Fever, unspecified***

The VICC is preparing a public submission to NCCH suggesting an amendment to **ACS 0011 *Admission for surgery not performed*** for patients who remain in hospital overnight.

#2210 IV Intragam infusion for Multiple Myeloma

Please advise correct coding for IV Intragam infusion for Multiple Myeloma? If coded as day chemotherapy it groups to R63Z ($565.1718) and if coded as transfusion it groups to R61C ($483.5469). There is contradictory advice on the NCCH database regarding it.

NCCH database Q1992 (23/09/2004) instructs to code to IV pharmacotherapy with extension of '00' as the intent is for treatment of neoplastic disease.

NCCH database Q2025 (08/10/2004), whilst never actually providing a coding directive, states that Intragam is derived from blood products, and was included in pharmacotherapy block [1920] due to the synthetic nature of the drug. This is obviously despite the fact that it is made from human proteins and there was a major shortage of Intragam recently due to the drop off in blood donations.

The advice in Q2025 directly contradicts that given in NCCH database Q2042 (21/10/2004) which states that Albumex has been categorised as a blood expander, and goes on to state that all transfusion of blood and gamma globulins (including extracts, synthetic/manufactured substances are classifiable to block [1893] and should be coded in accordance with ACS 0302 *Blood transfusions*.

Errata 2 instructed coders to add the following 'excludes' note under (05) gamma globulin in block [1920] but did not add an 'excludes' note under 13706-05 [1893].

VOL 3: [1920]–05 Gamma globulin excludes note 'Add when used in the treatment of neoplasms and/or neoplasm related conditions'.

The correct procedure code to assign for IV Intragam infusion for Multiple Myeloma is **13706-05 [1893] *Transfusion of gamma globulin*** as per advice in NCCH Q2025 and the 'excludes' note under Block [1920]-05. Note that transfusion may be documented as infusion.

The VICC also notes that Multiple Myeloma is the correct principal diagnosis.

The VICC has requested NCCH give consideration to removing gamma globulin from block [1920] because it is a blood product and retain only in block [1893].

#2212 Bleeding gastric arteriovenous malformation

83 year old female patient admitted with a bleeding gastric arteriovenous malformation, which is treated by an injection of adrenaline at gastroscopy.

Is Q27.3 *Peripheral arteriovenous malformation* the correct code to use in this instance? Although not stated in the index as peripheral, the actual code description in the Tabular list states peripheral and it groups to F65A Peripheral vascular disorders with CSCC.

The VICC advises that it is not correct to assign **Q27.3 *Peripheral arteriovenous malformation*** because in the index under Malformation, arteriovenous, the term aneurysmatic is an essential modifier.

As per **ACS 0034 *Conventions*** used in the alphabetic index of diseases under Cross references 'see also' directs the coder to refer elsewhere in the index if the statement being coded contains other information that is not found indented under the term to which 'see also' is attached. Because the term Malformation has a 'see also' cross reference to Anomaly, follow the index under Anomaly:

Anomaly, anomalous (congenital) (unspecified type) Q89.9
↓
-artery (peripheral) Q27.9

Therefore the appropriate code to assign in this scenario is:
Q27.9 *Congenital malformation of peripheral vascular system, unspecified*

#2213 Manual removal of placenta in an abortive episode

34 year old woman admitted at 18 weeks gestation with an incomplete miscarriage.

The operation report only stated manual removal of placenta. The cervix was still dilated. There was no dilatation and curettage or suctions done.

Which would be the most appropriate code?
90482-00 [1345] *Manual removal of placenta*
35643-01 [1267] *Suction curettage of uterus following abortion or for termination of pregnancy*
35643-02 [1267] *Dilation and evacuation of uterus [D&E]*

The correct procedure code to assign in your scenario is:
90482-00 [1345] *Manual removal of placenta*

It is not appropriate to assign the other procedure codes listed in your query because according to the information provided those procedures were not performed.

The diagnosis code will indicate that this is an abortive episode.

#2215 Foot debridement of diabetic patient

It was noted that many of our diabetic patients are having debridement of their feet by podiatrists. These debridements are done on the ward. ACS 1203 *Debridement* states that most debridements are excisional. Therefore should we use excisional debridement as the default as non-excisional debridement is not documented?

Additionally, as a podiatrist performs the debridements, should they be coded in addition to the generalised allied health podiatry intervention code?

As per **ACS 1203 *Debridement*** the procedure code for excisional debridement should be assigned as the default code when non-excisional debridement is not documented.

ACS 0032 *Allied health interventions* states that codes in other chapters may also represent interventions performed by health professionals and that a combination of the specific code and general code may be assigned.

#2216 Vasospasm of coronary arteries

The index lookup at vasospasm leads to I73.9 *Peripheral vascular disease*, unspecified. The lookup at Spasm, coronary (artery) leads to I20.1 *Angina pectoris with documented spasm*, which is the code I have used.

The patient had a coronary angiogram, which did not demonstrate any coronary artery disease, and is now being treated for vasospasm with Amlodipine and nitrate patches.

There is no index entry for coronary arteries under vasospasm, and the index entry under spasm leads to I20.1, but there is no mention of angina pectoris in this patient, nor does the condition seem appropriate to the section of codes I20-I25 Ischaemic Heart Diseases.

Vasospasm is defined as 'sharp and often persistent contraction of a blood vessel reducing its caliber and blood flow'
(http://www2.merriam-webster.com/cgi-bin/mwmednlm?book=Medical&va=vasospasm)

It is therefore appropriate to look up in the index Spasm, coronary (artery) to assign:
I20.1 *Angina pectoris with documented spasm*

As per **ACS 0940 *Ischaemic heart disease***, angina has many underlying causes and spasm is one of them, therefore it is appropriate for spasm of coronary artery to be classified to **I20.1 *Angina pectoris with documented spasm***.

#2218 Neurocardiogenic Syncope

Currently according to the alphabetic index we are coding R55 *Syncope and Collapse* for this condition.

Our cardiology registrar describes the condition, which is more complex than a simple faint. It is an inappropriate decrease (sudden drop) in blood pressure. Normally the body will react to some stimuli such as fear, extreme heat, high emotional levels, standing in one spot by releasing adrenaline to raise the heart rate and blood pressure. In a person with neurocardiogenic syncope the reaction to this surge of adrenaline is the opposite of normal. Heart rate and blood pressure drop dramatically. There is little warning and treatment can include a pacemaker. The Tilt Table is used to assist the diagnosis.

A search of NCCH coding queries found only Q2130. Is this a similar scenario or not?

R55 *Syncope and Collapse* does not adequately describe this condition. Is this a recognised condition rather than a symptom and therefore requires a designated code?

NCCH query Q2130 refers to a syndrome, which is coded according to ACS 0005 Syndromes. This standard is not applicable to neurocardiogenic syncope. Therefore as per coding convention, the correct code to assign is the default code at syncope:
R55 *Syncope and collapse*

#2219 Vitamin D deficiency in obstetric patients

We have a large number of obstetric patients who are Vitamin D deficient throughout their pregnancy. These patients are treated with Ostelin during their antenatal care and after giving birth are discharged with instruction to continue daily Ostelin.

We feel that the Vitamin D Deficiency is significant condition from a coding and research perspective. On our obstetric delivery summaries and the discharge summaries the Vitamin D Deficiency is listed as a maternal medical condition. Does the Vitamin D Deficiency meet additional diagnosis criteria as it is being monitored through the admission and the patient is instructed to continue with medication on discharge?

In patients with no other complications this will change the DRG as the O80 *Single spontaneous delivery* will not be used as we would assign:

O99.2 *Endocrine, nutritional and metabolic diseases complicating pregnancy, childbirth and the puerperium*
E55.9 *Vitamin D deficiency, unspecified*

If there is documentation to support that the Vitamin D deficiency is being monitored then it is appropriate to code this condition as it meets additional diagnoses criteria.

This advice is consistent with Additional diagnoses queries and responses query seven 'Obstetrics' on the HDSS website.

#2220 Positional talipes

We have a number of babies born at our hospital with documentation of Positional talipes. These patients have physiotherapy as their only treatment. On imaging there is no bone deformity.

We have been using Q66.89 *Other congenital deformities of feet*. We are receiving a number of requests from the Perinatal Data Collection Unit asking if the deformity is soft tissue or structural. Is there a more specific code we could be assigning?

The VICC referred this query to the Perinatal Data Collection Unit (PDCU) who provided the following response:

> The Perinatal Data Collection Unit (PDCU) is a mandated collection of births in Victoria. The maintenance of the Birth Defect Register (BDR) is one of the functions of the PDCU. One source of birth defect notification is the perinatal morbidity statistics form. If diagnoses are vague or non-specific, further specificity is sought for the completeness of the BDR. In these cases a query is generated from the PDCU, or if the pediatrician's details are available, a follow up letter will be sent.
>
> Where a birth defect has been diagnosed at the time of birth, a descriptive diagnosis is documented on the perinatal form (not an ICD-10-AM code). From this, a code is assigned by the PDCU coders for submission to the BDR. The classification used for reporting birth defects is the ICD-9 British Paediatric Association (BPA) supplement (a much more detailed 5 digit classification for birth defects).
>
> Codes such as **Q66.89 *Other congenital deformities of feet*** are very general as this code includes:
> Clubfoot NOS
> Hammer toe, congenital
> Talipes:
> - Asymmetric
> - NOS

Tarsal coalition
Vertical talus

This code is not specific enough for the purposes of the BDR and a description of the nature of the condition is required in order to determine whether it is notifiable to the BDR or not. For example, using the BPA classification, Clubfoot is assigned the code 75473, whereas Hammer toe is assigned 75560. In ICD-10-AM these conditions are both classified to **Q66.89 *Other congenital deformities of feet***. There may also be other foot anomalies assigned to this code, which may have a more appropriate BPA code.

Therefore, for coding purposes the correct code to assign is:
Q66.89 ***Other congenital deformities of feet.***

#2221 Islet cell transplantation

Please advise the procedure code to be used for Islet cell transplantation? This process involves isolating islet cells from donor pancreas and injecting them into the liver of patients with Type 1 diabetes. We code E10.9 *Type 1 diabetes mellitus without complication* as the principal diagnosis and 14203-01 [1906] *Direct living tissue implantation*. We looked up transplantation, pancreatic tissue. This groups to K06Z Thyroid Procedures. This DRG does not relate to the procedure being performed.

From the information provided, the VICC agrees with the procedure code assigned. This is an example of the classification not keeping up with new technology as this procedure is now performed using various tissues:

- adrenal
- thyroid
- cartilage
- pancreas
- parathyroid

The VICC will refer this to the Commonwealth for consideration of allocating the procedure code to DRG **K09Z *Other Endocrine, Nutritional and Metabolic OR Procedures.***

#2223 Feeding problems in infant

Babies admitted with feeding problems for assessment and maternal education (admitted patient program at early parenting centre). If the baby is older than 28 days, which code should be used.

Index entry for feeding problems:
Feeding
-difficulties and mismanagement R63.3
-faulty R63.3
-formula check (infant) Z00.1
-improper R63.3
-problem R63.3
--newborn P92.9
---breast refusal, persistent P92.5
---due to
----short frenulum P92.8
----tongue tie P92.8
---incoordinate suck P92.8
---specified NEC P92.8
---uncoordinate suck P92.8
--nonorganic F50.8

From the information provided, the babe is no longer a newborn and there is no evidence that the condition arose in the perinatal period, therefore the correct code to assign is:
R63.3 ***Feeding difficulties and mismanagement***

If there is documentation that the condition arose in the perinatal period (first 28 days) code **P92.9** ***Feeding problem of newborn, unspecified*** can be assigned as per **ACS 1605** ***Definitions of conditions originating in the perinatal period.***

Coding Corkboard

Victorian ICD Coding Committee activities

The contents of this page provide a brief overview of the current activities undertaken by the Victorian ICD Coding Committee (VICC). Victorian coders are welcome to contribute to any discussion highlighted here. Please contact Carla Read, Convener and Secretary Victorian ICD Coding Committee (Carla.Read@dhs.vic.gov.au) if you would like to have your views considered.

Additional diagnoses

A discussion paper submitted by DHS regarding Australian Coding Standard 0002 Additional Diagnoses was discussed at CSAC in February. As a result of this NCCH have made some commitment to amending the standard for 6th edition. The aim of the amendment will be to make the purpose of the standard clearer, and to provide additional guidance for application of the standard in certain specific situations.

Public Submissions to the NCCH

DHS have sent several public submissions to the NCCH for consideration in the development of 6th edition. Most of these submissions are in response to queries sent to the Victorian ICD Coding Committee. Public submissions will be accepted until 31st May 2006. Coders are encouraged to become involved in this process by submitted their own public submissions.

Details regarding how to submit a proposal can be found on the NCCH website at:
http://www3.fhs.usyd.edu.au/ncch/4.7.1.htm

ICD-10-AM/ACHI/ACS Fifth edition

The education package for 5th edition is available to be downloaded from the NCCH website. All coders should find the time to undertake this education before they attend the coding workshops in June. The 4th quarter newsletter will contain a summary of the significant changes in 5th edition.

The education package can be downloaded free of charge from:
http://www3.fhs.usyd.edu.au/ncchwww/site/4.4.htm#2006

The password will be sent to all Victorian registrants shortly.

Victorian ICD Coding Committee members as at April 2006

Jennie Shepheard	Human Services (Chair)
Carla Read	Human Services (Convener, Secretary)
Sara Harrison	Human Services (Victorian CSAC representative)
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Hancock	The Austin Hospital
Susan Peel	Southern Health
Maree Thorp	Peninsula Health
Kathy Wilton	3M
Diana Cheng	La Trobe University representative
Kylie Holcombe	Ballarat Health Services
Hayley Salter	The Royal Children's Hospital
Patricia Savino	The Northern Hospital
Pamela Williams	The Royal Women's Hospital

Victorian ICD Coding Committee meeting dates

Tuesday 16 May	DHS, 9:30am, 18th floor 50 Lonsdale Street, Melbourne
Tuesday 20 June	DHS, 9:30am, 18th floor 50 Lonsdale Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
ADx	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CC	Complication or Comorbidity
CCCG	Clinical Classification and Coding Groups
CCL	Complication or Comorbidity Level
CSAC	Coding Standards Advisory Committee
DHS	Department of Human Services
DRG	Diagnosis Related Group
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
LOS	Length Of Stay
MDC	Major Diagnostic Category
NCCH	National Centre for Classification in Health
PDx	Principal Diagnosis
PICQ	Performance Indicators for Coding Quality
PCCL	Patient Clinical Complexity Level
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee
WHO	World Health Organisation