

# ICD Coding Newsletter

Second quarter 2005-06

## **Distribution List**

- Health Information Manager/s (HIMs)
- Clinical Coders
- Information Technology (IT)
- Interested Others

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).

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An electronic coding query form can be completed at:

<http://hdss.health.vic.gov.au/icdcoding/codecommit/icdquery.htm>

An index to Coding Newsletters can be found at:

<http://www.health.vic.gov.au/hdss/icdcoding/newslet/qindex/index.htm>

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# Data quality

## VAED Notifiable edits update

Notifiable edits are those where the data would, in the majority of cases, be incorrect. For a very small number of episodes per year statewide, the combination of data items may be correct. The record is accepted by PRS/2 but something must be checked and possibly corrected.

If data are wrong and have been corrected, no further action is required by the hospital. However, if data are correct, hospitals will need to confirm this with HDSS. Where the data has not been corrected nor confirmed as correct, HDSS will periodically notify each hospital and ask them to do so. If data has not been corrected or the hospital has not provided a satisfactory explanation as to why the combination of data is correct, the episodes will be removed from the end of year VAED consolidated file. Public hospitals will receive no funding for removed episodes.

In early December 2005, spreadsheets of notifiable edits were sent to all hospitals. 3192 episodes triggered edits for July—November 2005 data. To date, only approximately 50 hospitals have sent responses. Between 17 November and 17 January, only 566 episodes have either been corrected, or acceptable comments regarding the validity of data provided to HDSS. This represents 18% of episodes, which is a disappointing response.

For 2005-06, some edits have been modified in order to reduce the number triggered. This would have reduced the effort required by hospital staff to check and confirm data. However, some edits are still triggering an unacceptable number of episodes and indicate a lack of understanding of PRS/2 data items or edits in some hospitals.

Below are some of the edits that have had a poor response and examples of how the edit can be avoided and the quality of data improved.

### **Codes used for billing**

A common response we receive from hospitals is that the codes reported are those used for billing purposes and therefore cannot be changed. PRS/2 reporting should not be driven by your financial systems. Hospitals should speak to software suppliers to have code mapping amended if this is an issue at your facility.

### **N192 Invalid Combination Intention to Readmit/Separation Mode**

This edit is a fatal edit, which means that the combination of data is definitely incorrect. However the data combination has been accepted to accommodate the PRS/2 logic in the update process.

When you correct the data you may find that the edit still triggers; this is because of the sequential method of processing updated E2 and X2 records in PRS/2 files. To overcome this processing issue you simply re-transmit the updated record a second time.

HDSS does not load these episodes into our notifiable database, as they must be corrected in all cases.

### **N358 Area Code Restraint**

A response has been received from only approximately a quarter of episodes triggered. The edit requires confirmation that the rare codes reported are correct. The Australian Institute of Health and Welfare requires that the Department of Human Services confirm all instances of the use of 'rare' codes.

### **N403 Qualified Newborn Without Justification**

The coding does not reflect the reason the newborn has been made Qualified. The only diagnosis code reported is Z38.0, Z38.1 or Z38.2 *Single liveborn infant*. The majority of cases will require further diagnosis codes to be reported, or the Qualification Status amended.

#### **N431 Newborn but not Newborn Accommodation**

A high number of episodes have triggered this edit, and few of them are being corrected. If the baby is less than 9 days old, then the Accommodation Type should be either C *Nursery Accommodation: NICU/SCN* or B *Other nursery accommodation or mothers bedside (rooming in)*. Newborns born in the hospital should not be reported under other Accommodation Types except in very unusual circumstances. The high number of episodes triggered indicates that some hospitals are incorrectly mapping beds to Accommodation Types and this should be referred to your software supplier.

#### **N465 Admission Duration < 15 minutes**

Some admissions under 15 minutes may be acceptable, but short admissions should always be checked to ensure they meet Admission Criteria. Refer to the current DHS Admission Policy available from our website.

<http://www.health.vic.gov.au/hdss/vaed/index.htm>

#### **N468 Not NHT, LOS > 365 Days**

A large number of episodes that trigger this edit have been separated, but a separation record has not been sent to PRS/2, or has been sent and rejected and not fixed. An update record must be sent to PRS/2, or if the episode was separated in a previous financial year a deletion record may be sent. Failure to do this will result in the episode accruing patient days and being included in the User Reconciliation Report each month. Refer to your software supplier if you having difficulties with these episodes. They **must** be corrected on the PRS/2 database as bed figures are skewed and all users of DHS data are affected. For public hospitals, these episodes will not attract any funding.

The large number of episodes triggered indicates that hospitals are not reconciling their PRS/2 using the Census Report. The Census Report lists patients that PRS/2 considers 'remaining-in' as at the end date of the PRS/2 file submitted. For example, if you send a PRS/2 file with header dates 1 December to 31 December, the Census Report will list patients remaining-in on 31 December. This should be checked against an internal bed status report for the same date, and any differences immediately corrected. If your Census Report is incorrect, then it will be impossible to reconcile your PRS/2 figures.

#### **N558 Miscellaneous Health Fund**

This edit produces a large number of episodes and highlights a general lack of understanding regarding the reporting of Health Insurance Fund. Health Insurance Fund indicates the insurance status of the patient, **not** the person or organisation paying for treatment. For example, a patient admitted for treatment covered by TAC or DVA should still be asked if they have insurance. If they do, you should report the appropriate fund code. If they do not have insurance, then report 999 *Uninsured*. The Account Class will indicate that the episode is covered by TAC or DVA.

Health Insurance Fund code 996 Miscellaneous Australian health insurance fund should **only** be used for a brand new fund for which HDSS has not yet allocated a code.

#### **N603/604 CCU/ICU Account Class, No CCU/ICU Hours**

This edit is notifiable because of the sequential method of processing E2 and X2 records in PRS/2 input files. All episodes triggered by these edits **must** be corrected.

CCU and ICU Account Classes (PX and PW) must only be reported when a patient is admitted over midnight in an approved CCU or ICU unit. Therefore, any episode with a PX or PW Account Class is expected to also have CCU or ICU hours reported.

#### **Conclusion**

Notifiable edits provide HDSS with an opportunity to review edits, but uncorrected data results in poor quality data. VAED data is not only used by DHS for funding purposes, but also for program and service planning, and a wide range of research projects. Data is also used by external agencies for research purposes. The VAED has a reputation for a high standard of quality, and HDSS is committed to ensuring that the standard is maintained, if not improved. Edit review and education form an important part of data quality improvement and we hope that hospitals will assist by reviewing episodes that trigger warning or notifiable edits and confirming that the data provided accurately reflects activity.

## List of selected ICD-10-AM coding queries

### #1988 Chronic obstructive airways disease (COAD) with asthma

I have always coded Chronic obstructive airways disease (COAD) with asthma (or emphysema) to J44.8 *Other specified chronic obstructive pulmonary disease*.

I think that at one point we were advised (I cannot find any advice to support this) that it should not be coded to J44.9 *Chronic obstructive pulmonary disease, unspecified* as this is not unspecified, therefore it should go to J44.8 *Other specified chronic obstructive pulmonary disease*.

At the beginning of J44 *Other chronic obstructive pulmonary disease* there is an inclusion note for obstructive asthma, which implies that you should use J44.9 *Chronic obstructive pulmonary disease, unspecified*.

Is this how we should be coding COAD/asthma, or is it more correct to assign J44.8? If this is the case, then there needs to be an amendment to the tabular and index.

The Victorian ICD Coding Committee referred this query to the NCCH who provided the following advice:

**J44 Other chronic obstructive pulmonary disease** is tabulated and indexed in ICD-10-AM as per ICD-10.

1. The conditions listed at the third character level at **J44 Other chronic obstructive pulmonary disease** may all be classified to the fourth character level.

That is, the listed conditions that present with an acute lower respiratory infection should be classified to **J44.0 Chronic obstructive pulmonary disease (COPD) with acute lower respiratory infection**.

Those listed conditions that present as an acute exacerbation should be listed as **J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified**.

**J44.8 Other specified chronic obstructive pulmonary disease** classifies the conditions listed at the third character level that do not state infective or acute exacerbation.

**J44.9 Chronic obstructive pulmonary disease, unspecified** is used to classify COPD without mention of asthma, emphysema or bronchitis/bronchiolitis and/or without mention of infective or acute exacerbation.

2. COPD with asthma not otherwise stated (that is, with no mention of infective or acute exacerbation) should be classified as **J44.8 Other specified chronic obstructive pulmonary disease**. The correct index pathways for this code are:

**Asthma**

- chronic

- - obstructive

or

**Asthma**

- obstructive, chronic

COPD with asthma described as an infective or acute exacerbation should be classified to one of the above codes (J44.0, J44.1) as appropriate. This advice is supported by **ACS 1008 Chronic obstructive pulmonary disease** and **ACS 1002 Asthma** that state: 'Asthma described as chronic obstructive or asthma documented with COPD should be assigned a code from J44.-'. The VICC will forward a recommendation to the NCCH for enhancements to the Index for COPD with asthma.

## #2016 Bladder washout

Should a procedure code for bladder washout be assigned when it is performed in the emergency department or on the ward (without any type anaesthesia)?

For example, patient attends emergency department, diagnosed with haematuria and clot retention. Indwelling catheter (IDC) inserted and bladder washout performed for clot retention.

Index:

### **Lavage**

- bladder (diagnostic) 11921-00 [1862]
- - for removal of blood clot(s) (closed) (endoscopic) 36842-00 [1092]
- - therapeutic, endoscopically controlled (hydrodilatation) 36827-00 [1108]

Tabular List:

36842-00 [1092] *Endoscopic lavage of blood clots from bladder*

In the index, the term 'endoscopic' is a non-essential modifier, yet in the tabular list it's in the title, which is a little off-putting, as the procedure was not performed endoscopically.

If coded without the procedure code:

R31            *Haematuria*  
N39.88        *Clot retention*

DRG L65B *Kidney + urinary tract signs and symptoms without catastrophic or severe CC* (medical DRG)(V4.2)(WIES = .4986)

If coded with the procedure code:

R31            *Haematuria*  
N39.88        *Clot retention*  
36842-00 [1092] *Endoscopic lavage of blood clots from bladder*

DRG L06B *Minor bladder procedures without catastrophic or severe CC* (surgical DRG)(V4.2)(WIES = .7034)

The assignment of this procedure code does have an impact on DRG assignment. Should it be coded if it is not performed in theatre?

The Victorian ICD Coding Committee received the following updated response from the NCCH:

A term appearing in a code title does not have to be an essential modifier in the index. This is the case with the indexing for 'lavage of bladder for removal of blood clot'. Within the classification there are some defaults and therefore some of the terms appearing in code titles will appear as nonessential modifiers in the index. This logic needs to be understood by coders when assigning codes. In the case cited the 'endoscopic' code is the default for bladder washout for removal of a blood clot. Although 'endoscopic' is a nonessential modifier in the index and a term in the code title in the tabular, this does not preclude clinical coders from assigning the code.

Following further discussion, the NCCH advises that a code should not be assigned for 'lavage of blood clots from bladder via IDC or supra pubic catheter'. However, if a code is required at a local level or the procedure is performed using anaesthesia, assign:

**36842-00 [1092] *Endoscopic lavage of blood clots from bladder***

The NCCH will consider adding this procedure to **ACS 0042 *Procedures Normally Not Coded***.

This advice overrides advice previously published in the ICD Coding Newsletter Third quarter 2004-05.



The VICC will refer this to the Commonwealth with a view to making this a non-OR procedure.

## #2039 Intraoperative computerised tomography

We wish to determine when to use the code 57341-00 [1966] *Intraoperative computerised tomography* in conjunction with surgical procedure using interventional techniques.

For example, a patient with low back pain, admitted for diagnostic dorsal root ganglion block. Injection of anaesthetic at L3 under CT guidance. At the NCCH 4th edition workshop this was an exercise scenario for the Pain Management topic. The answers included dorsal root ganglion block:

18274-02 [63] Administration of anaesthetic agent around paravertebral lumbar nerve and  
57341-00 [1966] Intraoperative computerised tomography

What is considered surgical procedure using interventional techniques? Does this include procedures without incision? Does this include injection of nerves paravertebral? We assumed surgical procedure required an incision.

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response. Their advice is reproduced below.

The NCCH agrees with the VICC interpretation for usage of intraoperative procedure codes.

'Intraoperative' procedures can include procedures performed without incision. **ACS 0016 *General Procedure Guidelines*** discusses the difficulty of distinguishing between surgical and non-surgical procedures. 'Intraoperative' procedure codes, including the following, should be assigned when performed in conjunction with any significant procedure, including traditional non-surgical procedures.

Assign codes in **block [1949] *Intraoperative ultrasound*** where an ultrasound has been performed with another procedure.

Assign codes in **block [719] *Intraoperative arteriography*** where an arteriogram has been performed with another procedure.

Assign **35200-01 [739] *Intraoperative venography*** where a venogram has been performed with another procedure.

The above advice excludes where these procedures are performed for diagnostic purposes.

The NCCH is considering amending the terminology in intraoperative procedure codes for standardisation for a future edition ofACHI.

Specifically addressing the questions in your query. A surgical procedure does not require an incision. Injection of paravertebral nerves would be considered to be a surgical procedure for the purposes of this query.

Assign intraoperative codes where a radiological procedure has been performed in conjunction with another procedure. For example:

CT guided biopsy of lung

**38412-00 [550] *Percutaneous needle biopsy of lung***

**57341-00 [1966] *Intraoperative computerised tomography***

as opposed to

CT of brain under sedation

**56001-00[1952] *Computerised tomography of brain***

## #2040 Follow-up of gastric ulcer

I would like to bring your attention to Example 2 in ACS 2113 *Follow-Up Examinations For Specific Disorders*.

Patient admitted for follow-up of gastric ulcer (treated with medication). The example directs coders to assign Z09.8 *Follow-up examination after other treatment for other conditions*.

I would suggest that in light of a code name change in 4th Edition a more appropriate code would be:

Z09.2 *Follow-up examination after pharmacotherapy for other conditions*

The Victorian ICD Coding Committee referred this query to the NCCH for information and advice.

The NCCH agrees with the suggestion to amend example 2 in **ACS 2113 *Follow-Up Examinations For Specific Disorders***.

The NCCH will amend the example for a future edition of the ACS.

## #2054 Discharge/Transfer in Labour

Does the criteria in ACS 1550 *Discharge/Transfer in labour*, apply to admission or discharge gestation?

Patient admitted at 36 weeks gestation in labour. Due to lack of beds in post natal ward and nursery patient transferred to another hospital the next day for further care (now 37 weeks gestation).

If the criteria were for gestation on discharge then a code from Z34 *Supervision of normal pregnancy* would be assigned.

However, if the criteria were for admission gestation then the correct code to assign would be O60 *Preterm delivery*.

ACS 1518 *Duration of pregnancy*, refers to duration of pregnancy on admission. This standard would also have to be followed when assigning O60 *Preterm delivery*, and it seems inappropriate to assign one code based on duration of pregnancy on discharge (Preterm labour) and the corresponding code based on duration of pregnancy on admission (Duration of pregnancy).

The Victorian ICD Coding Committee sought advice from the NCCH when preparing this response.

For the case cited, follow the index pathway(s):

**Contractions**

- preterm without delivery O60

or

**Labour**

- early onset (before 37 completed weeks of gestation) O60

or

**Pregnancy**

- complicated by

- - onset of contractions before 37 weeks of gestation

Assign the following codes:

**O60** *Preterm delivery*

**O09.5** *34-36 completed weeks*

Gestation at the onset of labour, as opposed to gestation at admission is used for determining appropriate code assignment.

**O60 Preterm delivery** is assigned when the onset of delivery (that is, the commencement of labour/contractions) is before 37 completed weeks of gestation, as in the case cited.

The absence of a code from **Z37 Outcome of delivery** in the code string indicates that the patient did not deliver during this episode of care.

Note that in Fifth Edition the title of this code will be *Preterm labour* with three new codes denoting *without delivery*, *with preterm delivery* and *with term delivery*.

## #2057 Diagnosis sequencing in cystic fibrosis

Patient with elective admission for Nissen Fundoplication. Patient has cystic fibrosis (CF) with GORD. The operation report states diagnosis as CF, severe reflux oesophagitis. Operation performed was laparoscopic Nissen Fundoplication. This patient also has bronchiectasis with pseudomonas treated during this admission.

If the GORD is sequenced as principal diagnosis this case groups to G03B *Stom, Oesophal, Duodenal Pr No Mal +C/S CC*, with WIES of 4.4602.

If CF with other manifestations (E84.8) is sequenced as principal diagnosis, this case groups to 901Z *Ext OR Proc unrel to PDX*.

Can CF with Intestinal manifestations (E84.1) be sequenced as principal diagnosis? If this is done, the case groups to G03B *Stom, Oesophal, Duodenal Pr No Mal +C/S CC*.

If Standard 0402 *Cystic Fibrosis* is followed, E84.8 should be principal diagnosis.

We thought it might be better to treat CF a bit like diabetes, and if the reason for admission is to treat one particular manifestation, that the CF code for that be sequenced as principal diagnosis and then the multiple code be sequenced further down in the string. This would then allow this to group to the gastrointestinal DRG.

The Victorian ICD Coding Committee referred this query to the NCCH who provided the following advice:

For the case cited, assign:

**E84.1 Cystic fibrosis with intestinal manifestations**

**K21.0 Gastro-oesophageal reflux disease with oesophagitis**

Thank you for your suggestions for reviewing the coding of cystic fibrosis. The NCCH will consider amendments for a future edition. In the interim, advice for your specific concerns is as follows:

- Q. Does intestinal include gastrointestinal?
- A. The NCCH will present a submission to the WHO Update Reference Committee to determine whether 'gastrointestinal' manifestations of cystic fibrosis should be classified to **E84.1 Cystic fibrosis with intestinal manifestations**. In the interim, the NCCH supports the classification of 'gastrointestinal' manifestations as per 'intestinal' manifestations of cystic fibrosis. For classification purposes this is the best fit available in **E84 Cystic fibrosis**.
- Q. Should consequences of manifestations always be coded or only if they meet **ACS 0002 Additional diagnoses**?

- A. **ACS 0402 Cystic Fibrosis** advises that; 'Cystic fibrosis should be coded with the appropriate code from **E84 Cystic fibrosis** followed by a code for any specified manifestation'. That is, whenever cystic fibrosis is coded for an episode of care, all specified manifestations should also be coded.
- Q. Clarify note in **ACS 0402 Cystic Fibrosis** that .8 is used for cases with combined manifestations.
- A. The NCH supports the guidelines in **ACS 0402 Cystic Fibrosis; E84.8 Cystic fibrosis with other manifestations** should be assigned for cases with combined manifestations.
- Q. Should these be coded out?
- A. As per the advice in **ACS 0402 Cystic Fibrosis**, a code for any specified manifestation should follow a code from **E84 Cystic fibrosis**. This advice is further supported by **ACS 0027 Multiple Coding** that advises multiple codes may need to be assigned to reflect the various components of a disease and to ensure that the entire medical concept is captured.
- Q. Once cystic fibrosis needs to be coded, should all manifestations be coded whether they meet criteria for coding or not?
- A. As per the advice above, whenever cystic fibrosis is coded for an episode of care, all specified manifestations should also be coded.

The VCC interpretation of the response is that you can code the specific manifestation (in this case .1) followed by other manifestations (.8) if the specific manifestation (in this case .1) is the reason for the admission.

CF patients are living longer and developing new manifestations of the disease that didn't occur previously when patients had a shorter life expectancy. This is an example where the classification is not managing to keep up with clinical practice.

The VCC will develop a public submission seeking review of the manifestations of cystic fibrosis for the ACS.

## #2066 Ca

Does Ca mean cancer or carcinoma? Unfortunately both have different M codes and so would be coded differently.

In the index under cancer there is a note that says, "The term 'cancer' when modified by an adjective or adjectival phrase indicating a morphological type, should be coded in the same manner as 'carcinoma' with that adjective or phrase. Thus, 'squamous cell cancer' should be coded in the same manner as 'squamous cell carcinoma', which appears in the list under 'carcinoma'.

Our hospital would like to be consistent between coders. So when Ca is written and no descriptive word as detailed above, we all know whether to code as cancer or carcinoma.

The following advice was published in Coding Matters Volume 12 Number 3 December 2005:

The NCCH was asked to clarify whether the abbreviation 'Ca' should be interpreted as 'cancer' or 'carcinoma'. The NCCH was also asked which morphology code to assign when the abbreviation 'Ca' is used in the absence of any other defining documentation in a medical record.

Clinicians, cancer registries and various medical dictionaries have all indicated that 'Ca' can be used interchangeably to mean 'cancer' or 'carcinoma'. On further review of the use of this abbreviation,

WHO ICD-10 indicates that the term 'cancer' when modified by an adjective or adjectival phrase indicating a morphological type should be coded in the same manner as 'carcinoma' with that adjective or phrase. Thus, 'squamous cell cancer' should be coded in the same manner as 'squamous cell carcinoma', which appears in the list under 'Carcinoma' (ICD-10-AM Fourth Edition Alphabetical Index of Diseases).

If the term 'cancer' is preceded by a term other than a morphological descriptor, assign the morphology code M8000/3 Neoplasm, malignant. Therefore, if prostate Ca is documented without any available histology report or clinical clarification, assign M8000/3 Neoplasm, malignant.

Inconsistencies in classification examples in the Australian Coding Standards (ACS) will be amended for ACS Fifth Edition.

This advice overrides advice previously published in the ICD Coding Newsletter Third quarter 2004-05.

## #2068 Flexion deformity

There appears to be errors in the index that were identified by our coders in a recent education session:

Flexion, deformity joint, hip congenital Q65.8  
Deformity, flexion (joint), hip, congenital Q65.9

Also the default appears incorrect for:

Flexion, deformity joint, M21.29  
Deformity, flexion (joint), M21.2x

The Victorian ICD Coding Committee forwarded this query to the NCCH for advice who provided the following response:

Thank you for bringing this issue to the attention of NCCH. The NCCH will consider amending the highlighted areas in the Alphabetic Index of Diseases.

## #2084 Pharmacotherapy via portacath

Many patients receive their pharmacotherapy intravenously via Port access (Port-A-Cath). From a clinical treatment perspective, this procedure is virtually identical to patients receiving IV pharmacotherapy via a peripheral or centrally inserted catheter (Hickmans or PICC). The difference being that the IV is connected to the Port, rather than an external catheter. Pharmacotherapy via Port access takes just as long as that via a peripheral or central catheter, as the patient remains in hospital until the IV protocol is completed. This is unlike loading of a Port, which takes only a matter of minutes.

In 3rd edition ICD-10-AM, the choices for Chemotherapy were:

**Chemotherapy** 90768-00 [1780]

-intravenous (> 1 hour) 13915-00 [1780]

--> 1 and < 6 hours 13918-00 [1780]

--> 6 hours 13921-00 [1780]

or

**Loading (of)**

-device

--drug delivery (infusion pump)

---external (ambulatory) (CADD) (Infusor) 13942-00 [1780]

---implantable (reservoir) 13939-00 [1780]

Intravenous chemotherapy via Port access would have been coded to 13915-00 [1780], as the only way to get to code 13939-00 [1780] was to look-up "Loading" in the index, and these patients were not having their Port loaded.

However, with the introduction of 4th edition, the 'excludes' notes at 96199-xx and 96204-xx, excludes administration of a pharmacological agent via an implantable infusion device or pump (a Port being an implantable infusion device), and directs the coder to 13939-00 [1921] *Loading of implantable infusion device or pump*

96204-00 Administration of pharmacological agent via external vascular catheter, antineoplastic agent

Administration of pharmacological agent via:

Administration of pharmacological agent via:

- Broviac } catheter
- central venous }
- Cook } catheter
- Groshong }
- Hickman }
- Permacath }
- PerQCath }
- PICC }

**Excludes:** administration of pharmacological agent via:

- ambulatory drug delivery device (13942-00 [1921])
- implantable infusion device or pump (13939-00 [1921])
- peripheral catheter (96199 [1920])
- surgical catheterisation with administration of pharmacological agent (see block [741])

13939-00 Loading of implantable infusion device or pump

Refilling of implantable infusion device or pump

**Includes:** maintenance such as:

- flushing
- injection of isotope to test pump
- withdrawing sample of fluid for culture

Patients receiving IV pharmacotherapy via Port access are NOT having their implantable infusion device loaded/refilled, however the 'excludes' note is directing coders to this code.

Procedure code 13939-00 is derived from MBS item 13939 IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies.

MBS item 13939 is listed on the Commonwealth Type C list (procedures not normally requiring hospital treatment).

Intravenous chemotherapy MBS items are listed on the Commonwealth Type B list (procedures normally requiring hospital treatment that does not include part of an overnight stay). Procedure codes 96199-00 and 96204-00 are mapped to 13915-00, which was derived from MBS item 13915 (Type B procedure).

I would like to propose that consideration be given to altering the procedure classification to reflect the clinical practice of IV pharmacotherapy via Port access.

The alternatives are:

1. Classify IV pharmacotherapy via Port access to 96204-xx.
2. Create a new code for IV Pharmacotherapy via Port access if there is a need to classify IV pharmacotherapy via Port access separately to IV pharmacotherapy via external (central) venous catheter.

I do not believe ACS 0045 *Drug delivery devices* requires any change, as the relevant section relates to LOADING of drug delivery devices and these patients are not having their drug delivery device loaded:

**Loading of a drug delivery device**

When the procedure involves loading of medication into a drug delivery device (external or implantable infusion pump) alone (ie the drug delivery device has been connected or inserted in a previous episode of care) assign the appropriate code from block [1921] Loading of drug delivery device:

13939-00 [1921] Loading of implantable infusion device or pump

13942-00 [1921] Loading of ambulatory drug delivery device

The Victorian ICD Coding Committee referred this query to the NCCH who provided the following response:

The NCCH agrees that IV chemotherapy via portacath is not the same as loading of the device.

Where IV chemotherapy is performed via portacath, assign:

**96204-00 [1920] *Administration of pharmacological agent via external vascular catheter, antineoplastic agent.***

The NCCH is aware that the above advice is in conflict with the term 'external' in the code title of **96204-xx**, but considers this the best code available to classify the procedure performed. The NCCH will consider amending this area of ACHI for a future edition. A Coding Matters article will be published in the interim to clarify these classification issues.

## #2088 Balloon test occlusion

Patient admitted with chronic headaches. Has a history of aneurysm of cavernous right ICA. The patient undergoes a Balloon Test Occlusion. This involves a balloon being inflated in the artery to see if the patient is suitable for an occlusion of the aneurysm.

We have coded this to:

90222-00 [720] Other procedure on arteries

60009-00 [1992] Digital subtraction angiography of head and neck,  $\geq$  10 data acquisition runs

60078-00 [1998] Digital subtraction selective arteriography or venography, 3 vessels

This will group to B04A *Extracranial Vascular Pr+ CSCC*

Are these the best codes to assign?

The Victorian ICD Coding Committee agrees that a balloon test occlusion would be coded as a transcatheter embolisation of a blood vessel with addition of angiogram codes as appropriate.

Coding Matters, Volume 6 Number 2 advised:

Transcatheter embolisation of blood vessels is performed to therapeutically block or occlude blood vessels. This may be performed to arrest a haemorrhage, treat vascular anomalies such as arteriovenous malformations (AVM) or fistulas or to block blood supply to a tumour. Embolisation can also be performed as a precursor to surgery, such as excision of tumour or clipping of AVM, as embolisation reduces the risk of haemorrhage or infarct.

The technique involves the delivery of an agent or device through a small catheter and is generally performed in X-Ray departments or catheter laboratories. Many agents or devices can be used to occlude blood vessels:

- Sponges—gelatin (Gelfoam) or plastic (polyvinyl alcohol)
- Balloons
- Ethanol
- Glue
- Silastic pellets

Assign the following codes:

**35321-00 [767] *Transcatheter embolisation of blood vessel***

and a code for the intraoperative arteriogram.

## #2150 Pathological crush fracture due to fall with osteoporosis

Could you please inform us on how we should code Pathological crush # due to fall, with osteoporosis.

We have thought to code:

M80.9x Osteoporosis with pathological fracture with the external cause codes W19 Unspecified fall Y92.9 Unspecified place of occurrence and U73.9 Unspecified activity. Or do we code the trauma site code (as principal diagnosis) with the external cause codes?

The Victorian ICD Coding Committee agrees with the enquirer's code selection. In this scenario the correct principal diagnosis to assign is:

**M80.9x *Osteoporosis with pathological fracture***

External cause code are not routinely required but may be assigned if you have documentation of a fall or other injury.



## #2075 Postural Orthostatic Tachycardia Syndrome

22 year old female admitted with a diagnosis of Postural Orthostatic Tachycardia Syndrome (POTS).

There is no index entry for this syndrome. Following ACS 0005 *Syndromes* we are instructed to code out the symptoms.

We have assigned:

I47.1 *Supraventricular tachycardia*

G98 *Other disorders of nervous system, not elsewhere classified*

R55 *Syncope and collapse*

Is this the best way to code this patient? Also, would it be possible to refer this to the NCCH seeking a code and index entry for this syndrome?

The Victorian ICD Coding Committee referred your query for a new ICD-10-AM code to the NCCH.

The NCCH agrees that postural orthostatic tachycardia syndrome should be classified by following the guidelines in **ACS 0005 *Syndromes***.

## #2176 Coding of Digital Subtraction Angiography

Please advise if we code out Digital Subtraction Angiography (DSA) with all other procedures. For example, coding of percutaneous angioplasty/ insertion stent left iliac artery with DSA 1 run. In addition to coding 35309-06 [754] *Percutaneous transluminal balloon angioplasty with stenting, single stent* do we code:

60048-00 [1996] *Digital subtraction angiography of lower limb, ≤ 3 data acquisition runs, unilateral*  
or

35200-00 [719] *Intraoperative arteriography*

or

do we not code the DSA at all?

A DSA performed with another interventional procedure (as described in the query) should be coded as an intraoperative angiography.

If the DSA is performed for diagnostic purposes, and then the procedure proceeds to include intervention, for example DSA performed and proceeds to embolisation, the DSA should be coded as a diagnostic and not an intraoperative angiogram.

## #2177 Grouping of ORIF of fractured sternum

23 year old male admitted following MVA with fracture sternum and fracture nose. Patient was taken to theatre for ORIF fractured sternum under general anaesthetic.

Codes assigned:

S22.2 *Fracture of sternum*

S02.2 *Fracture of nasal bones*

and appropriate external cause, place of occurrence & activity codes

47467-00 [1377] *Open reduction of fracture of sternum*

and appropriate anaesthetic codes

This groups to DRG 901Z *Extensive OR Procedure unrelated to Principal Diagnosis*.

I have checked the AR DRG Version 5.0 Definitions Manual and this DRG is not one allocated to this diagnosis code S22.2 = E66A, E66B, E66C, W61Z, pg 103, Vol 3 or procedure code 47467-00 [1377] = I12A, I12B, I12C, I28A, I28B, pg 190, Vol 3.

The Victorian ICD Coding Committee has forwarded this to the Commonwealth for investigation.

DRG 901Z is not listed beside codes in Appendix B of Volume 3. To access codes that will group to 901Z when mismatched with principal diagnosis, refer to Functions, Unrelated OR procedure on page 383 of volume 2 of the AR-DRGs Definitions Manual.

## #2178 PTP implants™

Further to NCCH Q2010 regarding PTP implants™.

The above procedure is performed at our facility for the repair of either internal sphincter dysfunction or internal anal sphincter (IAS) dysfunction. Both diagnoses refer specifically to sphincter dysfunction of which both result in faecal incontinence.

I would like to suggest that a more appropriate procedure code would be:

**Repair**

-anus, anal

--sphincter(direct)(for anal fissure)(for anal incontinence) 32126-00 [940].

This groups to G11B *Anal & Stomal Procedures – CSCC*, which I believe is an appropriate DRG assignment for this procedure.

A query response on the NCCH database provides guidance for coding PTP implants™. Response to NCCH Q2010 advises:

The procedure cited should be classified as follows:

**90316-00 [942] Other procedures on anus**

In the interests of data consistency, please follow this advice.

Note that this procedure is not a repair of the anus, rather is bulking up of the muscle.

## #2180 Documentation of codes on operation report

We have a dentist who operates at our theatre suite and for all his patients, he documents the actual ACHI procedure code that are performed, for example, 97323-00 x 2, and 97311-00 x 2.

Would you require actual documentation of surgical removal of a tooth or is documentation of the ICD-10-AM procedure code adequate to assign the codes?

Yes, documentation of surgical removal of tooth is required.

**ACS 0010 General Abstraction Guidelines** states 'Before coding any diagnosis/procedure recorded, the clinical coder must verify information recorded on the front sheet by reviewing pertinent documents in the body of the clinical record.'

Likewise your documentation must support any code assignment by a clinician.

## #2182 ACS 0110 Septicaemia

A one month old male patient presents with fever (38.9) and irritability (HR 120bpm). The patient was admitted with initial notes indicating a 'probable UTI'. A full septic work up was completed. Results from this indicated a UTI, which grew enterobacter, and klebsiella species (sensitive to Gentamicin) CSF culture was negative. The patient was treated with antibiotics and discharged 4 days later.

According to the information provided in the medical record, we would have coded the case as:

N39.0 *Urinary tract infection, site not specified*

B96.1 *Klebsiella pneumoniae [K. pneumoniae]* as the cause of diseases classified to other chapters

B96.88 *Other and unspecified bacterial agents* as the cause of diseases classified to other chapters

However on reading ACS 0110 *Septicaemia* we are slightly confused. According to the standard the definition of SIRS is manifested by two or more of the following:

- Temperature >38 C or <36 C
- Heart rate >90 beats/min
- Respiratory rate >20 breaths/min or PaCO<sub>2</sub> of <32 torr (4.3 kPa)
- Leukocyte count >12,000 cells/mm<sup>3</sup>, <4,000 cells/mm<sup>3</sup> or >10% immune (band forms)

This patient has both a high temperature and a high heart rate (per min). Does this mean this patient meets the definition of SIRS and we can code it to Sepsis?

We are having trouble interpreting this standard as many of our patients presenting with fever have a septic workup, however final diagnosis is often UTI. Most have a high temperature and are treated with IV antibiotics. How does ACS 0108 *Sepsis secondary to UTI/Urosepsis* also come into play here?

A patient must have documentation of SIRS or sepsis for this to be coded. Definition information in the ACS is provided for information only, and not for diagnostic purposes. Coders should follow the information in the 'Classification' section of the ACS.

## #2183 CHARGE Association

We have a small number of patients who have CHARGE Association (also known as CHARGE Syndrome). CHARGE Association: Choanal Atresia, Posterior Coloboma, Heart defect, choanal Atresia, Retardation, Genital and Ear anomalies.

CHARGE Association refers to children with a specific set of birth defects. 'CHARGE' originally came from the first letter of some of the most common features seen in these children:

C = coloboma  
H = heart defects  
A = atresia of the choanae  
R = retardation of growth and development  
G = genital and urinary abnormalities  
E = ear abnormalities and/or hearing loss

Each time one of these patients is admitted to our hospital we are unsure of how to best code the CHARGE Association when it meets the definition of additional diagnosis. Should we code out all of the conditions to fully capture the syndrome (which would be quite lengthy) or can it be captured through Q87.89 Other specified congenital malformation syndromes, not elsewhere classified?

Over the ICD editions, the congenital malformation chapter has been greatly improved and expanded with many conditions being classified into their own codes. Could consideration be given for a code to be created for CHARGE Association?

**ACS 0005 Syndromes** advises to code **Q87.89 Other specified congenital malformation syndromes, not elsewhere classified** in addition to the components/manifestations of the specific syndrome. The standard allows for only coding the component/manifestation that is receiving treatment with Q87.89 if desired.

The Victorian ICD Coding Committee suggests that you prepare a public submission to request a new code for CHARGE Association for the next public submission period. Submission guidelines can be found at:

<http://www3.fhs.usyd.edu.au/ncch/4.7.1.htm>

## #2184 Grouping of ORIF of infraorbital ridge

The following combination of codes has grouped to 901Z *Extensive OR Procedure unrelated to Principal Diagnosis*.

Patient presents with a fractured orbital margin and underwent an open reduction with internal fixation of the infraorbital ridge. Codes assigned:

S02.8 *Fractures of other skull and facial bones*  
and appropriate external cause codes

45590-00 [1716] *Reconstruction of orbital cavity*  
and GA code.

The Victorian ICD Coding Committee has forwarded this query to the Commonwealth for consideration of allocating the code to MDC 1.

## #2186 Nerve conduction studies

An admitted patient had a number of investigations, including electromyography and nerve conduction studies on a number of nerves in the patient's arm. Should nerve conduction studies be coded?

ACS 0042 *Procedures Normally Not Coded* includes Electromyography (EMG). Therefore, we would not code the electromyography. However, there is no mention in the ACS of nerve conduction studies.

Block [1826] Neuromuscular electrodiagnosis inclusion terms are:

EMG [electromyography]:

- of  $\geq 1$  muscle(s)
- using concentric needle electrodes Study of neuromuscular conduction

The block includes codes for electromyography, conduction studies and for conduction studies with electromyography.

It seems anomalous to code nerve conduction studies, as this would entail giving a code for nerve conduction studies alone when in fact they may have been performed in conjunction with electromyography, which ACS 0042 *Procedures Normally Not Coded* directs us not to code.

If an EMG is performed by itself, this would not normally be coded. When performed with a nerve conduction study, this can be coded, following index entry:

### Study

-conduction

--nerve

---1 nerve 11012-01 [1826]

----with electromyography 11012-02 [1826]

----repetitive 11021-01 [1826]

-----with quantitative computerised analysis electromyography 11021-02 [1826]

---2 or 3 nerves 11015-00 [1826]

----with electromyography 11015-01 [1826]

----repetitive 11021-01 [1826]

-----with quantitative computerised analysis electromyography 11021-02 [1826]

--- $\geq 4$  nerves 11018-00 [1826]

----with electromyography 11018-01 [1826]

----repetitive 11021-01 [1826]

-----with quantitative computerised analysis electromyography 11021-02 [1826]

---single nerve fibres and muscles

----with electromyography 11018-02 [1826]

## #2187 Repositioning of pacemaker generator

Patient admitted for repositioning of pacemaker generator.

Cardiology advised this procedure is rarely performed but this patient was severely emaciated and the generator protruded on the chest wall.

We have looked under several terms, for example reposition, adjustment, relocation. The generator was not removed or replaced. There is a code:

38524-02 [656] *Adjustment of automatic defibrillator generator*

From the operation report provided, the Victorian ICD Coding Committee noted that this procedure seems to be an adjustment of the skin pocket.

Therefore in this scenario assign:

**90219-00 [663] *Revision of skin pocket***

## #2189 Transferred neonates and ACS 1618 Prematurity and low birth weight

I seek clarification on advice given in query #1720 Transferred Neonates and information given in ACS 1618 Prematurity and Low Birth Weight.

In the scenarios documented in query #1720 I would have thought that Z51.88 *Other specified medical care* could not be used for Scenario 1 and 3 as the admission weight was only 1510g and the standard states that you only use Z51.88 "if the infant is > 28 days old AND >= 2500g on admission". Otherwise you would use the prematurity code as the principal diagnosis.

I am not sure that I understand the standard if the coding scenarios given in #1720 are correct.

If I am reading the standard correctly how do I code the following scenario:

Babe born at Hosp A at 640g and 25 weeks gestation. Transferred to Hosp B for NICU. Transferred back to Hosp B 6 weeks later, documented as prematurity requiring ongoing SCN.

If I code as directed in ACS 1618 *Prematurity and low birth weight* with prematurity and low birth weight codes reflecting those at birth I get DRG 963Z *Neonatal diagnosis not consistent with age/weight*. Yet I don't feel that I can code Z51.88 as although the baby is over 28 days, it still weighs under 2500g.

The response to query #1720 was published in the May 2002 ICD Coding Newsletter, before the development of **ACS 1618 *Prematurity and Low Birth Weight***.

Therefore coders should apply **ACS 1618** and no longer refer to query #1720.

## #2192 Same day coronary angiograms principal diagnosis selection

I would like some coding advice regarding principal diagnosis selection for same day coronary angiograms.

Example 1:

Patient has a history of chest pain and a diagnostic coronary angiogram reveals 60% CAD for medical management. Should the principal diagnosis be the chest pain or the CAD?

Example 2:

Patient admitted for a diagnostic coronary angiogram for a positive stress test. Angiogram results revealed 60% CAD for medical management. Should the principal diagnosis be the positive stress test or the CAD?

We have asked various hospitals and have been given differing opinions.

I have referenced ACS 0046 *Diagnosis selection for same day endoscopy*, which talks about same day endoscopy admissions. If a causal link is established then the symptom should not be coded. If a causal link is ruled out then the symptom should be coded as principal diagnosis. If a causal link is neither established nor ruled out then we need to apply the clinical coders creed (which I feel could lead to differing opinions).

NCCH query Q1308 where a patient admitted for investigation of chest pain has undergone an angiogram, which revealed coronary artery disease advises:

Based on the information that you have provided, it appears that coronary artery disease was established on angiogram; therefore this should be the principal diagnosis (please assign a relevant code from category 'I25.1- Atherosclerotic heart disease'). The chest pain does not need to be coded because a more definitive diagnosis (i.e. coronary artery disease) was established (see instructions for coding symptoms and signs in ACS 0001 PRINCIPAL DIAGNOSIS and ACS 1802 SYMPTOMS AND SIGNS and instructions for assignment of the underlying condition as principal diagnosis in ACS 0001).

The Victorian ICD Coding Committee noted that because this is not an endoscopy, **ACS 0046 *Diagnosis selection for same day endoscopy*** does not apply.

## #2197 ACS 0020 Multiple/Bilateral Procedures and ECT

My query relates to Standard 0020 - Multiple/Bilateral Procedures.  
In section (b) of the 'exceptions' the Standard instructs coders to have one code assigned 'per OPERATIVE episode'.

As multiple administrations of ECT are each performed in different OPERATIVE episodes, but often within the one PATIENT episode, strict adherence to the Standard would suggest a coder should assign 93340-02 [1907] Electroconvulsive therapy [ECT] <=12 treatments at each OPERATIVE episode (followed by the anaesthetic code), rather than once for the PATIENT episode, followed by the anaesthetic code(s) for each OPERATIVE encounter.

Example:

Patient presents with severe depressive episode without psychotic symptoms and receives 4 treatments of ECT within the current admission, before separation for further same day ECT to complete the course.

Current method of recording:

F32.20 Severe depressive episode without psychotic symptoms  
93340-02 [1907] Electroconvulsive therapy [ECT] <= 12 treatments  
92514-99 [1910] General anaesthetic  
92514-99 [1910] General anaesthetic  
92514-99 [1910] General anaesthetic  
92514-99 [1910] General anaesthetic

Following Standard 0020 – Multiple/Bilateral procedures:

F32.20 Severe depressive episode without psychotic symptoms  
93340-02 [1907] Electroconvulsive therapy [ECT] <=12 treatments  
92514-99 [1910] General anaesthetic  
93340-02 [1907] Electroconvulsive therapy [ECT] <=12 treatments  
92514-99 [1910] General anaesthetic  
93340-02 [1907] Electroconvulsive therapy [ECT] <=12 treatments  
92514-99 [1910] General anaesthetic  
93340-02 [1907] Electroconvulsive therapy [ECT] <=12 treatments  
92514-99 [1910] General anaesthetic

Could you please clarify the correct method of reporting multiple episodes of ECT within the same patient episode?

The NCCH has previously published information regarding the number of episodes of ECT in Coding Matters Volume 7, Number 2. This information overrides **ACS 0020 Multiple/Bilateral procedures**.

The Victorian ICD Coding Committee has forwarded this query to the NCCH for consideration of removing ECT from the example box in part (b) of ACS 0020 and incorporating the advice in Coding Matters into the Classification by creating a separate category for ECT in ACS 0020 or creating a specialty standard for ECT.



## #2198 Coding of ECT

If a patient is assessed as requiring a course of ECT exceeding 12 treatments, but receives (say) six treatments during one admitted episode, and then is separated to continue the course by a series of same day admissions, should the ECT code be that for less than (or equal to) 12 treatments, as the patient has not received twelve treatments within any one episode, or should the code reflect the intention to administer a course exceeding twelve treatments?

The Victorian ICD Coding Committee advises to code according to the number of ECT treatments administered in the episode. It is not correct to code what is planned for future treatments.

## #2199 Encysted hydrocele

I have been trying to code an encysted hydrocele in a three year old female. I have looked at NCCH Q1046, but I do not seem to be able to rectify my problem. I have coded:  
N43.0 *Encysted hydrocele*  
30614-02 [990] *Repair of inguinal hernia, unilateral*  
but this gives a DRG of 960Z. I have also tried N94.8 *Other specified conditions associated with female genital organs and menstrual cycle* but this gives an age code warning, and allocates DRG 902Z.

As this patient is female, it is appropriate to follow the index for female as follows:

**Hydrocele** (spermatic cord) (testis) (tunica vaginalis) N43.3

-canal of Nuck N94.8

-congenital P83.5

-encysted N43.0

-female NEC N94.8

**N94.8 *Other specified conditions associated with female genital organs and menstrual cycle***

The Victorian ICD Coding Committee has forwarded a proposal for modification of the grouper to the Commonwealth.

## #2202 Fever, dehydration and hyponatraemia

7 month old male admitted with fever. Final diagnosis is listed as 'fever, no clear focus'.

On examination, the patient is noted to have mild dehydration. Urea/electrolyte/creatinine tests performed and hyponatraemia is documented.

The patient's treatment was to perform bloods (FBE, Urea/electrolyte/creatinine, BC, CRP), urinalysis and give paracetamol.

Can I code the dehydration and hyponatraemia and can you please explain why or why not.

We are of different opinions as to whether there has to be something specifically done for these conditions to code them as per ACS 0002 *Additional Diagnoses* or whether ACS 0001 *Principal Diagnosis* applies as they are all conditions responsible for occasioning the episode of care.

Documentation must support coding these conditions either as:

- Two or more conditions that equally meet the definition of principal diagnosis; or
- **ACS 0002 *Additional diagnoses***

If there is no documentation in the record that supports coding as either of these, then the conditions cannot be coded.

Based on the information provided, the fever is the principal diagnosis. Dehydration and hyponatraemia do not meet additional diagnosis criteria and therefore are not coded.



## 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](mailto:Carla.Read@dhs.vic.gov.au)) if you would like to have your views considered.

#### **Coding queries**

2005 was an extremely busy year for the Committee, which resolved 113 queries. Of those, many queries have been referred to the Commonwealth for consideration of changes to the grouper and several queries have resulted in the Committee making recommendations to the NCCH for changes to future editions of the ICD-10-AM/ACHI/ACS.

There are currently 34 queries awaiting feedback from the NCCH.

#### **Additional diagnoses**

The Additional diagnoses discussion is continuing at the State and National levels. A Victorian paper outlining the issues and recommendations for future directions has been forwarded to the Coding Standards Advisory Committee (CSAC) and the Statistical Information Management Committee (SIMC).

#### **Public Submissions to NCCH**

The NCCH will be receiving public submissions for modification to ICD-10-AM from 1 March 2006 to 31 May 2006. The Committee is currently working on several submissions. All coders are encouraged to participate in the process if you have suggestions for modifications or improvements to the classification.

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 NCCH is now accepting orders for ICD-10-AM/ACHI/ACS Fifth edition. For details see the NCCH website at:

<http://www3.fhs.usyd.edu.au/ncch/8.12.htm>

## ICD-10-AM/ACHI/ACS Fifth edition implementation coding workshops

HDSS has negotiated with the NCCH to provide fifth edition implementation coding workshops for 300 Victorian coders, a substantial increase on previous years. As DHS is committed to coding and data quality, DHS will be funding these workshops for Victorian coders.

The following workshops have been scheduled:

<b>Melbourne (1)</b>	Monday 19 June
<b>Melbourne (2)</b>	Tuesday 20 June
<b>Geelong</b>	Wednesday 21 June
<b>Traralgon</b>	Friday 23 June
<b>Melbourne (3)</b>	Monday 26 June
<b>Melbourne (4)</b>	Tuesday 27 June
<b>Melbourne (5)</b>	Wednesday 28 June
<b>Shepparton</b>	Thursday 29 June
<b>Bendigo</b>	Friday 30 June

Registration forms for these workshops will be provided with the next edition of *Coding Matters* scheduled for distribution in March. Coders should register early as it is envisaged that places in these workshops will be in demand. To ensure an appropriate audience, registrations will only be accepted from HIMs and clinical coders where coding forms a significant part of their workload. Hospitals are requested to register no more than three coders per hospital however are welcome to provide a 'waiting list' of coders who are not in the initial three. Additional places will be offered after the registration closing date (in order of registration) if these are available.

Attendance at these workshops is optional. Educators will reinforce some of the major changes to the classification and there will also be the opportunity to complete coding exercises to further highlight these changes.

A pre-requisite for attendance at these workshops will be the completion of the Fifth edition education package that will be made available for downloading from the NCCH website prior to the workshops.

Coders are strongly encouraged to take advantage of this DHS funded education.

## Call for expressions of interest in membership of the Victorian ICD Coding Committee

There is currently a vacancy on the Victorian ICD Coding Committee. Health Information Managers and Clinical Coders are invited to express interest in serving on this important Department of Human Services committee. The selection criteria and the obligations for membership are set out below.

### **Criteria for Coding Committee membership-Coder members:**

1. Hold an undergraduate qualification in Health Information Management or Medical Record Administration or a qualification in Clinical Coding.
2. Have graduated at least three years ago.
3. Be currently employed in and have at least two year's work experience in a position or positions where coding comprises a significant part of the work.
4. Have completed the most recent ICD-10-AM upgrade education package.

### **Obligations of Victorian ICD Coding Committee-Coder members:**

- Accept appointment for a two-year period (dependant on continuing work with ICD-10-AM or related areas). The Convener of the committee will review membership annually.
- Attend at least most of the monthly meetings (duration approximately five hours) at the Department and, when unable to attend a meeting, shall notify an apology to the Secretary.
- Before the meeting, work through agenda papers, particularly consulting specialist clinicians where appropriate. Shall consult any specialist reference material available to the coder, as appropriate. Shall bring to the meeting proposed answers to queries. If unable to attend, shall provide comments (by email) on agenda items, particularly any falling in the specialist area of that representative.

If you are interested in serving on the Coding Committee and meeting the criteria listed above, please send a relevant CV to arrive by Friday 17 March 2005 to:

Carla Read  
Convener, Victorian ICD Coding Committee  
Health Data Standards and Systems Unit  
Department of Human Services  
GPO Box 4057  
Melbourne Victoria 3001  
[carla.read@dhs.vic.gov.au](mailto:carla.read@dhs.vic.gov.au)

## Victorian ICD Coding Committee members as at December 2005

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
Leanne Stokes	Beachplace Pty Ltd
Maree Thorp	Peninsula Health
Kathy Wilton	3M
Diana Cheng	La Trobe University representative

### Victorian ICD Coding Committee meeting dates

Tuesday 7 March	DHS, 9:30am, 16 <sup>th</sup> floor 555 Collins Street, Melbourne
Tuesday 4 April	DHS, 9:30am, 16 <sup>th</sup> floor 555 Collins Street, Melbourne

## Abbreviations

ACBA	Australian Coding Benchmark Audit
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
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