

ICD Coding Newsletter

Fourth quarter 2004-05

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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Coding features

A reminder about prefixes

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Last year the Department of Human Services, with help from the Victorian ICD Coding Committee (VICC), revised the Vic Prefixes document. This was released with the *Victorian Additions to the Australian Coding Standards* effective July 1 2004.

Discussions have been held with the VICC members regarding the possibility of developing edits that would check the validity of the assigned prefixes. This idea developed in response to the growing number of people and groups who use the prefixes to analyse data, particularly in respect to adverse events in hospital.

A cursory examination of the 2004-05 data suggests that many coders are not aware of the correct way to assign prefixes. For example there are over 3000 instances in this data set of E11.23 *Type II diabetes with advanced renal disease* being prefixed with A. The prefix definitions clearly indicate that this code would, in most cases, be prefixed with P.

- The code contains two 'concepts' (1 = diabetes and 2 = renal disease).
- A code will be prefixed with P *Primary* if the condition required:
 - o Treatment, *or*
 - o Diagnostic procedures, *or*
 - o Increased nursing care and/or monitoring, *or*
 - o Active evaluation.
- As diabetes is usually coded because it receives diagnostic procedures and increased nursing care (via the taking of BSLs), it should, in these cases, be prefixed with P.
- The hierarchy of prefixes instructs that the prefix highest on the list will be assigned when two or more concepts are included in the one code. In the example of E11.23 the renal disease may not meet the definition of primary condition but because the diabetes does, the code will be prefixed with P.

Examples and improved definitions provided in the Vic Prefixes document 2004-05 include the following points:

1. There is now a hierarchy of prefixes that must be used when a code contains more than one concept.
2. There are many new examples in the document to illustrate the definitions.
3. Advice is provided regarding the prefixing of Z codes in obstetrics and neonate episodes.
4. Advice is provided about the prefixing of 'groups' of codes.

The Prefixes document is again being discussed at Victorian ICD Coding Committee with a view to further developments. The possibility of imposing national prefixes is also being discussed

at Commonwealth level. As Victoria is the only state currently assigning prefixes in a formal manner, other States and Commonwealth personnel are looking at our prefixes and how they work to inform further developments at national level.

It is therefore important that Victorian coders take the assigning of prefixes seriously and make an effort to assign them correctly.

The Vic Prefix document will be reproduced in the *Special Edition Newsletter June 2005* as part of the *Victorian Additions to the Australian Coding Standards*.

Coders are advised to read the document carefully as the data will be analysed during the coming financial year with a view to making decisions regarding the application of edits and future developments.

Selection ICD-10-AM coding queries

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#2067 Impingement shoulder

Often we have the diagnosis of impingement shoulder documented as the reason for a subacromial decompression. There is no index entry for impingement shoulder.

The only appropriate code, that contains the word 'syndrome', is M75.4 Impingement syndrome of shoulder. Is impingement shoulder syndrome the same as just impingement shoulder?

Dictionary definitions:

- Impingement - no definition
- Impingement syndrome - a progressive condition of shoulder pain and dysfunction, usually caused by repetitive placement of the arm in overhead positions.

VICC members consider M75.4 *Impingement syndrome of shoulder* to be the correct code to assign for this case. Impingement describes a symptom of the underlying condition of the shoulder.

The VICC has referred this to the NCCH requesting indexing of this condition under 'Impingement, shoulder'.

#2072 Dementia with psychotic symptoms

Dementia with psychotic symptoms

Psychosis, psychotic F29
- due to or associated with
-- present dementia F03
-- senile dementia F03

There is no Index entry for Psychosis 'due to or associated with' dementia. We have been advised by some colleagues to code this to F03. Since present and senile are old terms no longer used in our hospital, is it possible to modify the Index to include dementia with psychosis and delete senile and present?

VICC members consider that psychosis/psychotic symptoms with dementia should not be coded separately from the dementia. Look up 'dementia' for code assignment. The VICC has forwarded the following suggested index amendments to the NCCH.

Can the NCCH please consider reviewing the index entry for:

Psychosis, psychotic F29
- due to or associated with
-- present dementia F03
-- senile dementia F03

VICC members suggest the removal of the references to 'presenile' and 'senile', or alternatively amend the index (if considered clinically correct) to read:

Psychosis, psychotic F29
- due to or associated with dementia
-- see dementia

#2076 Antegrade cerebral perfusion

Need to code 'antegrade' cerebral perfusion with deep hypothermia circulatory arrest.

The procedure code 38577-00 [642] *Retrograde cerebral perfusion during hypothermic arrest* describes 'retrograde' perfusion. However, the index entry for it lists 'retrograde' as a non-essential modifier, as listed below.

Perfusion
- cerebral (retrograde)
--during hypothermic arrest 38577-00 [642]

Would it be acceptable in the meantime to use this code for 'antegrade' cerebral perfusion?

It would be appropriate to use:

38577-00 [642] ***Retrograde cerebral perfusion during hypothermic arrest for antegrade cerebral perfusion with deep hypothermia circulatory arrest.***

However you should consider **ACS 0909 Coronary artery bypass grafts (CABGs)**, in particular 'Additional procedures performed in conjunction with CABGs' to determine whether antegrade cerebral perfusion with deep hypothermia circulatory arrest should actually be coded. This standard instructs that hypothermia is a routine part of the CABGs procedure and is not coded when CABGs are performed.

The VICC will notify the NCCH about the discrepancy between the tabular list and the index with regard to modifiers.

#2085 Failed intravenous (IV) access

Patient admitted for colonoscopy but anaesthetist noted 'IV access impossible secondary to IV drug use'. Sedation anaesthesia given via percutaneous central vascular catheter (CVC) inserted. The CVC was then removed in the post-op suite.

Here are the codes we have used:

K92.2 *Gastrointestinal haemorrhage, unspecified*
F10.2 *Mental and behavioural disorders due to use of alcohol, dependence syndrome*
T98.2 *Sequelae of certain early complications of trauma*
Y87.0 *Sequelae of intentional self harm*
Y92.9 *Place of occurrence at or in unspecified place*
Z72.2 *Drug use*
Z22.52 *Carrier of viral hepatitis C*
Z72.0 *Tobacco use, current*

32090-00 [905] *Fibreoptic colonoscopy to caecum*
13815-01 [738] *Percutaneous central vein catheterisation*
34530-04 [738] *Removal of venous catheter*

Please advise if there is a T code to indicate that due to the lack of IV access, the treatment plan was changed? This had also occurred in a previous episode for this patient.

A code similar to T88.4 *Failed or difficult intubation*, such as T88.x *Failed or difficult cannulation*, would be ideal. Can the Coding Committee please consider submitting a request for such a code to the NCCH?

Although failed IV access has changed the treatment protocol for this patient, this is not a condition and there is no code for 'difficulty with IV access'.

If documentation of a condition of vein as the reason for the failed IV access is recorded, you can code this. Based on the information you have provided, there is no condition to be coded.

Additionally, the removal of the CVC does not need to be coded. Per **VICC #1937 Removal of supra pubic and central venous catheters** printed in the Victorian ICD Coding Newsletter February 2004 (reprinted at the end of this response).

92515-xx [1910] *Sedation* should also be assigned.

The VICC is unable to comment on the remainder of the coding due to lack of information.

VICC #1937 Removal of supra-pubic and central venous catheters (reproduced)

I would like to know under which circumstances you would code the removal of supra-pubic catheters (SPCs) and central venous catheters (CVCs)? Should they only be coded if performed by a medical officer, or if removed under an anaesthetic? Or should all removals of such devices be routinely coded?

The Committee feels that these procedures should not be coded unless performed under anaesthetic (refer **ASC 0042 Procedures not normally coded**, Note c.), or unless admission was specifically for the removal of the device in question. This opinion is based on the logic used in **ACS 1436 Trial of void** in which the direction is to code the removal of the urinary catheter when admission is specifically for the purpose of ensuring that voiding is functioning, and therefore, the catheter is no longer required. The standard states that: These procedures would not normally be coded (see **ACS 0042 Procedures normally not coded**) but they are relevant in these circumstances and are therefore included.

#2086 Misoprostol insertion for cervical dilation

Patient was known to have a tightly closed cervix and was given misoprostol PV prior to dilation and curettage (D & C)/hysteroscopy for recurrent endometritis. There doesn't appear to be any way to code the misoprostol except when to cause an induction of labour.

The operation report also reveals that the cervix was dilated to 6 Hagar and then to 8 Hagar but required a suture through the anterior cervix for traction. Is there anyway of indicating a procedure code for the cervix in this case, apart from 16511-00 [1274] *Insertion of cervical suture*, as this seems to be for cervical incompetence?

There is no need to code either the insertion of misoprostol or the cervical suture, as these are procedural components of the dilatation and curettage (per **ACS 0016 General Procedure Guidelines** - Procedural components').

#2087 Lemierre's syndrome

A 13 year old female patient admitted with Lemierre's syndrome and gram-negative anaerobes. Research from Paediatric Infectious Diseases Journal indicates thrombophlebitis of the internal jugular vein and *Fusobacterium necrophorum*, which constitutes part of the syndrome. The patient had both of these conditions. Can you please advise on the correct coding of this syndrome? In the interim we have coded:

I80.8 *Phlebitis and thrombophlebitis of other sites*

A41.4 *Sepsis due to anaerobes*

We have attached a copy of the research material and micro results for your review.

Based on the information provided, the correct codes are:

I80.8 *Phlebitis and thrombophlebitis of other sites*

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

Sepsis must be documented before **A41.4 Sepsis due to anaerobes** can be coded.

Apply **ACS 0001 Principal diagnosis** to determine the principal diagnosis.

#2091 Definition of metastatic status

Over coding discussions with one of our senior surgeons, it was pointed out in the case to hand that the patient was not what the surgeon would call 'in a metastatic state'.

Following coding protocol and supported by the encoder prompts, this patient was assigned both primary and metastatic codes. The initial phase of diagnosis shows lymph node involvement of which some were positive to metastases, as is the case quite often with breast cancer patients.

The surgeon implied that for a patient to be termed 'with metastases or in a metastatic state' this would mean an area metastasised away from the primary area, travel to another part and different area of the body affected. For example, secondaries of liver or bone. He considered regional lymph node involvement in the area of the primary not to fall into the criteria for labeling a patient with metastases. He has indicated with earnest for some feedback from the coding authorities in relation to the above scenario.

This has raised the point that there may be a definition for coding purposes, and may be one in the clinical context and setting for treating patients.

It is acknowledged that there are some differences between coding and clinical interpretation of a condition. Coders should code according to the classification system, therefore if the patient has breast cancer with documented lymph node involvement, this should be coded as metastatic to lymph nodes.

#2092 Cord blood collection

For the first time we have had cord blood collected at delivery for potential use of stem cells. This is only documented on the mother's record. Is 13750-04 [1892] *Apheresis of stem cells* applicable in this case as there is no re-transfusion, it is for future use should the need arise? Hospital staff carried out collection of the blood; transportation to appropriate facility for storage was the responsibility of the patient and her partner.

The NCCH advised in query 1640 (NCCH database) that cord blood collection is not coded. This is not apheresis.

The response to query 1640 is reproduced here for your information:

Cord blood is usually collected after the baby is born but before the placenta is delivered. A four to eight inch area of the umbilical cord is cleaned with antiseptic solution and a blood bag needle is inserted into the umbilical vein. The blood flows into the bag by gravity until it stops, after which the collection is complete.

As neither the mother nor baby is admitted specifically for this procedure, the NCCH does not advocate the coding of cord blood procurement. The classification advice in **ACS 0301 *Stem cell procurement and transplantation*** applies to procurement of stem cells via apheresis and bone marrow.

#2094 Cord around neck

Our midwifery patients often have cord around neck 'YES' circled. Should we code cord entanglement if there are no problems caused by the cord entanglement, as the descriptor says 'labour and delivery complicated by...' or only if there is some documentation of foetal distress, problems caused and etc, by the entanglement?

Documentation of 'cord around neck' should be coded as:

O69.2 *Labour and delivery complicated by other cord entanglement*

Refer to **NCCH # 255 *Cord around neck, without compression*** for the definitive answer to this question.

VIIC #1800 *Perinatal recording in record and eBOP* published in the *August 2002 ICD Coding Newsletter* also provides information regarding documentation of perinatal conditions.

#2095 Male sling procedure for stress incontinence

A 75 year old male with stress incontinence (post radical prostatectomy) admitted for 'Invance sling – male sling procedure'.

Operation record states: Removal of old ACT balloons and insertion of Invance sling after insertion of 6 bone screws.

I have coded:

37044-00 [1109] *Retropubic procedure for stress incontinence, male.*

Or should I code the revision procedure. I have also coded the removal of the artificial urinary sphincters.

From the documentation provided, the Victorian ICD Coding Committee does not consider this to be a revision procedure but rather a new procedure for the same condition. Therefore the committee recommends assigning the following codes:

- 37390-02 [1113] Removal of artificial urinary sphincter for the removal of the ACT balloons**
- 37044-00 [1109] Retropubic procedures for stress incontinence, male for the insertion of the Invance sling.**

#2096 Cholesterol embolus

A 77 year old man admitted as a day case for removal of lesion from shin area of leg, histology showed 'fat necrosis, fibrosis, chronic inflammation and a cholesterol embolus'. It also stated 'difficult to tell with certainty whether or not the cholesterol embolus is the cause of the other findings'.

Suggested codes for the cholesterol embolus are L98.8 *Other specified disorders of skin and subcutaneous tissue*, plus a code from lipidaemia block, possibly E78.8 *Other disorder of lipoprotein metabolism*.

Cholesterol embolism is defined as an embolism of lipid debris from an ulcerated atheromatous deposit, generally from a large artery to small arterial branches; it is usually small and rarely causes infarction. (Better Health Channel On-line Dictionary)

Embolus is defined as a plug composed of a detached thrombus or vegetation, mass of bacteria or other foreign body occluding a vessel. (Stedman's Medical Dictionary)

Therefore, following the index entry, the correct code to assign in this scenario is:

Embolism (septic) I74.9
- lower extremity I80.3

I80.3 *Phlebitis and thrombophlebitis of lower extremity, unspecified*

#2098 Malaligned fracture radius

Young boy fractures radius and has general anaesthetic, manipulation and plaster (GAMP).

Is readmitted 2 weeks later because on check x-ray the fracture is found to be malaligned (still healing), so referred for GAMP.

Can this be coded as 'malunion', or would the current injury code be reused because the injury is still in the healing process. Although this would not reflect accurately what has happened? Or can a 'sequelae of fracture' code be used, although the current condition is still represented?

This should be coded to a current fracture, as the bones have not united.

If a fracture has united crookedly, this would be coded to malunion.

#2106 Virtual colonoscopy

A new procedure is being conducted at our hospital called a Virtual Colonoscopy (VC). VC uses x-rays and computers to produce and display two and three-dimensional images of the large intestine, small intestine and rectum. The procedure is used to diagnose colon and bowel disease, including polyps, diverticulosis and cancer. VC can be performed with computerised tomography (CT colonography with IV contrast) or with magnetic resonance imaging (MRI) and is performed in the Radiology department of our hospital. In consultation with a clinician at the hospital, he advised me that VCs will be replacing colonoscopies in some patients.

Is it suitable to use the CT abdomen with contrast code, 56407-00 [1962] *Computerised tomography of abdomen with intravenous contrast medium*, or does a new code need to be developed to adequately describe this procedure.

Based on the information provided, Virtual Colonoscopy should be coded to CT or MRI; whichever is performed. A new code is not required because the CT or MRI is the procedure actually being performed.

#2110 Hepatitis C positive

According to ACS 0104 *Viral hepatitis*, if a patient is documented as being Hepatitis C positive, the patient has to be symptomatic for us to be able to assign a code for Chronic Hepatitis C. In a recent case the patient had had their Hepatitis C investigated extensively 2 years prior but was lost to follow-up. At the time her Hepatitis C was symptomatic (lethargy, jaundice and generally unwell) and her liver function tests (LFTs) were grossly abnormal. In the current episode she is still noted to be Hepatitis C positive, but no other information about her hepatitis C virus (HCV) was given.

Are we able to use previous documentation to support the fact that the patient has a symptomatic past and code them as chronic HCV? If a previous episode has been documented as chronic HCV (finding on a liver biopsy), can we code all subsequent episodes as chronic HCV (the standard does not appear to allow this)? Or can a person go from having chronic HCV back to being a carrier?

What constitutes a symptom of HCV? Are abnormal LFT's alone an indicator that a pt is more than a carrier?

Could we please have some clarification and guidance with the application of this standard?

Based on current clinical information obtained by the Victorian ICD Coding Committee it is considered possible that, with treatment, a person may go from having chronic HCV back to being a carrier, therefore previous documentation cannot be used to determine if a patient is symptomatic.

Abnormal LFTs attributable to HCV are enough to distinguish chronic hepatitis from carrier, but this should be supported by documentation in the medical record.

#2113 IV administration of gamma globulin

Could you please clarify the use of these two procedure codes when coding intravenous administration of gamma globulin:

13706-05 [1893]	<i>Transfusion of gamma globulin</i>
96199-05 [1920]	<i>Intravenous administration of pharmacological agent, gamma globulin</i>

ACS 0214 Intragam provides advice on code assignment based on route of administration.

If injection is documented, assign a code from block **[1920] Pharmacotherapy**, with extension **05 Gamma globulin**.

If IV access, infusion or transfusion is documented assign:

13706-05 [1893] Transfusion of gamma globulin

Please note that **ACS 0214 Intragam** overrides the index entry for IV administration of gamma globulin.

#2114 Breast reconstruction

Patient admitted for breast reconstruction. Please advise:

1. Should the excision of cartilage be coded?
2. Prolene mesh used in the abdominoplasty repair of donor site, should this be coded? If so, what is the correct code?

Excision of cartilage should not be coded as it is the operative approach. This logic is supported by advice published in ICD Coding newsletter February 2004, **VICC #1909 Coding of uncinectomy**.

Nor is it necessary to code the prolene mesh separately from the abdominoplasty, as it is the method of repair.

Assign **30403-05 [1000] Repair of abdominal wall following procurement of myocutaneous flap** only.

#2115 Removal of impacted wisdom teeth

Can removal of impacted/wisdom teeth be assumed to be surgical or must the surgeon state surgical removal? This is a problem for us because if surgical is not written on the operation report than we are unable to use the correct code if the index trail is followed.

Removal of impacted wisdom teeth is not necessarily surgical, therefore surgical needs to be documented before the procedure code is assigned. If coders are unable to obtain further documentation from surgeons, apply **ACS 0038 Procedures Distinguished on the Basis of Size, Time or Number of Lesions** and code to the least invasive, in this case, non-surgical.

#2116 Metallosis of total hip replacement

I would be interested to know which code other orthopaedic coders are allocating to the diagnosis of Metallosis. This condition is an allergic reaction to the metal components of the prosthesis. We are using T84.5 *Infection and inflammatory reaction due to internal joint prosthesis* because of the inflammatory reaction.

Is this correct?

T84.5 Infection and inflammatory reaction due to internal joint prosthesis is assigned only if inflammation is documented in the clinical notes.

Therefore for the episode cited, the correct codes to assign are:

- T84.8** *Other complications of internal orthopaedic prosthetic devices, implants and grafts*
- Y83.1** *Surgical operation with implant of artificial internal device*
- Y92.22** *Place of occurrence, health service area*

#2118 Gastroenteritis due to food poisoning

We have noticed a discrepancy in the index when coding gastroenteritis due to food poisoning. Food poisoning is not specified as bacterial in the documentation:

Gastroenteritis (acute) (epidemic) (presumed infectious) (septic) (*see also Enteritis*) A09

- due to

- - food poisoning (*see also Intoxication, food-borne*) A05.9

(3M Code Finder also assigns K52.9)

Poisoning (acute) (*see also Table of drugs and chemicals*) T65.9

- food (acute) (diseased) (infected) (noxious) NEC T62.9

Code gastroenteritis as a manifestation as per ACS 1901

We are unsure which is the correct way to code this. Do we code:

A05.9 *Bacterial foodborne intoxication, unspecified*

K52.9 *Noninfective gastroenteritis and colitis, unspecified*

(Is K52.9 required?) Or:

T62.9 *Noxious substance eaten as food, unspecified*

K52.9 *Noninfective gastroenteritis and colitis, unspecified*

X49 *Accidental poisoning by and exposure to other and unspecified chemicals and noxious substances*

Y92.9 *Unspecified place of occurrence*

U73.2 *While resting, sleeping, eating or engaging in other vital activities personal hygiene*

Clinical information obtained by the Victorian ICD Coding Committee suggests that food poisoning can cause conditions other than gastroenteritis. Also, viruses, bacteria, parasites or toxic agents such as wild mushrooms can cause food poisoning. Coders should look up the lead term depending on documentation in the clinical notes and apply excludes notes accordingly. The Committee does not believe there is a discrepancy in the index.

Therefore, if only food poisoning is documented assign code **T62.9 Noxious substance eaten as food, unspecified**. If gastroenteritis due to food poisoning is documented assign code **A05.9 Bacterial food-borne intoxication, unspecified**.

K52.9 Noninfective gastroenteritis and colitis, unspecified is not required as an additional code as it is not adding any further information.

#2119 Perimenopausal bleeding

What is the correct code to assign for Perimenopausal bleeding? We have been using:

N92.4 *Excessive bleeding in the premenopausal period.*

If this is the correct code, is it possible for it to be added as an inclusion term in the tabular list under N92.4, and have an index entry as well?

Perimenopause is defined as the three to five year period prior to menopause during which oestrogen levels begin to drop. (Better Health Channel Online medical dictionary)

Postmenopause is defined as the physiological period following the menopause, the permanent cessation of the menstrual life. (Better Health Channel Online medical dictionary)

Therefore the correct code to assign for perimenopausal bleeding is **N92.4 *Excessive bleeding in the premenopausal period.*** See index entries as follows:

Bleeding

uterus, uterine NEC

- - climacteric N92.4

- - menopausal N92.4

- - preclimacteric or premenopausal N92.4

#2120 *Aspergillus fumigatus*

A 55 year old female presented for a bronchoscopy to investigate haemoptysis and an abnormality found on CT. The results, as reported on a computer generated bronchoscopy report, are:

No endobronchial lesion seen. Purulent discharge from lingular lobe noted. No cause for haemoptysis found.

Washings were taken and the pathology report states:

CULTURE: Org 1. *Aspergillus fumigatus* Scanty growth

There is no further information in the admission notes regarding this diagnosis, follow up plans or treatment. The episode is a same day episode.

I am querying the assignment of a code for the *Aspergillus Fumigatus* culture. I have already assigned R04.2 *Haemoptysis* as my Principal Diagnosis code. Would it be correct to assign B44.1 *Other pulmonary aspergillosis* in accordance with ACS 0046 *Diagnosis selection for same-day endoscopy* because the result of the washing is a finding, which has not been linked to the symptoms? Or, Does the culture result first require interpretation by the treating clinician as per ACS 0010 *General abstraction guidelines*, and documentation of the infection in the clinical notes as per the Coding Organisms Coding feature, in which case no code would be assigned for the *Aspergillus fumigatus*.

I'm not sure if a culture result should be considered differently to a histological finding. This query was raised as a result of B44.1 *Other pulmonary aspergillosis* being a Notifiable code in PRS2.

Index:

Infection, infected (opportunistic) B99
- *Aspergillus* (*flavus*) (*fumigatus*) (*terreus*) (*see also Aspergillosis*) B44.9

Aspergillosis, aspergilloma B44.9
- pulmonary NEC B44.1

Tabular:

B44 ***Aspergillosis*** (Includes: aspergilloma)
B44.0 ***Invasive pulmonary aspergillosis***
B44.1 ***Other pulmonary aspergillosis***
B44.2 ***Tonsillar aspergillosis***
B44.7 ***Disseminated aspergillosis*** (Includes: Generalised aspergillosis)
B44.8 ***Other forms of aspergillosis***
B44.9 ***Aspergillosis, unspecified***

As pointed out in your query, **B44.1 *Other pulmonary aspergillosis*** cannot be coded without clinical interpretation.

Microbiology findings need clinical interpretation regardless of the length of stay of the patient as per **ACS 0010 *General Abstraction guidelines***.

ACS 0046 *Diagnosis Selection for Same-Day Endoscopy* does not provide justification for the coding of **B44.1**.

Therefore for the case cited assign the following diagnosis codes:

R04.2 ***Haemoptysis***

R91 ***Abnormal findings on diagnostic imaging of lung***

#2125 Metabolic acidosis with diabetes mellitus coding

A 30 year old patient with a principal diagnosis on discharge summary of metabolic acidosis. Patient also has insulin-dependent diabetes mellitus, with a history of a 'flu like' illness for the past week, and noted to be dehydrated on admission. Patient stated blood sugar level readings had been good. Length of stay 4 days. Following the Index

Diabetes, diabetic (controlled) (mellitus) E1-.9

- with
- - acidosis
- - - lactic (without coma) E1-.13
- - - - with coma E1-.14
- - - - and ketoacidosis (without coma) E1-.15
- - - - - with coma E1-.16

Diabetes, acidosis, lactic - lactic is an essential modifier and there is no default or entry for metabolic or any of the other types of acidosis apart from ketoacidosis.

1. There is an excludes note under E87.2 *Acidosis: Excludes: diabetic acidosis (E10-E14 with common fourth character .1)*. It would seem as though the classification is telling coders to code all types of acidosis to 'lactic acidosis' when in a diabetic patient. However the Index entry under Diabetes does not give this impression. Please could the committee confirm that the correct code/s would be E10.13 *Type 1 diabetes mellitus with lactic acidosis, without coma* for the diagnosis of metabolic acidosis in a diabetic patient
2. Respiratory, lactic, and metabolic acidosis, ketoacidosis and acidosis not elsewhere classified are all indexed to E87.2. Should coders code all the above conditions in a diabetic patient to E1x.1x *Diabetes with lactic acidosis* (except of course ketoacidosis which has an index entry under diabetes)?

Metabolic acidosis is not the same as ketoacidosis and lactic acidosis. As metabolic acidosis is not linked to Diabetes in the index, follow the index entry:

Acidosis (lactic) (respiratory) E87.2
- metabolic NEC E87.2

Assign code **E87.2 Acidosis**.

#2126 Familial adenomatous polyposis (FAP)

Patient has a past history of FAP of the colon and presents for a same day colonoscopy/gastroscopy. The results on histology show benign polyps of the stomach. After consulting the gastroenterology team it was confirmed that FAP, although most commonly found in the colon, can also be found in the stomach.

Questions:

1. Should the morphology code assigned be based on the histology results (benign polyps) or should a morphology code for FAP be assigned?
2. If FAP of the stomach is diagnosed, should D12.6 *Colon, unspecified* be assigned as per ACS 0246 *Familial adenomatous polyposis* or should D13.1 *Benign neoplasm of stomach* be used?

The Victorian ICD Coding Committee has identified that FAP is not always reported as a histological change. Therefore if FAP is documented in the clinical notes, even though the histology report states benign polyp, the morphology for FAP should be assigned for this episode. A condition can be coded from clinical documentation in the absence of histological evidence.

If FAP of the stomach is diagnosed, **D13.1 *Benign neoplasm of stomach*** should be assigned.

#2127 Coding of cancer with insertion/removal infusaport

NCCH Query database number 1982 (18/10/04) states:

Question:

Patient with breast cancer admitted for insertion/removal of infusaport.

At our state coding committee, a query was received regarding a patient with breast cancer admitted for insertion/removal of infusaport, asking what the principal diagnosis should be. Committee members agreed that *Z45.2 Adjustment and management of vascular access device* should be the principal diagnoses. Then followed much discussion about whether the breast cancer met the definition of additional diagnosis and should be coded. Many wanted to code the cancer to indicate the reason why the patient had a vascular access device. We would appreciate your advice on this.

Answer:

The NCCH agrees with the assignment of *Z45.2 Adjustment and management of vascular access device* as the principal diagnosis for the case cited.

ACS 0236 Neoplasm coding and sequencing states that 'the primary malignancy should be coded as a current condition if the episode of care is for: medical care related to the malignancy'. This guideline overrides the advice in *ACS 0002 Additional diagnoses*.

Also, as *Z45.2 Adjustment and management of vascular access device* describes an admission for a procedure, it is necessary to provide an additional diagnosis code to 'complete the picture'.

Therefore, the NCCH supports the assignment of codes for the 'breast cancer' for this case.

I have some questions about this response:

1. Why is admission for infusaport insertion or removal considered to be 'medical care related to the malignancy'?
2. If it is 'necessary to provide an additional diagnosis code to complete the picture' for admissions for vascular access devices (VADs), would this advice (to also code the condition) apply to admissions for other VAD insertions/removals, e.g. CVC for dialysis?

VICC #1943 Continuous ambulatory drug device (CADD) disconnections, May 2004, does not mention coding the condition as an additional diagnosis. We are confused whether to now routinely assign a cancer or other condition code having now read the NCCH response.

Answer 1

The Victorian ICD Coding Committee agrees with the response in NCCH Q1982 (18/10/04) to assign a code for the neoplasm as an additional diagnosis because the infusaport insertion or removal is facilitating the medical care of the malignancy as per **ACS 0236 Neoplasm coding and sequencing**.

The Committee notes that **Z45.1 Adjustment and management of implantable infusion device or pump** is the appropriate code to assign as principal diagnosis in the scenario discussed in NCCH Q1982.

Answer 2:

The advice in NCCH Q1982 applies only to patients described in that scenario. For patients with non-neoplastic conditions admitted for VAD, the non-neoplastic condition should meet **ACS 0002 Additional diagnoses** before it is assigned.

VICC #1943 Continuous Ambulatory Drug Device (CADD) disconnections does not mention coding the condition as an additional diagnosis because the query related to the assignment of the principal diagnosis.

#2129 Dexamethasone Suppression test

A patient has been admitted for investigation of query Cushing's syndrome. She initially underwent an oral Dexamethasone Suppression Test, which, for technical reasons, was not completely successful, so was converted to an intravenous (IV) Dexamethasone Suppression test.

Dexamethasone, a synthetic glucocorticoid hormone, often fails to suppress the function of the hypothalamus, pituitary and adrenal glands in patients with Cushing's syndrome and so forms the basis for the suppression test.

[www.cushings-help.com/dex_tests.htm]

The test involves daily urine collection in conjunction with IV dexamethasone administered over a number of days.

My question is how to code the suppression test. At this stage I have used the following codes:

92204-00 [1866]	<i>Non-invasive diagnostic tests, measures or investigations, NEC</i>
96199-03 [1920]	<i>IV administration of pharmacological agent, steroid</i>

I have not included a code to identify the oral administration of dexamethasone, given that oral administration of any drug is rarely coded.

The Victorian ICD Coding Committee agrees with the procedure codes assigned by the enquirer for a patient specifically admitted for IV Dexamethasone Suppression Test.

#2130 Query Snake bite

We have recently had a 67-year-old man admitted with query bite from brown snake. He was exhibiting similar symptoms of snakebite and antivenom was given. This gentleman subsequently passed away and his blood culture results came back after his death showing gram negative Bacilli and negative on snake bite venom tests. Thus his cause of death has been determined as gram negative sepsis.

Should this case be coded as T63.0 *Toxic effect of contact with snake venom* considering the antivenom was administered or should it not considering the snakebite has been ruled out?

As the condition occasioning admission after study was determined to be gram negative sepsis in this scenario, the gram negative sepsis should be assigned as the principal diagnosis.

T63.0 Toxic effect of contact with snake venom would not be coded as it was excluded on the snakebite venom test result.

A procedure code for administration of antidote from Block **[1920] Pharmacotherapy** should be assigned.

#2133 Grouping of complete urethrectomy

Patient admitted with bladder cancer that has extended into urethra (patient has already had a cystectomy and ileal conduit), complete urethrectomy was performed.

This is grouping to L62A Kidney and Urinary Tract Neoplasms W Catastrophic or Severe CC, which is a medical diagnosis related group (DRG). The procedure for complete urethrectomy 37330-01 [1118] *Complete urethrectomy* is not listed in the definitions manual at all.

Could you advise if the grouping is correct or if this procedure needs to be considered for the next version of the grouper?

The enquirer is correct in that **37330-01 [1118] Complete urethrectomy** is not recognised by the grouper as an operating room procedure, hence the episode is grouping to a medical DRG.

The DHS will forward this grouping anomaly to the Commonwealth.

#2140 Driver of transport vehicle activity code

We are currently auditing our external cause codes. With activity codes, do you use U73.8 *Other specified activity* for a driver of a transport vehicle NOS because you know the activity he was doing was 'driving' or would you use U73.9 *Unspecified activity* because you don't know what activity he was involved in whilst driving (ie. leisure, working, hobby and etc.) and the external cause code already specifies that he was driving a vehicle?

Coding Matters Vol 11 no. 2 Activity codes provides the following information:

For the code range, **V01 - V99 *Transport accidents***, where the activity at the time of the accident is not specified as sport, leisure or working for an income, assign **U73.9 *Unspecified activity***.



Coding Corkboard

Medical Science Short Course for Clinical Coders

Curtin University of Technology is running a Medical Science Short Course for Clinical Coders. This course will provide an introduction to the topics of pharmacology and disease processes and is suitable for clinical coders or other persons interested in learning about disease processes at an introductory to intermediate level. The knowledge gained will improve your understanding of disease pathophysiology and provide an introduction to pharmacology. The course would be ideal for clinical coders who wish to improve their knowledge or as part of the staff development process for clinical coders. The course workbooks follow the chapter headings from the International statistical classification of diseases and health related problems, 10th revision, Australian modification (ICD-10-AM).

See http://publichealth.curtin.edu.au/html/areasofstudy_coursesshrt.htm for further information or contact Brian Stanley, Lecturer Department of Health Information Management, School of Public Health, GPO Box U1987, Perth WA 6845, Ph: (08) 9266 7531, email: b.stanley@exchange.curtin.edu.au

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, Secretary Victorian ICD Coding Committee (Carla.Read@dhs.vic.gov.au) if you would like to have your views considered.

Coding queries

At the time of writing this article discussion of queries was up to date with several queries awaiting confirmation of the answer at the next meeting.

Additional diagnoses

Several discussions have taken place at a Commonwealth level regarding the additional diagnoses standard and VICC members have been able to contribute to these discussions via Victorian representatives on these committees.

If coders have comments that they would like discussed regarding the additional diagnoses standard as it currently appears please send them via email to Carla Read (email address above).

Victorian ICD Coding Committee members as at 1 March 2005

Jennie Shepheard	Human Services (Chair, Acting La Trobe University representative)
Carla Read	Human Services (Convener, Secretary)
Sara Harrison	Human Services (Victorian CSAC representative)
Melinda Avram	Epworth Hospital
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	Southern Health
Sonia Grundy	St Vincent's Hospital
Lauren Morrison	The Austin Hospital
Megan Morrison	St John of God Health Care Geelong
Susan Peel	Southern Health
Leanne Stokes	Beachplace Pty Ltd
Maree Thorp	Peninsula Health
Kathy Wilton	3M

Victorian ICD Coding Committee meeting dates

Tuesday June 21st	DHS, 10:00am, 16 th floor 555 Collins Street, Melbourne
Tuesday July 19th	DHS, 10:00am, 16 th floor 555 Collins Street, Melbourne
Tuesday August 16 th	DHS, 10:00am, 16 th floor 555 Collins Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACS	Australian Coding Standard
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