ICD Coding Newsletter

Second quarter 2004-05

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Department of Human Services

Victoria
The Place To Be

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

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

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

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

If you have any mailing list changes or queries or comments regarding the ICD Coding Newsletter, contact the HDSS Help Desk:
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Fax 9616 7743
Email PRS2.Help-Desk@dhs.vic.gov.au

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Coding features

Calculating the Patient Clinical Complexity Level (PCCL) for any given Diagnosis Related Group (DRG)

Author: Jennie Shepheard, Health Data Standards and Systems Unit, Department of Human Services

Introduction

An understanding of the grouping process makes the clinical coder's task more interesting and enables both Health Information Managers and clinical coders to communicate more effectively with other relevant people in the organisation about grouper issues.

An article published in May 2004 Victorian ICD Coding Committee (VICC) newsletter provided an overview of the Australian Refined Diagnosis Related Groups (AR-DRG) Definitions Manual and aimed to assist Health Information Managers and Clinical Coders to be comfortable using these manuals.

This article aims to introduce the processes involved in calculating the Patient Complication or Comorbidity Level (PCCL) value for a coded episode, from the Complication or Comorbidity Level (CCL) scores of the diagnosis codes.

This process is complex and extremely difficult to do manually. However many of the steps can be completed using the information provided in the manuals (result will not be precise), or the CCL calculator and the PCCL simulator, both of which are available on the CD that accompanies the definitions manuals.

Complication and Comorbidity Level (CCL): CCLs are severity weights given to all additional diagnoses. The CCL values range from 0-4 for surgical and neonate episodes, and 0-3 for medical episodes.

Patient Clinical Complexity Level (PCCL): The PCCL is a measure of the cumulative effect of a patient's complications and comorbidity, and is calculated for each episode. The calculation is complex and has been designed to prevent similar conditions from being counted more than once.

The CCL for each additional diagnosis code is used to calculate the PCCL. The PCCL values range from 0-4.

- 0-No CC effect
- 1-Minor CC effect
- 2-Moderate CC effect
- 3-Severe CC effect
- 4-Catastrophic CC effect

Refer to 'The treatment of severity' page 7 Volume 1 and Appendix C page 213 Volume 3 AR-DRG Definitions Manuals Version 5.0 for further information.

Calculating the PCCL

To calculate a PCCL, you first need to know the adjacent DRG (ADRG) to which the case will group. The adjacent DRG can be determined by referencing Appendix A and Appendix B in Volume 3 AR-DRG Definitions Manual Version 5.0. In the example below the adjacent DRG is E02.

AR-DRG v5.0	PCCL Required
E02A Other Circulatory System Diagnosis W Catastrophic CC	>3
E02B Other Circulatory System Diagnosis W Severe CC	>2
E02C Other Circulatory System Diagnosis W/O Catastrophic or Severe CC	≤2

Calculating the PCCL can be done either manually or electronically. Both methods are described below.

Manual calculation of PCCL

Manual calculation of the PCCL is very complex and at best can only be estimated. There are two places to look for guidance.

1. Appendix C, Volume 3 AR-DRG definitions manual contains a list of diagnoses defined as complications or co-morbidities. This lists the CCL values possible for each code when it is listed for a medical or a surgical DRG. Using this list you will be able to estimate the CCL for each of your additional codes. However it will be very difficult to translate this into a PCCL as the recursive exclusion process (see below) is not included here.

2. The CCL exclusion list, available on the CD provided with Volume 3 AR-DRG Definitions Manual, will enable you to determine which codes CCL can be excluded from your calculation.

If you need an accurate estimate of the PCCL for your DRG, manual methods of calculation are not recommended.

Electronic calculation of PCCL

The CD provided in Volume 3 AR-DRG Definitions Manuals provides the tools you need to calculate the PCCL for your DRG.

CCL calculator

Load the CCL calculator onto your computer hard drive and open it. See 'Loading the CCL calculator onto your PC' at the end of this article.

Enter the adjacent DRG. Then enter each additional code in turn. The calculator will give the CCL for that code in that DRG.

For obstetric and neonate patients you can also enter the principal diagnosis code into the calculator as the grouper uses this for AR-DRG assignment for these patients.

See 'Notes' below for details of processes that the grouper uses which may change the CCL allocated to a particular code.

PCCL simulator
Copy the PCCL simulator from the CD to your hard drive and open. See 'Loading the PCCL simulator onto your PC' at the end of this article.

Enter the CCL for your first additional code into the simulator. Then enter the CCL for subsequent additional codes. The simulator will calculate the PCCL for you.

For obstetric and neonate cases you can enter the principal diagnosis code first as it is used in PCCL calculation for these patients.

Important Notes

Non-neonate episodes:
During the process of assigning CCLs for diagnosis codes the grouper may reassign the CCL to zero. For details see page 214 Volume 3 AR-DRG Definitions Manual Version 5.0. The following list briefly outlines the steps the grouper undertakes during this process.

- If the code forms part of the adjacent DRG (ADRG) definition it is allocated a value of zero. Obstetric DRGs are excluded from this step.
- If the ADRG involves multiple trauma, additional diagnoses in the range S00.00 – T14.9, and T79.0 – T79.9 are given a CCL of zero.
- If the ADRG involves HIV, additional diagnoses in the range B20-B24 are given a value of zero.
- If the code is a duplicate of the principal diagnosis or a previously processed additional diagnosis the CCL is changed to zero.
- If the code is closely related to the principal diagnosis it may be given a value of zero. This information can be obtained from CC Exclusion list – available on the CD-ROM. Obstetric DRGs are excluded from this process.
- For non-neonate episodes only the additional diagnosis codes are used to determine the PCCL. Obstetrics are the exception with all codes being used to determine the PCCL.

Neonate episodes:
All diagnosis codes on a neonate record are treated as additional diagnoses. CCL values are obtained from a separate Neonate CC table. If the code is not on this list it is given a CCL of zero.

Recursive Exclusion Process

Once CCL values have been obtained for every diagnosis on an episode (regardless of whether the record relates to a neonate or non-neonate episode), the grouper arranges the additional diagnosis codes alphabetically within descending order of CCL value, and then applies a *recursive exclusion process.*

This process treats each diagnosis in turn as if it was the principal diagnosis, and the CC status of the remaining codes is reviewed in relation to this code.

During this process some additional codes can have their CCL value reassigned to zero because of their relationship to other additional diagnoses.

Loading the CCL calculator onto your PC

When you put the CD into your CD drive, a Microsoft Internet Explorer page will open. This page outlines the contents of the CD. You can minimise or close this page. It can also be printed for your reference if you wish.

Open Windows Explorer on your PC (Place the cursor on the My Computer icon on your desk top and right click, then left click on 'explore'. Or, right click on Start and then left click on 'explore').

In Windows Explorer:

- Click on the cross beside the CD drive in the left hand window.
- Click on Appendix C (CCL) folder.
- Copy the CCL Calculator folder (a sub folder of Appendix C) from the right hand window to your hard drive in a folder of your choice.
- In the left hand window, click on the folder in which you have copied the CCL Calculator folder.
- Click on the CCL calculator folder.
- In the right hand window, click on Setup.exe and follow instructions.

(*If this doesn't work it may be that you have restricted access to opening programs on your PC. Contact your IT support person to help you open the program*)

Loading the PCCL simulator onto your PC

Follow the instructions provided for loading the CCL calculator up to 'In Windows Explorer'. Then follow these steps:

- Click on the cross beside the CD drive in the left hand window.
- Click on Appendix C (CCL) folder.
- Copy the PCCLSIM excel file from the right hand window to your hard drive in a folder of your choice.
- In the left hand window, click on the folder in which you have copied the PCCLSIM.
- In the right hand window, click on PCCLSIM. The PCCL simulator will open as an excel spreadsheet.

Data quality

Resubmission of coding

The HDSS Help Desk receives the following query several times each year. This information is provided to clarify the arrangements for all public hospitals.

Question:
The hospital has submitted the X2/Y2 data (including the ICD-10-AM codes) in time to meet the data requirements for full funding of the episode. If the coding is later changed after the data timelines, due to an audit or other quality activities such as PICQ, which changes the DRG (and therefore the WIES) of the episode, are these changes funded, or are penalties applied.

Answer:
The data timelines apply only to when the X2/Y2 data is first accepted. Hospitals have until the end of year consolidation date (17 September 2005 for the 2004-05 financial year) to make any amendments. The final funding for the financial year is based on the data from this date.

Selection ICD-10-AM coding queries

#1944 Coding anaemia from haemoglobin (Hb) result

I wish to clarify if 'anaemia' can be coded in the following instances:

1. Patient admitted for chemotherapy for Non-Hodgkin lymphoma (NHL). Summary specifies 'Hb was 90, so 2 units of red blood cells given'. Pathology report for the date in question specifies 'Hb. 90L' (L meaning 'low'), but the word 'anaemia' is not mentioned in the actual admission. Can I code anaemia on the basis of the pathology report specifying that the Hb was low? Index entry for 'low haemoglobin' is D64.9 *Anaemia, unspecified*.

2. When an Hb reading is specified in the progress notes, for example, Hb 90, and blood transfusion is given. Again, no reference is made to 'anaemia' in the progress notes, but pathology report specifies that Hb is L (Low).

3. Can I code D62 *Acute posthaemorrhagic anaemia* when Hb is specified as low in pathology reports, having been normal prior to surgery, but only the Hb reading is specified in the progress notes with no mention of the word 'anaemia', and transfusion is given. During a coding workshop for 3rd edition revision of ICD-10-AM, I gave similar examples and was told I could code anaemia because the diagnosis had been made by the pathologist on the pathology report (that is, when the pathologist states the reading is 'low') and not by me as the coder, but we would like confirmation of this.

The following response has been ratified by the NCCH.

The vital point underlying this issue is documentation. Coders may be able to recognise a result, which potentially indicates a condition. Pathology results alone cannot be used as criteria for assigning a code, and the record should be further reviewed for evidence of clinical documentation, which confirms a diagnosis.

Documentation of a condition on a discharge summary can be confirmed by an abnormal result specified in the body of the record. However, if there is nothing more than a reading or result to indicate a condition, then this should be queried with the clinician and, if appropriate, it should then be documented by the clinician.

Coders should be aware that arrows might indicate a trend, rather than a high/low reading.

The clinical significance of pathology results should be evidenced by documentation in the medical record.

Please refer to VICC query#1735 (November 2001) for further information.

In the three scenarios in your query, anaemia cannot be coded.

#1968 Induction of labour due to fractured ankle

A 28-year-old female was admitted to our (obstetric) hospital due to fall, resulting in a fractured ankle.

The patient was then readmitted the next day for an induction of labour due to the fractured ankle (requiring open reduction surgery). By coding the fracture and external cause codes in the delivery admission, it appears as though the fracture occurred in the current admission, which it didn't. However, since the fracture has been identified as the reason for the induction, it somehow needs to be coded.

According to ACS 1521 *Conditions complicating pregnancy* the use of O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* excludes codes in the S and T chapters, and the Z33 *Pregnant state, incidental* would be inappropriate, as the delivery occurred in the current admission. The fracture has been coded as an associated condition.

Could you please advise on the correct coding in this instance?

The NCCH has provided the following information in response to a similar query from the Committee.

1. The exclusion note at the beginning of Chapter XV Pregnancy, Childbirth and the Puerperium simply indicates that injuries should be classified to another chapter. It does not say that a code from the obstetric chapter cannot be used with a code from the injury chapter. In the presented case, it is valid to describe the injuries of the pregnant woman with a code from the injury chapter as well as a code from the obstetric chapter to indicate problems with the pregnancy as a result of the trauma.

2. **ACS 1521 *Conditions complicating pregnancy*** indicates that some conditions aggravating, or aggravated by pregnancy would be coded to **O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*** or **O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium*.** O98 does not apply in the presented case because it relates to infectious and parasitic diseases. O99 has an 'excludes' note for injury in the same way as the exclusion note at the beginning of the obstetric chapter. In the presented case, the codes from the injury chapter are sufficient to describe the injury and comply with the 'excludes' notes described here.

   The coding of injury in a pregnant patient should be guided by the rules of ICD-10-AM, not by a need to describe the clinical service being provided to the patient, that is, obstetric care. The 'excludes' notes at the chapter and O99 should be followed as a priority. To assign a code from 099, while indicating that the patient is receiving obstetric care, would contravene the exclusion note.

The VICC suggests the following code assignment for this scenario:

O80 ***Single spontaneous delivery***
Z37.x ***Outcome of delivery***
S82.88 ***Fracture of other parts of lower leg***
W19 ***Unspecified fall***
Y92.9 ***Unspecified place of occurrence***
U73.9 ***Unspecified activity***

This advice may change current coding practice.

#1970 Video assisted thorascopic (VATS) thymectomy

What is the procedure code for (R) video assisted thorascopic (VATS) surgery? I spoke with the treating doctor, and it seems none of the codes in block 128 fit exactly, since the surgery was via thoracoscopy. An incision was made in the mediastinum but the doctor says it was not a mediastinoscopic thymectomy.

This was referred to the NCCH for advice.

> In accordance with **ACS 0023 *Laparoscopic/Arthroscopic/Endoscopic Surgery***, 'if a procedure is performed laparoscopically, arthroscopically or endoscopically, and there is no code provided which encompasses both the endoscopy and the procedure, then both procedures should be coded'.

Therefore, the Committee suggests the following code assignment:
38446-01 [128] *Removal of thymus via sternotomy*
38436-00 [559] *Thoracoscopy*

The NCCH will consider the creation of a code for this procedure for a future edition of ICD-10-AM.

#1971 Transoesophageal echocardiogram (TOE) during CABGs

Would you please clarify if we are to code transoesphageal echocardiograms performed during CABGs. We were advised in 2001 (query no. 1691) that the Victorian Coding Committee considered TOEs a routine part of CABGs and not to code. NCCH data base query no. 1806 directs that TOEs should be coded as they are 'commonly performed during CABGs, but are not routine'. Your advice would be appreciated.

Recent advice published by the NCCH (Q1806 Intra-operative transoesphageal echocardiogram (TOE)) supercedes the advice provided in the June 2001 ICD Coding Newsletter (Query #1691 ACS 0909 Additional procedures performed in conjunction with CABGs).

Therefore, as these are not routinely performed during all CABGS procedures, TOE performed during a CABG procedure should be assigned
55130-00 [1942] ***2 dimensional real time transoesophageal ultrasound of heart performed during cardiac surgery*.**

Likewise, Swan Ganz catheterisation should also be coded when performed during CABGS.

#1976 Motor Neuron Disease (MND) with respiratory failure

At our hospital we treat many Motor Neuron Disease (MND) patients who present with various problems associated with their MND. One such problem is respiratory failure. Where the patient has known MND and presents with respiratory failure secondary to MND (documented this way on the discharge summary), it is often difficult to decide whether to sequence the MND or the respiratory failure as the principal diagnosis. It is firstly difficult to determine if this is actually a 'secondary to' or 'due to' relationship.

I am erring on the side of a 'due to' relationship, because I believe the respiratory failure is a direct result of the MND and would be somewhat expected and considered normal development of the MND. In this case, using the advice in the November 2002 Coding Newsletter (Underlying Condition as Principal Diagnosis), I should probably apply the underlying condition aspect of the principal diagnosis standard and assign the presenting condition as principal diagnosis. However, I also feel that the respiratory failure is an indicator of the progression of the MND and not actually a condition in its own right when associated with MND. Meaning, in this case, it may be more correct to sequence the MND first and respiratory failure, being the indicator of severity, second.

Can the Committee please advise?

This was referred to the NCCH for advice.

> We have presumed from your query that only the respiratory failure has been treated.
>
> If the underlying condition (that is, the motor neuron disease) is known at the time of admission and this condition is not treated, then the principal diagnosis is the respiratory failure. With the information provided, the codes would be:
>
> **J96.9** ***Respiratory failure, unspecified***
> **G12.2** ***Motor neuron disease***
>
> If the underlying condition is not known at the time of admission, that is, diagnosed during this admission, then the principal diagnosis is the motor neuron disease and the respiratory failure is not coded. (Per **ACS 0001** ***Principal diagnosis*** 'Assignment of the underlying condition as principal diagnosis').

The Committee notes that in this case, the underlying condition is not a respiratory condition and therefore the respiratory failure is a presenting problem. If the underlying condition were a respiratory condition, the respiratory failure would represent an exacerbation of that condition.

The Committee also notes the existence of the index entry:

Failure
-respiratory
- -centre G93.8

and advised that this may be relevant in this case, however the coder should check with the clinician for advice before assigning this code.

#1977 Trauma during pregnancy

Patient involved in high-speed car accident with splenic rupture. Currently 29 weeks pregnant. The patient was admitted to our hospital for 24 hours before being transferred because of mild hydrocephaly and subdural haematomas of the fetus. An obstetrician had assessed her, and ultrasound was performed and there was CTG monitoring.

I have coded both the injuries from the car accident and also a code to reflect that there was a problem with the fetus as:

S36.04 *Massive parenchymal disruption of spleen*

External cause codes

O35.8 *Maternal care for other (suspected) fetal abnormality or damage*

Questions:

1. Is the code that I have used for the mild hydrocephaly and subdural haematomas correct?
2. At the front of the pregnancy chapter of the tabular listing there is an exclude note for S00-T98 with the use of an O code. What would you do in this situation?

This was referred to the NCCH for advice.

The correct codes for this scenario are:

S36.04 *Massive parenchymal disruption of spleen*

Appropriate external cause, place of occurrence and activity codes

O35.8 *Maternal care for other (suspected) fetal abnormality and damage*

1. The exclusion note at the beginning of Chapter XV Pregnancy, Childbirth and the Puerperium simply indicates that injuries should be classified to another chapter. It does not say that a code from the obstetric chapter cannot be used with a code from the injury chapter. In the presented case, it is valid to describe the injuries of the pregnant woman with a code from the injury chapter as well as a code from the obstetric chapter to indicate problems with the pregnancy as a result of the trauma.

2. **ACS 1521 *Conditions Complicating Pregnancy*** indicates that some conditions aggravating, or aggravated by pregnancy would be coded to **O98 *Maternal infectious and parasitic diseases classifiable elsewhere but complicating pregnancy*,**

childbirth and the puerperium or **O99** ***Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium***. O98 does not apply in the presented case because it relates to infectious and parasitic diseases. O99 has an 'excludes' note for injury in the same way as the exclusion note at the beginning of the obstetric chapter. In the presented case, the codes from the injury chapter are sufficient to describe the injury and comply with the 'excludes' notes described here. **O35.8** ***Maternal care for other (suspected) fetal abnormality and damage*** is correct for describing the care of the mother related to fetal injuries from the accident.

The coding of injury in a pregnant patient should be guided by the rules of ICD-10-AM, not by a need to describe the clinical service being provided to the patient, that is, obstetric care. The 'excludes' notes at the chapter and O99 should be followed as a priority. To assign a code from O99, while indicating that the patient is receiving obstetric care, would contravene the exclusion note.

This advice may change current coding practice.

#1986 Accidents and injuries during pregnancy

Scenario 1:
Obstetric patients present following motor vehicle accidents, accidents in the home or work place. The O&G clinician sees them, and CTG is performed to assess fetal well being. We code these episodes according to the 'Minor Trauma Coding Guidelines' (ICD Coding Newsletter June 2001), as well as coding O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium* as the principal diagnosis. That is, if a pregnant patient presents for observation, we would assign:

O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium*
Z04.1 *Examination and observation following transport accident*
V43.xx *Car occupant injured in collision with car, pick-up truck or van*
Y92.40 *Roadway*
U73.8 *Other specified activity*

Is this correct?

Scenario 2:
Obstetrics patient presents with abdominal pain/strain following seatbelt injury. Obstetrics team assesses patient, and CTG is performed. We would assign:

O99.8 *Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium*
S39.8 *Other specified injuries of abdomen, lower back and pelvis'*
V43.xx *Car occupant injured in collision with car, pick-up truck or van*
Y92.40 *Roadway*
U73.8 *Other specified activity*

which groups to DRG O65B *Other Antenatal W Moderate/No Comp Diagnosis*.

However, some HIMs are now not using O99.8 and using Z33 *Pregnant state, incidental* as the last code. That is:

S39.8 *Other specified injuries of abdomen, lower back and pelvis'*
V43.xx *Car occupant injured in collision with car, pick-up truck or van*
Y92.40 *Roadway*
U73.8 *Other specified activity*
Z33 *Pregnant state, incidental*

which groups to DRG *X60C Injuries Age < 65*.

Is preceding the injury code with O99.8 (as principal diagnosis) correct, or is Z33 as last diagnosis the correct option?

This was referred to the NCCH for advice.

Z33 *Pregnant state, incidental* should not be assigned if a patient requires obstetric observation or care (see **ACS 1521 *Conditions Complicating Pregnancy***, Incidental pregnant state). Both scenario 1 and 2 state observation by obstetric clinicians and specialist obstetric procedures (CTG monitoring), therefore, **Z33 *Pregnant state, incidental*** should not be assigned for either of these scenarios.

The NCCH suggests the following codes for the cases cited:

1. Where an accident has occurred, no injuries are sustained but the patient is seen by the O & G clinician and CTG is performed:
   Z04.1 *Examination and observation following transport accident*
   Z34.x *Supervision of normal pregnancy*
   With appropriate external cause, place of occurrence, activity and procedure codes.

2. Where injuries have resulted from an accident but there is no indication of a resulting problem with the pregnancy and the patient is seen by the O & G clinician and CTG is performed:
   S39.8 *Other specified injuries of abdomen, lower back and pelvis*
   Z34.x *Supervision of normal pregnancy*
   With appropriate external cause, place of occurrence and activity codes followed by relevant procedure codes.

O99 *Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium* has an 'excludes' note for injury. To assign a code from O99, while indicating that the patient is receiving obstetric care, would contravene the exclusion note. In the second scenario, the codes from the injury chapter are sufficient to describe the injury and comply with the 'excludes' note.

In addition, the official WHO updates to ICD-10 for 2003 include complete code ranges for 'Pregnancy, complicated by, conditions in'. Codes from Chapter XIX Injury, poisoning and certain other consequences of external causes (S00-T98) are not included in these index entries.

This advice may change current coding practice.

#1987 Acute exacerbation of chronic obstructive airways disease (COAD)

Exacerbation of chronic obstructive airways disease (COAD) not otherwise specified.

Does the word 'acute' have to be documented in order to assign J44.*1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified* for exacerbation of COAD?

To me, exacerbation indicates an acute increase in severity. The index does not allow you to get to J44.1 without 'acute' being used.

The following information was provided by the NCCH:

> By definition, 'acute' means short term and 'exacerbation' is an increase in severity. Therefore, **J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified*** indicates a short-term increase in severity of COPD.
>
> J44.1 is indexed only once in ICD-10-AM Fourth Edition as follows:
>
> **Disease**
> - lung
> ↓
> - - obstructive (chronic) J44.9
> - - - with
> - - - - acute
> - - - - - exacerbation NEC J44.1
>
> The logic behind this indexing (an ICD-10 issue) is to specify that J44.1 is the correct code to assign for a short term increase in severity of the COPD, in contrast to a progressive increase in the severity of the 'chronic' disease.

Therefore, documentation of 'exacerbation of COAD' should be coded to **J44.9 *Chronic obstructive pulmonary disease, unspecified*** and 'acute exacerbation of COAD' should be coded to **J44.*1 Chronic obstructive pulmonary disease with acute exacerbation*** as per the index entry above.

#1989 Indexing of arthroscopic synovectomy of shoulder

As per ICD-10-AM Volume 4 procedures page 203:
Release
- contracture
- - joint
- - - shoulder
- - - - with synovectomy 48954-00 [1397]

48954-00 [1397] *Arthroscopic synovectomy of shoulder*

This code is for arthroscopic synovectomy of shoulder. The index entry indicates the synovectomy is with open release of the shoulder. Is this an error? Should 'with synovectomy' be indented underneath the arthroscopic entry?

This was identified as an index error and was referred to the NCCH for advice.

The correct pathway should be:
Release
- contracture
- - joint
- - - shoulder 90600-01[1395]
- - - - with synovectomy 48936-00 [1397]
- - - - - arthroscopic 48954-00 [1397]
- - - - arthroscopic 90600-00 [1395]
- - - - - with synovectomy 48954-00 [1397]

This information will be incorporated into a future errata.

#1997 High grade prostatic intraepithelial neoplasia (PIN)

We would like confirmation of correct code for 'high grade PIN' (prostatic intraepithelial neoplasia). ICD-10-AM only offers grade I, II or III.

Search Details:
Our pathologist says that:

1. High grade PIN does not necessarily equate to grade III PIN;
2. They don't talk in terms of grade I, II or III PIN; rather, high or low grade and they also don't talk in terms of ca in situ of prostate.

Vic Cancer Registry, advised to code to grade III/in-situ to D07.5 Carcinoma in situ of prostate and that cases of high grade PIN should be notified.

This was referred to the NCCH for information and advice.

Clinical advice indicates that 'high grade prostatic intraepithelial neoplasia (PIN)' should be classified as **D07.5 *Carcinoma in situ, prostate.***

The NCCH will consider amending the terminology for prostatic intraepithelial neoplasia (PIN) and the relevant indexing for a future edition of ICD-10-AM.

#1999 Epidurolysis / Racz procedure / epiduroplasty

Our problem is regarding the coding of a procedure, epidurolysis. The procedure involves a catheter being inserted into the epidural space and then injecting different drugs usually to break down the formation of adhesions or scar tissue that have formed from a previous spinal injury or surgery which can cause chronic back pain in patients.

The principal diagnosis in the majority of cases is listed as chronic back pain. We had been using 39140-00 [32] *Epidural injection for lysis of adhesions*, but it was suggested at audit, that with the principal diagnosis being 'back pain', and the doctor listing 'Epidurolysis' as the procedure with no mention of adhesions, or scar tissue formation of the spinal canal, that we further investigate the usage of this procedure code as the code for epidurolysis.

This suggestion was warranted by the fact that there is no way to look it up in the alphabetic procedure list, as by using the 39140-00 [32] we are assuming a diagnosis of adhesions or scar tissue.

Therefore, my questions are:

1. Can we use the procedure code 39140-00 [32] *Epidural for lysis of adhesions* when a doctor has listed 'epidurolysis' as the sole procedure code when the principal diagnosis is back pain or similar?

If no,

2. Do we use 90018-02 [32] *Epidural, specified therapeutic substance NEC, combined preoperative, intraoperative & postoperative*?

If no, your suggestion as to what code to use would be greatly appreciated.

Search Details:
Prior to audit, the following path was used:
Injection
- epidural (space)(with catheterisation)
- - for
- - - lysis of adhesions (hyaluronic acid)(hypertonic saline) 39140-00 [32]

This was referred to the NCCH for advice.

The NCCH agrees that epidurolysis should be classified as:
39140-00 [32] ***Epidural injection for lysis of adhesions***

The NCCH will consider the addition of 'epidurolysis' and 'Racz procedure' to the Alphabetic Index of Procedures for a future edition of ICD-10-AM.

#2000 Multiple peripheral angioplasty

Currently the code for peripheral angioplasty (without stenting) does not provide a breakdown for the number of times performed. When multiple peripheral angioplasties are performed, we are unsure as to how we should apply ACS 0020 *Multiple/Bilateral Procedures*.

Our understanding is that when a balloon is inflated multiple times at the site of a single lesion, this would be counted as one angioplasty.

Should angioplasty be coded as many times as it is performed for multiple sites? And if so, how should multiple sites be counted? Should it be based on the number of lesions, number of vessels or number of limbs angioplastied or should it be based on the number of incisions made to catheterise?

This was referred to the NCCH for advice. The NCCH agrees that the number of peripheral vessels angioplastied should be coded.

The VICC has suggested amendments to the peripheral angioplasty codes. The NCCH will consider them when making amendments to a future edition of ICD-10-AM.

#2021 Hydrodilatation of shoulder

92 year old male patient was admitted with multiple medical problems. He complained of shoulder pain and shoulder X-ray showed gross atrophy or tearing of rotator cuff, some degenerative changes were present at gleno-humeral joint. Orthopaedic surgeon recommended hydrodilatation of shoulder. This was performed in X-ray Department and report reads as follows:
11.4mgs of Celestone Chronodose in 2% Xylocaine was administered to the left shoulder and hydrodilatation undertaken with 25cc of contrast and saline. There is extensive opacification of the subacromial bursa consistent with complete tearing of the rotator cuff. The humeral head approximates the acromion.

I am unsure how to code this procedure. There are no queries on the NCCH queries database or coding matters and there is no entry in procedure index for hydrodilatation of shoulder.

This was referred to the NCCH for advice.

> Please assign the following codes for documentation of 'hydrodilatation of the shoulder':
> ICD-10-AM Third Edition:
> 50124-01 [1552] 'Injection into joint or other synovial cavity, not elsewhere classified'
> 59751-00 [1985] 'Arthrography'

ICD-10-AM Fourth Edition:
50124-01 [1552] 'Administration of agent into joint or other synovial cavity, not elsewhere classified'
59751-00 [1985] 'Arthrography'

It is not necessary to assign a separate code for the specific agent that is administered, in either edition of ICD-10-AM.

The excludes note following extension -09 in [1920] 'Pharmacotherapy' applies to the whole block (ie all of the codes in block [1920]).

Coding corkboard

NCCH Conference

We wish all our readers who are attending the NCCH conference in March a very successful conference, and happy networking!

HIMAA Conference

This conference will be held in Geelong this year on 28th and 29th of July. The Victorian Branch of HIMAA will be holding a coding workshop preceding this conference, on 27th July. Watch the HIMAA website for details.

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

Coding queries

The committee had a rest during January and met for the first 2005 meeting in February. If you have submitted a query during the last two months please be patient; we will be addressing these and getting responses to you as soon as possible.

ICD Coding Newsletter

HDSS staffing issues have caused the publication of this newsletter to be delayed. This has also resulted in fewer than usual resolved coding queries being included. We are hopeful that we will get 'back on track' with a quarterly newsletter being produced on time each quarter henceforth. Your feedback on the newsletter is welcome at any time.

Public submissions

Although the public submission time frame is limited to a three-month period of time every second year, the committee works constantly to respond to issues raised by our enquirers. Many of these responses involve sending recommendations to NCCH for consideration in future editions of ICD-10-AM. Coders should therefore send any suggestions to us via the query process.

AR-DRGs

Version 5.1 has been released by the Commonwealth Department of Health, and the Definitions Manuals have been purchased by the Department. All queries regarding grouping issues will be checked against Version 5.1 before any action is taken on them. Hospitals may wish to consider obtaining copies of these books for use by the coders before a grouping issue is submitted as a query.

Victorian ICD Coding Committee members as at 1 January 2005

Jennie Shepheard	Human Services (Chair, Acting La Trobe University representative)
Carla Read	Human Services (Convener)
Sara Harrison	Human Services (Secretary, 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 Royal Women's Hospital
Megan Morrison	St John of God Health Care Geelong
Susan Peel	Healesville and District Hospital
Leanne Stokes	Beachplace Pty Ltd
Maree Thorp	Peninsula Health
Kathy Wilton	3M

Victorian ICD Coding Committee meeting dates

Tuesday 15 February	DHS, 10:00am, 16th floor 555 Collins Street, Melbourne
Tuesday 22 March	DHS, 10:00am, 16th floor 555 Collins Street, Melbourne
Tuesday 19 April	DHS, 10:00am, 16th 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