

ICD Coding Newsletter

First quarter 2006-07

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).

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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An electronic coding query form can be completed at:

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

An index to Coding Newsletters can be found at:

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

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Coding features

ICD-10-AM Fifth Edition implementation coding workshops

HDSS was pleased to be able to offer Victorian coders the opportunity to attend the ICD-10-AM Fifth Edition implementation coding workshops by fully subsidising the costs. There were eight workshops run over two weeks in June that were attended by approximately 280 Health Information Managers and clinical coders.

We are interested in your feedback regarding all aspects of the workshops. However in making comment please bear in mind that the criteria for venue selection included:

- Ease of access for attendees
- The provision of suitable space for coding books and laptops
- The cost of the venue relative to the limited budget available
- Where catering was not included in the cost of hiring the venue, a very limited budget was available for bringing in external catering.

Feedback regarding the workshops can be sent to Carla.Read@dhs.vic.gov.au.

HDSS staff were present at each workshop and took the opportunity to present information regarding the Victorian Additions to the Australian Coding Standards and Vic DRGs. This provided an opportunity for Victorian HIMs and clinical coders to clarify several issues. We hope to be able to continue to provide these opportunities.

The chance to collaborate with NCCH in this process has strengthened our relationship with NCCH. This can only benefit Victorian HIMs and coders, and we thank the NCCH staff for maintaining their commitment and energy at the end of a long series of workshop presentations.

DHS allocated spaces for 300 coders in these workshops and it was disappointing that not all these places were taken up. At each workshop there were also some 'failures to attend' of registrants. Our intention when offering these workshops was to make them available to as many coders as possible, while ensuring that each hospital had the opportunity to take part. While it is acknowledged that sometimes unforeseen circumstances do occur, DHS had to fund both the education and catering for each person who registered and did not attend and this waste of resources is regrettable. Additionally the failures to attend and register may jeopardise the number of places that DHS will be prepared to subsidise for future workshops. Coding workshops provide excellent professional development and networking opportunities for our coding workforce. DHS has a strong commitment to ensuring the quality of the data and competency of the coding workforce, and would encourage hospitals to send more coders to future workshops and do their best to promote attendance.

Notwithstanding the above concern, it was great to put faces to the voices and names at the other end of our help desk line and to see the participants making the most of the day. We enjoyed meeting so many coders and would like to thank everyone who took the time to introduce themselves, and discussed any issues and concerns with us.

Feedback regarding questions asked of DHS at the Fifth Edition coding workshops

Use of multiples of the same external cause code

At the recent Fifth Edition coding workshops, an issue was raised regarding the use of multiples of the same external cause, place of occurrence and/or activity codes being required to reflect external cause of injuries sustained by the patient.

For example when a patient is admitted for treatment of a surgical wound infection, and then suffers a head injury due to a fall from bed, the place of occurrence code Y92.22 *Health service area* is required in both the string of codes reflecting the infection and the string of codes reflecting the head injury.

This issue is currently under discussion at NCCH and has also been discussed at VICC. Until these discussions have been finalised and a resolution has been formulated, Victorian coders should continue coding these cases as they have been.

As soon as a definitive direction is available this will be published by VICC.

Use of Activity code U73.0- *Working for income* for patients injured while driving to and from work

The inclusions at U73.0 *Working for income* must be followed by all coders. Thus patients who are injured while driving to or from work will have an activity code from the U73.0- range assigned. These patients in Victoria will be covered by TAC (Transport Accident Commission) insurance rather than VWA (Victorian Workcover Authority). However this account classification should not influence the way in which coding decisions are made.

Vic 0002 Additional diagnoses

This addition to the Australian Coding Standard was introduced for the first time on 1 July 2006. Probably the most significant aspect of this Vic addition is covered in point 1 Active evaluation.

The term 'clinical evaluation' was originally listed in ACS 0002 as one of the criteria that would affect patient management and therefore allow for the coding of a condition. When the ACS was amended in July 2000 this criterion was removed. At that time VICC coined the phrase 'active evaluation' to allow for the coding of conditions that were actively evaluated in hospital but were not treated, investigated further, and did not require increased nursing care or monitoring. The definition of 'active evaluation' is:

Review of current, active conditions as evidenced by documentation in the medical record that is not simply part of routine admission/anaesthetic examination.

Examples of the application of this point are provided in the Vic addition. The following examples are provided by way of further clarification.

Example 1:

An 82-year-old patient was admitted with CCF, dementia, not coping at home (wife died 3 months ago), NFR (not for resuscitation). On day 11 of admission the patient developed pneumonia (nosocomial stated by clinician) and was noted to be severely dehydrated. A decision was made that no active treatment of this condition would be initiated. Therefore no tests were ordered, IV fluids were not commenced, as patient wanted sips of fluid only, and no antibiotics were given. The patient died 36 hours later.

As an active decision was made about the pneumonia and the dehydration, these conditions can be coded.

Example 2:

A patient was admitted for surgical treatment of his diverticulosis. Post operatively he was noted to be anaemic. It was noted that this was in fact a pre-existing condition and a decision was made to wait and see if the treatment of his diverticulosis also affected his anaemic state. He was referred for follow up by his GP.

As an active decision was made regarding his anaemia, it can be coded.

The important aspect of this point is that some 'active' evaluation, consultation, decision making has taken place. This point is not designed to allow the coding of any condition that is documented in the patient notes.

Example 3:

A patient was admitted for rehabilitation following surgery for his fractured NOF. He was noted to have hypercalcaemia during his stay. Documentation stated 'mild hypercalcaemia – may need review later'.

As there is documentation to support 'evaluation' of the hypercalcaemia, a code can be assigned for this condition.

Data quality

2005-06 PICQ Analysis: High frequency fatal indicators at a hospital level

Performance Indicators for Coding Quality (PICQ) is a product developed by the National Centre for Classification in Health (NCCH). It contains a series of indicators which analyse admitted patient morbidity data coded with ICD-10-AM and is based on the Australian Coding Standards and coding conventions. The Health Data Standards and Systems (HDSS) Unit purchased a statewide PICQ 2004 licence for use by Victorian public and private hospitals. Fifty-nine Victorian hospital sites have applied to obtain the PICQ 2004 software.

In preparation for the end of the financial year, (as noted in the *HDSS Bulletin, Issue 103* (21 July 2006)), HDSS ran the 2005-06 data to date (as of 17 June 2006 VAED consolidation) through the PICQ 2004. One outcome of this exercise is that each hospital that triggered at least 50 episodes for any individual fatal indicator, was contacted by HDSS and asked to amend their coding practices.

The following tables provide information about the logic of fatal indicators that were triggered by at least one hospital for 50 or more episodes.

* The indicator, rationale, denominator and numerator rows are directly taken from the PICQ2004 product.

Indicator*	10020 Infectious agent code as principal diagnosis
Episodes triggered in Victoria	247
Rationale*	This indicator identifies records with a code from 'bacterial, viral and other infectious agents' as principal diagnosis. As indicated by the code title, these codes are assigned in addition to identify the infectious agent in diseases classified elsewhere.
Denominator*	Total records containing an infectious agent code.
Numerator*	From denominator, total records with an infectious agent code as principal diagnosis.
HDSS Additional Notes	<p>There are several references that highlight that these codes should not be principal diagnosis:</p> <ul style="list-style-type: none"> • ICD-10 ('pure' not ICD-10-AM): A note at the beginning of block B95-B97 states '[these codes] are provided for use as supplementary or additional codes when it is desired to identify the infectious agent(s) in diseases classified elsewhere'. • <i>Coding Matters</i> Vo1 8, No 3 (Dec 2001): The 10-AM Commandments included the following, 'It should be remembered that codes in this block are not intended for use as principal diagnoses. As indicated in the code titles, they are provided for use as supplementary or additional codes when it is desired to identify the infectious agent(s) in diseases classified elsewhere.'¹ <p>The ICD-10-AM Fifth Edition library file will be updated so that these codes will no longer be able to be used as a principal diagnosis.</p>

¹ Extracted from NCCH eBook, July 2006, 10-AM Commandments.

Indicator*	10038 Secondary neoplasm site code without primary site code
Episodes triggered in Victoria	1430
Rationale*	This indicator identifies records containing a secondary neoplasm code but no code for the primary site. ACS 0236 'Neoplasm coding and sequencing' states that, when a secondary neoplasm is treated, a code for the primary site is added (either a site-specific primary neoplasm code or the unknown site code). A personal history of neoplasm code should not be used in place of a primary site code when the secondary neoplasm is being treated.
Denominator*	Total records containing a secondary neoplasm code.
Numerator*	From denominator, total records without a primary site neoplasm code.
HDSS Additional Notes	According to ACS 0236, if the secondary site is coded 'An additional diagnosis code(s) should be assigned for the primary site(s) if known, or C80 <i>Malignant neoplasm without specification of site</i> if the primary site is unknown. ² '

Indicator*	100248 Admit for dialysis as only diagnosis code, without dialysis procedure code
Episodes triggered in Victoria	1336
Rationale*	This indicator identifies records with 'admission for dialysis' as only diagnosis code but no dialysis procedure code. ACS 1404 'Admission for renal dialysis' states that the principal diagnosis for a patient admitted for a same day or over one night stay for renal dialysis should indicate the admission is for dialysis. If a patient was admitted for renal dialysis but did not undergo the procedure because of contra-indications, a code for 'procedure not carried out' should be assigned in addition or the episode cancelled, dependent on the admission policy of your State. Also run Indicators 100240 and 100241 to verify this principal diagnosis is correct for the length of stay.
Denominator*	Total records with an admit for dialysis code as the only diagnosis code.
Numerator*	From denominator, total records without a dialysis procedure code.
HDSS Additional Notes	If a patient was admitted for renal dialysis but did not undergo the procedure because of contra-indications, the episode may or may not be cancelled, depending on how the circumstances of the episode compare to the guidelines listed in the <i>DHS Hospital Admission Policy</i> , which can be found at: http://www.health.vic.gov.au/hdss/vaed/index.htm

² Extracted from NCCH eBook, July 2006, Neoplasms.

Indicator*	101435 Neoplasm malignant secondary code without morphology malignant secondary code
Episodes triggered in Victoria	246
Rationale*	<p>This indicator identifies records containing a malignant secondary neoplasm diagnosis code and a morphology code but the behaviour suffix of the morphology code is not malignant secondary. The suffix of the morphology code indicating the behaviour should match the type of neoplasm indicated by the diagnosis code.</p> <p>ACS 0233 'Morphology' states that the decision on whether to use morphology codes is a State/Territory policy. This Indicator is not useful if any of the data being tested are from a State/Territory which has not required morphology codes.</p>
Denominator*	Total records containing a malignant secondary neoplasm code and a morphology code.
Numerator*	From denominator, total records without a malignant secondary morphology code.
HDSS Additional Notes	<p>The <i>Victorian Additions to the Australian Coding Standards</i> state that 'The assignment of morphology codes, where appropriate, is mandatory in Victoria.' Thus it would be expected that all episodes triggering this indicator would be fixed.</p> <p>This edit is usually triggered because coders accidentally put /3 instead of /6.</p>

Indicator*	101595 Termination of pregnancy procedure code without medical abortion code
Episodes triggered in Victoria	686
Rationale*	<p>This indicator identifies records containing a termination of pregnancy procedure code but no medical abortion diagnosis code. Episodes with missed abortion, other abnormal products of conception or spontaneous abortion coded are excluded from the indicator. A termination of pregnancy performed in a hospital is a medical abortion and the diagnosis code should be 'medical abortion', not 'other abortion' or 'unspecified abortion'. This indicator may also identify episodes incorrectly coded with a retained products of conception following abortion code instead of the appropriate abortion code; or a curettage of gravid uterus code but the diagnosis is not abortion.</p>
Denominator*	Total records containing a termination of pregnancy procedure code.
Numerator*	From denominator, total records without a medical abortion, missed abortion, other abnormal products of conception or spontaneous abortion diagnosis code.
HDSS Additional Notes	<p>The logic of this indicator is that a termination of pregnancy procedure code should have a 'matching' diagnosis code from:</p> <ul style="list-style-type: none"> O02.1 <i>Missed abortion</i> O02.8 <i>Other specified abnormal products of conception</i> O02.9 <i>Abnormal product of conception, unspecified</i> O03.- <i>Spontaneous abortion</i> O04.- <i>Medical abortion</i> <p>Feedback from users in Victoria (and others), has lead to this indicator being amended in PICQ 2006 to include O02.0 <i>Blighted ovum and nonhydatidiform mole</i>; therefore, any episodes with O02.0 do not need to be fixed, as they are correct.</p>

Indicator*	101938 Diabetes mellitus code and a renal failure or impairment code
Episodes triggered in Victoria	531
Rationale*	This indicator identifies records containing a Diabetes mellitus code and a renal failure or impairment code but no Diabetes mellitus with advanced renal disease code, other specified renal complication code or multiple microvascular complications code. ACS 0401 'Diabetes mellitus and impaired glucose regulation (IGR)' states that, when a patient has diabetes and renal failure or impairment, a Diabetes mellitus with advanced renal disease code, other specified renal complication code or multiple microvascular complications code should be assigned. A causal link between the diabetes and renal failure or impairment does not need to be documented in the medical record
Denominator*	Total records containing a Diabetes mellitus code and a renal failure or impairment code.
Numerator*	From denominator, total records without a Diabetes mellitus with advanced renal disease code, other specified renal complication code or multiple microvascular complications code.
HDSS Additional Notes	The problem with the numerator records is that a code from N17-N18.91 (renal failure codes) and a diabetes code is used, but the diabetes code is not: E1-.71 <i>Diabetes with multiple microvascular complications</i> E1-.23 <i>Diabetes with advanced renal disease</i> E1-.29 <i>Diabetes with other specified renal complication</i>

Indicator*	101939 Diabetes mellitus or Impaired glucose regulation (IGR) code and hypertension code
Episodes triggered in Victoria	871
Rationale*	This indicator identifies records containing a Diabetes mellitus (excluding Type 1) or Impaired glucose regulation (IGR) code and a hypertension code but no Diabetes mellitus or IGR with features of insulin resistance code. ACS 0401 'Diabetes mellitus and impaired glucose regulation (IGR)' states that, when a patient has diabetes or IGR and hypertension, a code for Diabetes mellitus or IGR with features of insulin resistance should be assigned.
Denominator*	Total records containing a Diabetes mellitus (excluding Type 1) or IGR code and a hypertension code.
Numerator*	From denominator, total records without a Diabetes mellitus or IGR with features of insulin resistance code.
HDSS Additional Notes	The problem with the numerator records is that I10 <i>Essential (primary) hypertension</i> and a diabetes (excluding Type 1 diabetes) or IGR code are used, but a diabetes code is not: E1-.72 <i>Diabetes with features of insulin resistance</i>

Indicator*	101944 Diabetes mellitus with nephropathy code assigned more than once
Episodes triggered in Victoria	157
Rationale*	This indicator identifies records containing more than one Diabetes mellitus with nephropathy code. ACS 0401 'Diabetes mellitus and impaired glucose regulation (IGR)' states that, when diabetic nephropathy changes classifiable to more than one code are documented, only the most advanced stage should be coded.
Denominator*	Total records containing a diabetes mellitus with nephropathy code.
Numerator*	From denominator, total records containing more than one diabetes mellitus with nephropathy code.
HDSS Additional Notes	The problem with the numerator records is that more than one of the following codes (for a single type of diabetes) is present (only the most advanced stage should be coded): E1-.21 <i>Diabetes with incipient diabetic nephropathy</i> E1-.22 <i>Diabetes with establish diabetic nephropathy</i> E1-.23 <i>Diabetes with advanced renal disease</i>

Indicator*	101965 Generalised allied health intervention - physiotherapy code assigned more than once
Episodes triggered in Victoria	216
Rationale*	<p>This indicator identifies records containing more than one generalised allied health intervention - physiotherapy code. ACS 0032 'Allied health interventions' states that, the general code representing a professional group should be assigned once only for an episode of care, regardless of the number of specific interventions performed by the relevant professional.</p> <p>Indicators 101962 - 101965 check for generalised allied health interventions assigned more than once.</p>
Denominator*	Total records containing a generalised allied health intervention - physiotherapy code.
Numerator*	From denominator, total records containing more than one generalised allied health intervention - physiotherapy code.
HDSS Additional Notes	The problem with the numerator records is that the code 95550-03 [1916] <i>Allied health intervention, physiotherapy</i> has been assigned more than once.

Indicator*	101982 Adjustment and management of implantable device or pump without appropriate procedure code.
Episodes triggered in Victoria	2184
Rationale*	This indicator identifies records containing an adjustment and management of implantable infusion device or pump code but no appropriate procedure code. ACS 0045 'Drug delivery devices' describes the difference between implantable and non-implantable devices. Coders must ensure the appropriate diagnosis and procedure code combination is used. If a patient were admitted for attention to the device but did not undergo the procedure because of contra-indications, a code for 'procedure not carried out' should be assigned in addition or the episode cancelled, dependent on the admission policy of your State.
Denominator*	Total records containing an adjustment and management of implantable infusion device or pump code.
Numerator*	From denominator, total records without an appropriate procedure code or a procedure not carried out code.
HDSS Additional Notes	<p>The problem with the numerator records is that a Z45.1 <i>Adjustment and management of implantable infusion device or pump</i> code has been used, without one of the following codes:</p> <p>39127-00 [39] <i>Insertion of implantable spinal infusion device</i> 39128-00 [39] <i>Insertion of implantable spinal infusion pump</i> 90011-04 [40] <i>Removal of implantable spinal infusion device or pump</i> 13939-01 [766] <i>Maintenance (alone) of implantable infusion device or pump</i> 30400-00 [766] <i>Insertion of implantable vascular infusion device, intra-abdominal vessel</i></p> <p>34527-00 [766] <i>Insertion of implantable vascular infusion device, other vessel</i> 34527-01 [766] <i>Insertion of implantable vascular infusion pump</i> 34528-00 [766] <i>Percutaneous insertion of implantable vascular infusion device</i> 34528-01 [766] <i>Percutaneous insertion of implantable vascular infusion pump</i> 34530-02 [766] <i>Revision of implantable vascular infusion device or pump</i> 34530-03 [766] <i>Removal of implantable vascular infusion device or pump</i> 13939-00 [1921] <i>Loading of implantable infusion device or pump</i> Z53.- <i>Persons encountering health services for specific procedures, not carried out</i></p> <p>Analysis of data indicates that instead of one of the above procedure codes being used, a procedure code for a non-implantable vascular access device (VAD) is being used.</p> <p>This situation may also occur if the procedure code is correct but the diagnosis code is not Z45.1.</p>

Indicator*	101983 Adjustment and management of non-implantable vascular access device (VAD) without appropriate procedure code.
Episodes triggered in Victoria	580
Rationale*	This indicator identifies records with an adjustment and management of vascular access device code but no appropriate procedure code assigned. ACS 0045 'Drug delivery devices' describes the difference between implantable and non-implantable devices. Coders must ensure the appropriate diagnosis and procedure code combination is used. If a patient were admitted for attention to the device but did not undergo the procedure because of contra-indications, a code for 'procedure not carried out' should be assigned in addition or the episode cancelled, dependent on the admission policy of your State.
Denominator*	Total records containing an adjustment and management of vascular access device code.
Numerator*	From denominator, total records without an appropriate procedure code or a procedure not carried out code.
HDSS Additional Notes	<p>The problem with the numerator records is that a Z45.2 <i>Adjustment and management of vascular access device</i> code has been used, without one of the following codes:</p> <p>13300-00 [738] <i>Catheterisation/cannulation of other vein in neonate</i> 13300-01 [738] <i>Scalp vein catheterisation/cannulation in neonate</i> 13300-02 [738] <i>Umbilical vein catheterisation/cannulation in neonate</i> 13319-00 [738] <i>Central vein catheterisation in neonate</i> 13815-00 [738] <i>Central vein catheterisation</i> 13815-01 [738] <i>Percutaneous central vein catheterisation</i> 34521-02 [738] <i>Intra-abdominal vein catheterisation/cannulation</i> 34530-04 [738] <i>Removal of venous catheter</i> 90220-00 [738] <i>Catheterisation/cannulation of other vein</i> 13942-01 [766] <i>Maintenance (alone) of ambulatory drug delivery device</i> 92058-00 [1921] <i>Irrigation of vascular catheter</i> 13942-00 [1921] <i>Loading of ambulatory drug delivery device</i> Z53.- <i>Persons encountering health services for specific procedures, not carried out</i></p> <p>Analysis of data indicates that instead of one of the above procedure codes being used, a procedure code for an implantable device or pump is being used.</p> <p>This situation may also occur if the procedure code is correct but the diagnosis code is not Z45.2.</p>

Indicator*	101985 Pharmacotherapy session for neoplasm code as additional diagnosis when not same day stay
Episodes triggered in Victoria	206
Rationale*	<p>This indicator identifies records of episodes longer than same day containing the pharmacotherapy session for neoplasm code as an additional diagnosis. ACS 0044 'Chemotherapy' was amended in ICD-10-AM Fourth edition to remove the need to assign the Pharmacotherapy session for neoplasm code as an additional diagnosis code in a non-same-day episode of care. The procedure code for pharmacotherapy provides this information.</p> <p>Indicator 100002 checks for Pharmacotherapy session for neoplasm as the principal diagnosis when not same day stay.</p>
Denominator*	Total records containing the pharmacotherapy session for neoplasm diagnosis code and the episode is not same day.
Numerator*	From denominator, total records containing the pharmacotherapy session for neoplasm diagnosis code as an additional diagnosis.
HDSS Additional Notes	The problem with the numerator records is that the Z51.1 <i>Pharmacotherapy session for neoplasm</i> has been assigned for an episode longer than same day, as an additional diagnosis. This code is not required at all for episodes that are not same day.

Audits of Hospital Admitted Patient Data 2005-08

Following an open tendering process, Healthcare Management Advisors Pty Ltd (HMA) has been contracted by DHS to undertake this project, 'Audits of Hospital Admitted Patient Data 2005-2008'.

The conduct of these audits of admitted patient data is foreshadowed in the *Victoria-Public Hospitals and Mental Health Services Policy and Funding Guidelines 2005-06* (sections 10.3 and 10.4) and *2006-07* (section 10.2.5) and the *General Conditions of Funding* for each year.

In early September, letters were sent from the Department of Human Services (DHS) to the Chief Executive Officer and Health Information Services Manager of all Victorian public hospitals, advising of the imminent commencement of this project to audit admitted patient data from Victorian public hospitals, for the financial years 2005-2006 to 2007-2008.

For your information, the substance of that letter, including the objectives, scope and key aspects of the methodology of this project are reproduced below.

Two information sessions were held in Melbourne in September, with one of these sessions video linked to five regional venues. Representatives of hospitals' Health Information and/or Clinical Coding service(s) were encouraged to attend one of these sessions.

Audits of Hospital Admitted Patient Data 2005-2008

The project will audit hospital admitted patient record data in Victorian casemix-funded public hospitals, including publicly-funded denominational hospitals and Small Rural Health Services (SRHSs), as reported by hospitals to the Victorian Admitted Episodes Dataset (VAED) for the three financial years 2005-2006 to 2007-2008 inclusive.

Objectives

The key objectives of the project are to:

- Assess the validity of casemix-based payments to Victorian public hospitals;
- Assess the application of the contemporary DHS Hospital Admission Policy, particularly for short stay admitted episodes;
- Support improvements in the accuracy of admitted patient data reporting.

The project will provide:

- A measure of the accuracy of the ICD-10-AM codes submitted by Victorian public hospitals, and the extent to which the codes reported are supported by the clinical documentation and allocated in accordance with contemporary reporting requirements;
- A measure of the impact of any code changes on Victorian-modified Diagnosis Related Groups (Vic-DRGs), and the impact of these changes, and/or inaccuracies in other relevant data, on hospital payments under the prevailing funding arrangements, as indicated by change in Weighted Inlier Equivalent Separations (WIES).

'Accurate' reporting is considered to be reporting in accordance with DHS' requirements to completely and accurately reflect the events of each admitted patient episode.

Scope

For this first year, some 10,000 episodes from 2005-2006 will be reviewed across 60 sites. Randomly selected samples will represent approximately one per cent of each site's annual separations, with a minimum sample size of 40 episodes.

A further 60 sites will be audited in each of the second and third years, with sample sizes for randomly selected sites similar to those in the first year. However, sites reviewed in the previous round where change of DRG and/or WIES exceed rates deemed by DHS to be acceptable may be reviewed again, with larger sample sizes designed to achieve more statistically significant results. If this second review also returns unacceptable results, the site may be the subject of a supplementary audit, the cost of which will be passed on to the hospital, as set out in the *Policy and Funding Guidelines*.

Approximately 13,000 episodes will be reviewed for each of the second (2006-2007) and third (2007-2008) years of the project, making a total of 36,000 episodes to be reviewed over the three years of the project. This total may include targeted audits of particular case types, sites or data items, and additional cases may be reviewed, depending on findings.

Episodes for audit

Apart from targeted reviews, audit episodes will be limited to those reported with Care Types 4 (Acute), K (Non-Designated Rehabilitation Program/Unit) or U (Unqualified Newborn), and excluding same day chemotherapy (Vic-DRG R63Z) and dialysis (Vic-DRG L61Z). Episodes for review will be drawn from throughout the relevant financial year, although consideration will be given to exempting some months immediately following the introduction of significant changes in admitted patient reporting.

Data for audit

Data to be evaluated include all ICD-10-AM diagnosis and procedure codes, including Victorian alphabetic code prefixes and contracted procedure flags, morphology codes and a range of administrative and demographic data items impacting on Vic-DRG grouping or WIES allocation, including admission and separation dates and times, indigenous status, special funding and other contract arrangements, separation mode, account classification, admission weight for infants, duration of mechanical ventilation and accommodation type.

Assessments performed on administrative and demographic data will be quantitative and descriptive in the first instance.

Assessments on the application of DHS Hospital Admission Policy will in the first instance evaluate compliance with requirements for clinicians to document justification for admission for short stay episodes.

Notification of participation

Sites to be audited will be notified by HMA of their involvement two to three weeks before the scheduled visit.

In order to expedite communication of audit information, hospitals are asked to provide the name and title/role of their preferred contact person for this purpose, and her/his phone and email details, to Joanne McLachlan by email (see below) as soon as possible. Email contact details are preferred by HMA.

The notification advice from HMA will indicate the date(s) on which the casemix auditor(s) will visit that site. A list of the episodes to be audited will be included, along with a Pre-Audit Survey. This survey, to be completed and returned to HMA before the auditor's visit, will provide the auditor with some background to the circumstances under which coding and other data reporting are performed at that site.

Key members of the site's Health Information and Clinical Coding Service should be available during the auditor's visit to discuss cases and answer the auditor's questions, and to assemble relevant people for the final de-briefing, before the auditor leaves the hospital. Please advise HMA promptly if this will not be possible.

Casemix auditors

All data reviews will be conducted by suitably qualified and experienced health information managers.

Casemix audits are conducted under the provisions of the *Health Services Act*, which sets out the role and functions of casemix auditors. Casemix auditors will carry authority from DHS to perform this role.

Confidentiality

Casemix auditors are bound by both professional ethics and practices to maintain the confidentiality of patient information, as well as their obligations as casemix auditors not to release details of their work on this project.

Review methodology

Each episode will be reviewed by the casemix auditor 'blind', that is, without reference to the hospital-assigned codes, or values for administrative and demographic data. This will require the hospital to prepare each record for review to obscure those hospital-assigned codes and other data values, either by removing, covering or folding over the relevant page(s), depending on their design.

All patient documentation for the episode under review, including laboratory investigation and imaging reports, will need to be accessible to the casemix auditor to assign their codes. Where such reports, or other episode documentation, is held electronically rather than in the hard copy patient record, the site will need to facilitate access to those resources for the auditor.

All ICD-10-AM codes for the episode will be reviewed, to their full extent. That is, codes will not be limited to 3-digit level, nor the review limited to only the first three diagnosis or procedure codes, for example. Morphology codes will also be reviewed, as will the alphabetic code prefixes P, A, C and M, and the contract procedure flags.

Casemix auditors will apply all relevant Australian Coding Standards (ACSs), including any Victorian Additions to those Standards, and changes to these notified from time to time by authoritative sources, in particular the National Centre for Classification in Health (NCCH) publication *Coding Matters*, the *Victorian ICD Coding Newsletter*, and the NCCH's Coding Query Database, where these are not inconsistent with DHS advice.

Administrative and demographic data will be assigned by casemix auditors in accordance with data and code definitions and reporting requirements set out in the relevant edition of the *VAED Manual*, including updates issued from time to time by DHS.

Casemix auditors will discuss with relevant hospital representative(s) those cases where the auditor-assigned data grouped to a different Vic-DRG to that achieved with the hospital-assigned data, with a view to resolving those differences. These discussions may take place daily, or towards the end of the auditor's visit. Hospital staff will be given an opportunity to review the case before this discussion. Casemix auditors may also outline other findings, but hospitals should understand the auditor is not able to enter detailed discussion about the full extent of their data review due to time constraints. While the aim of these discussions is educative, hospital representatives may put their case if they feel they can justify the allocation of different codes than those used by the auditor. If, after discussion, agreement cannot be reached, a second auditor will review the case, usually requiring de-identified episode documentation to be copied and sent off-site. The second auditor's values will be provided to the hospital, for further discussion.

Casemix auditors may include observations on coding infrastructure (including patient record format, content and structure, and resources available to coders, including references, continuing education, ergonomics of work location, staffing and information technology) as it affects the coding result achieved at that site. Such observations will refer to objective measures/standards, or to widely accepted conventions; observations based on personal opinion will be acknowledged as such.

Reporting

A written report will be produced for each site audited. These will be prepared by the site's auditor, in conjunction with the HMA Project Manager, Angela Cook, and conveyed to the hospital via DHS approximately one month after the conclusion of the site visit. These reports will list values assigned for reviewed cases by both the hospital and the casemix auditor, some analysis and tabulations summarising findings, and commentary by the auditor, along with the Pre-Audit Survey, for reference.

Hospitals will be expected to address issues identified by auditors, and will be asked by DHS to describe action to be taken in this regard.

A final report will be produced for each year of the overall project, in which each site's results will be summarised.

Partner agencies

During this project, samples will be reviewed at some sites for other payor agencies: the Department of Veterans' Affairs, the Victorian Transport Accident Commission and the Victorian WorkCover Authority. Where a sample for one or more of these 'partner agencies' is drawn for a site, that sample will be reviewed in the same way as other cases, but will be reported separately within the site's report. A copy of this report for that agency's sample will also be forwarded to the relevant agency.

Casemix auditors will review the election of patients reported with Department of Veterans' Affairs Account Class.

Auditors' needs at the hospital

Hospitals are asked to provide an appropriate well-lit, quiet work area for the casemix auditor's sole use during her/his visit, ideally close to the Health Information Service/Patient Record Department. Each auditor will require a desk and chair. Auditors will each have a laptop computer, which will require access to a power point. It will also be useful for auditors to have access to a telephone, for communication with HMA. While a single auditor will visit sites with smaller sample sizes, larger sites may host two or up to three auditors concurrently.

In order to perform their task, casemix auditors will require access to the hospital's patient records, in whatever format is usually accessed by the site's coders. Hospital Health Information Service/Patient Record Department staff will need to retrieve the sample medical records from the list supplied, and prepare each record to obscure the hospital-assigned codes, as described above.

Depending on the auditor's schedule of visits to different sites, auditors may also wish to perform some work out of usual business hours, including on weekends. If this is the case, you are asked to facilitate the auditor's access to her/his place of work and the records and other resources required to perform their task at those times. Please discuss with HMA if this either poses difficulties for your site, or would assist your own schedule.

Contacts for queries

Queries regarding this audit of hospital admitted patient data should be directed to Joanne McLachlan at the Department of Human Services (ph 9096 8704) or emailed to joanne.mclachlan@dhs.vic.gov.au.

List of selected ICD –10 -AM coding queries

#2081 Pain management procedures

Please provide advice for coding the following scenarios:

Scenario 1:

Query involves the procedure code for a patient with pain to left chest, arm and back up to level of her left breast. The patient has small cell lung carcinoma with extensive left hilar, mediastinal and pleural tumour with infiltration of the T2 vertebral body, left T1-2 and T2-3 nerve root foramen. There is compression of the left side of the cord at these levels. The patient was treated with a subcutaneous lignocaine infusion via a Grasby pump. Clinical advice from the Pain Clinic stated the treatment was systemic and not targeting any specific nerve.

When using Third Edition we were instructed to use code 92193-00 [1885] *Lignocaine infusion for pain management*. In Fourth edition this block no longer exists and Block 1920 excludes pain management. Therefore because we have no specific nerve, we coded it to 90022-00 [63] *Administration of anaesthetic agent around other peripheral nerve*.

Can you instruct us on the correct code for Subcutaneous/ IV infusion of Lignocaine for pain management? Are we to code all Pain Management procedures to Blocks specified at the Excludes note at Block [1920]?

Scenario 2:

This is a pain management procedure performed for Back Pain (diagnosis given).

As it was a pain management procedure the code 18274-03 [63] *Administration of anaesthetic agent around paravertebral sacral nerve* was proposed. However, the Pain Clinic medical officer said that this was not the procedure performed but injection was directly into the joint. Therefore code chosen was 50124-01 [1552] *Administration of agent into joint or other synovial cavity, not elsewhere classified*.

1. Can you confirm this code or advise another code.
2. Pain management is excluded from Block [1920] and we are sent to Blocks [31] to [32] and [60] to [66]. Can we use codes from other parts of the Tabular List, as we have done with this procedure, for pain management.

Scenario 3:

Diagnosis: Chronic Neck and L Shoulder/Arm Pain

Operative Detail: 1:4 mixture of Celestone / 2% Xylocaine injected into Trigger Points of left trapezius, left pectoralis, left forearm extensors

Codes considered:

96197-03 [1920] *Intramuscular administration of pharmacological agent, steroid*

96197-09 [1920] *Intramuscular administration of pharmacological agent, other and unspecified pharmacological agent*

However Block [1920] excludes pain management.

90022-00 [63] *Administration of anaesthetic agent around other peripheral nerve*

90560-00 [1552] *Injection, muscle NEC*

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

Answer one:

Within the current structure of ACHI, there is no specific code for subcutaneous infusion of lignocaine via a Grasby pump for pain management, nor intravenous infusion of lignocaine. The NCCH advises that the most appropriate codes for these interventions, considering that they are for systemic rather than localised treatment, are:

Subcutaneous infusion of lignocaine:

96200-09 [1920] ***Subcutaneous administration of pharmacological agent, other and unspecified pharmacological agent***

Intravenous infusion of lignocaine:

96199-09 [1920] ***Intravenous administration of pharmacological agent, other and unspecified pharmacological agent***

Answer two:

The NCCH confirms that the correct code for sacroiliac joint block for pain relief is:

50124-01[1552] ***Administration of agent into joint or other synovial cavity, not elsewhere classified***

Answer three:

It is not appropriate to assign a code from **Block [1920] Pharmacotherapy** for the procedure of trigger point intramuscular injections, as codes from this block are intended for systemic, rather than localised, effect. The correct code to assign in this case is:

90560-00 [1552] ***Administration of agent into soft tissue, not elsewhere classified***

The NCCH acknowledges that the code ranges provided at the 'excludes' note in **Block [1920] Pharmacotherapy** are too specific and that codes from other chapters in the classification may be appropriate for localised pain management procedures. This note will be reviewed as part of an overall revision of pain management interventions for a future edition of ACHI.

The VICC accepts the NCCH responses to these queries and notes that codes in **Block [1920] Administration of pharmacotherapy** are intended for systemic, not localised, effect.

#2131 ICD implantation

Patient admitted to have ICD implantation. The type used was a Biotronic Cardiac Airbag, which is listed by our catheter lab as a combined VVI (single chamber) pacemaker/ICD. The documentation in the record supported this, however there was only one lead inserted into the R Ventricle. On checking with the catheter lab this device does only have one electrode, which provides both functions.

Which code should be used for the electrode? The choices would appear to be either:

38278-01 [648] *Insertion of permanent transvenous electrode into ventricle*

or

38521-03 [653] *Insertion of defibrillation electrodes*

Should we use both codes, even though only one electrode was used?

With any of the above choices for electrodes the coding does not actually represent what was done.

The grouping does not appear to be affected, as once a defibrillator is coded, the DRG assigned is F01 *Implantation or Replacement of AICD, Total System* regardless of whether defibrillator electrodes are coded or not, or a pacemaker is inserted.

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

If a patient has a combined AICD/Biventricular device inserted, coders need to assign separate codes for the insertion of the AICD and the pacemaker. This device combines the functions of both in a single unit and would normally require only three transvenous electrodes.

Coders need to check the operation report for the number of electrodes inserted and code accordingly. Where there is a combined device inserted but there is no specific information regarding the placement of the leads, the electrodes will be coded to the pacemaker leads as these

leads will be inserted into both ventricles and the atrium (Biventricular pacemaker) and have dual action to pace as well as defibrillate.

There is no appropriate place in **Chapter 8 Procedures on Cardiovascular System** of ACHI to place codes for combined devices. A choice had to be made by NCCH to classify combined devices with either AICDs or pacemakers. As pacemaker codes are more specific than AICD codes in ACHI, the decision was made to classify the combined devices to pacemakers. This was proposed and agreed to by the Coding Standards Advisory Committee for ACHI Fourth Edition. However, following ACHI Fourth Edition production, changes were made due to DRG/funding implications (not classification reasons) that require both AICD and pacemakers to be coded for combined devices.

The VICC notes the NCCH response and advises that the 'code also' coding convention at both the AICD insertion and pacemaker insertion, means that when only one electrode is inserted that performs both functions, a code is assigned for each electrode function. It is acknowledged that this results in the assignment of two codes. If there is no information on the function of leads, default to pacemaker electrodes.

#2132 Renal failure NOS with diabetes

Male, aged 83 with diagnosis of renal failure, likely obstructive nephropathy secondary to prostate adenocarcinoma; urinary retention and haematuria on presentation, R) stent in situ. Indwelling catheter inserted on admission, voiding well on discharge (no catheter). The prostate cancer was diagnosed in 1995. Patient also NIDDM on insulin.

See Disease Index:

Diabetes

-with

--failure

---renal

----acute

----chronic

----end-stage

There is no option for renal failure NOS, therefore I coded the episode as follows:

N19 *Unspecified renal failure*
N13.8 *Other obstructive and reflux uropathy*
R33 *Retention of urine*
R31 *Unspecified haematuria*
C61 *Malignant neoplasm of the prostate*
M8140/3 *Adenocarcinoma NOS*
Z96.0 *Presence of urogenital implants*
E11.9 *Type 2 diabetes mellitus without complication*
Z92.22 *Insulin*

This coding was challenged in an audit and discussed at a round- table coding exercise. There was no documented history of previous renal failure in the medical record, so I could have used my Coders Creed and assumed acute renal failure and coded to E11.29 *Type 2 diabetes mellitus with other specified renal complication*, N17.9 *Acute renal failure*. Renal Impairment defaults to chronic. Does this also apply to renal failure and therefore coded to E11.23 *Type 2 diabetes mellitus with advanced renal disease*, N18.91 *Chronic renal impairment*?

I disagreed with these suggestions, believing that I should follow the index.

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

Coders should, where possible, confirm with the treating clinician whether the renal failure is acute or chronic. When documentation is insufficient and further clinical advice cannot be obtained, assign:

E1-.23 *Diabetes mellitus with advanced renal disease*
N18.90 *Unspecified chronic renal failure*

#2175 MRI brain and cerebral cell study

I am querying how to code MRI Brain and cerebral cell study. I rang the reporting radiologist to enquire what the procedure involved and he stated 'to help plan the neurosurgery to be performed. 3

Dimensional acquisitions are made, using surface markers to determine where to make the incision for neurosurgery'. Do we code 90901-00 [2015] *MRI of brain* or 40803-00 [1] *Intracranial stereotactic localisation*? We have decided to code MRI brain only for the interim.

Search Details: The report is as follows:

MRI brain and cerebral cell study - (GHB)

Clinical indication:

Two-week history of headache. Right parietal lesion seen on CT. Past history of melanoma 20yr ago.

Findings:

There is an ill-defined mass involving both cortex and underlying white matter situated predominately within the right temporal lobe, extending superiorly into the inferior aspect of the right parietal lobe. The lesion extends medially to involve the lateral fibres of the splenium of the corpus callosum, although no extension across the midline is shown. There is a moderate amount of mass effect, with effacement of the overlying sulci, the right sylvian fissure, the temporal horn of the right lateral ventricle, and to a lesser extent the body of the right lateral ventricle, with slight subfalcine shift to the left and a mild degree of mass effect on the right lateral aspect of the midbrain. Following intravenous contrast administration, there is predominantly ring enhancement in a dominant focus, which is superficially placed, with at least one other small focus of ring enhancement more anteriorly within the right temporal lobe. No other intra or extra axial lesion is shown. Paranasal sinus disease noted. A Stealth study was performed with fiducial markers in place, with the data downloaded to disc in preparation for surgical planning.

Conclusion:

The right, predominately temporal and to a lesser extent parietal, lesion has features compatible with a primary glial tumour, the presence of central necrosis and ring enhancement is compatible with a glioblastoma multiforme. Involvement of the splenium of the corpus callosum noted, however no extension across the midline is shown.

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

The NCCH agrees that **40803-00 [1] *Intracranial stereotactic localisation*** is the appropriate code for the case cited. There is an includes note for magnetic resonance imaging (MRI) at this code.

Please also refer to ACS 0629 Stereotactic Radiosurgery, Radiotherapy and Localisation for further information regarding intracranial stereotactic localisation.

#2190 Transcystic exploration of Common Bile Duct

33 year old female presented with a cystic duct calculi for removal. What procedure code should be assigned for a laparoscopic cholecystectomy with a transcystic exploration of the common bile duct, without retrieval of a calculus? The index does not allow you to assign a code for a laparoscopic exploration of the CBD (via cystic duct) without removal of a calculus. For example:

1. Cholecystectomy

- laparoscopic
- with removal of common bile duct calculus
- via
- cystic duct 30448-00 [965]
- laparoscopic choledochotomy 30449-00 [965]

OR

2. Exploration

- bile duct(s)
- common (open)
- with
- cholecystectomy (with removal of calculus) 30454-01 [965]

However, 30454-01 [965] *Cholecystectomy with choledochotomy* cannot be assigned. Choledochotomy was not performed as the CBD was explored via the cystic duct. Also, this code excludes that via laparoscopy. The excludes note leads you to 30449-00 [965] *Laparoscopic cholecystectomy with removal of common bile duct calculus via laparoscopic choledochotomy*. This code includes choledochotomy, so it is incorrect.

Therefore we are left with code 30448-00 [965] *Laparoscopic cholecystectomy with removal of common bile duct calculus via cystic duct*, however the calculus was not removed. The removal of the calculus is an essential modifier in the index (in example one). Can we still assign this code or should we assign only the laparoscopic cholecystectomy? The laparoscopic cholecystectomy on its own does not reflect the procedure being performed because the exploration of the CBD is time consuming and adds risk to the procedure.

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

The NCCH agrees for the case cited that 30448-00 [965] Laparoscopic cholecystectomy with removal of common bile duct calculus via cystic duct is currently the most appropriate code.

The NCCH will review these codes for a future edition of ACHI.

The VICC has provided the NCCH suggested index entry amendments for this procedure.

#2191 Dysphagia and ACS 0604

A 26 year old male was admitted with an intracranial haemorrhage. Notes from Speech Therapist state 'moderate oropharyngeal dysphagia' requiring 'vitamised diet/ grade 2 thickshake fluids.' This modified diet was still required 6 days later when the patient was transferred to a rehabilitation facility.

ACS 0604 *Stroke* states that dysphagia should only be coded when requiring nasogastric tube/enteral feeding, or still requiring treatment more than 7 days after the stroke occurred.

Why does this differ from incontinence, which can be coded if present at discharge?

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

The NCCH agrees there is inconsistency in the guideline for the coding of incontinence and dysphagia in ACS 0604 *Stroke* with regards to the advice to code if 'present at discharge.'

This will be reviewed for a future edition of ACS. The current guidelines should be followed in the interim.

#2193 KTP bladder neck vaporisation

What procedure code should be assigned for KTP bladder neck vaporisation performed for bladder neck contracture/stenosis?

The VICC has sent a referral to the NCCH requesting consideration of a new code for this procedure, as there is already a code for vaporisation of the prostate. In the meantime, the most appropriate code for this procedure is:

36854-02 [1101] Endoscopic resection of bladder neck

The VICC received the following advice from NCCH:

The NCCH will consider developing a new code for bladder neck vaporisation for a future edition of ACHI.

#2194 Infected wound with cellulitis

Use of T89.0x codes with cellulitis. Does the presence of cellulitis following open wounds indicate that the wound is infected (T89.02)? It would seem that in some cases apparently uncomplicated trauma to the skin can be identified as the precipitant for the cellulitis which can manifest after the initial injury has healed. In these cases is cellulitis considered a separate disease process but still a complication of the open wound (T89.03)?

Please advise on codes to use in the following scenarios.:

1. Patient admitted with cellulitis of the forearm following being scratched by her cat a week previously. The scratches were healing and did not receive attention. The patient was given IV antibiotics, then switched to oral antibiotics and discharged home.
2. Patient admitted with open wound of leg with surrounding cellulitis following walking into a trailer in the dark 2 days earlier. The wound was debrided in theatre and the patient given IV antibiotics for several days, then discharged home on oral antibiotics.
3. Patient admitted with cellulitis of the foot and ankle. On examination the patient was found to have tinea of the toes, which was presumed to be the entry point for the infection. The patient was given IV then oral antibiotics and a topical treatment and podiatry attention for the tinea.
4. Patient admitted with cellulitis of the lower leg following being scratched by rose thorns while gardening two days previously. The wounds were cleaned and dressed. Dressings were changed every second day and the patient placed on IV then oral antibiotics.

In general if the wound is treated, then this should be coded as the principal diagnosis. If the cellulitis is treated and the wound is not, then the cellulitis would be the principal diagnosis. With regards to your scenarios:

1. For this patient, as the underlying cause is a scratch and not an open wound, the cellulitis is the only condition being treated, therefore the cellulitis should be the principal diagnosis:

L03.10 Cellulitis of upper limb

2. This patient has an open wound complicated by cellulitis. As the wound is treated, code the complicated wound code, followed by a code for the cellulitis:

S81.9 Open wound of lower leg, part unspecified

T89.02 Open wound with infection

appropriate external cause codes

L03.11 Cellulitis of lower limb

3. This patient was admitted for their cellulitis. While the tinea was later found to be the point of entry for the infection, cellulitis is not a presenting problem of tinea. For this patient, the cellulitis should be the principal diagnosis and the tinea an additional diagnosis:

L03.11 Cellulitis of lower limb

B35.3 Tinea pedis

4. The documentation for this patient indicates that the scratches may be more than superficial injuries, however if these are documented as scratches, the cellulitis should be the principal diagnosis, followed by the superficial injury as an additional code:

L03.11 Cellulitis of lower limb

S80.7 Multiple superficial injuries of lower leg

appropriate external cause codes

The NCCH confirms that the advice in **ACS 1210 Cellulitis** applies to open wounds only.

The NCCH also agrees with the coding of the scenarios cited.

The VICC also notes that cellulitis is an inflammation of the skin caused by an infection. The presence of cellulitis following an open wound indicates an infected wound therefore the correct code to assign is **T89.02 Open wound with infection**.

The advice in this query supersedes the advice published in query #1793 in the May 2002 ICD Coding newsletter.

#2201 Catheter cryoablation of accessory pathway

24 year old male has had a cryoablation via catheter for accessory pathway. Clinical advice is that catheter ablation may be performed with microwave, cryotherapy or radiofrequency.

1. Could the Committee please confirm if the radiofrequency ablation catheter code 38212-01 [665] *Cardiac electrophysiological study with radiofrequency ablation* can be used for any type of catheter ablation? The index entries for this code are:

Ablation

- arrhythmia circuit or focus — see Ablation, cardiac
- cardiac
- - by radiofrequency with electrophysiological study 38212-01 [665]
- - arrhythmia circuit or focus, involving
- - - both atrial chambers 38290-00 [601]
- - - one atrial chamber 38287-00 [601]
- - muscle, ventricular 38518-00 [609]
- - myocardial septal (percutaneous transluminal) 38748-01 [616]
- - to induce complete AV block 38212-01 [665]

Induction

- complete AV block
- - by cardiac ablation 38212-01 [665]

Study

- electrophysiological (EPS)
- - cardiac
- - -for follow up testing of implanted defibrillator 38213-00 [665]
- - - with
- - - - ablation by radiofrequency 38212-01 [665]

The index entry:
Ablation, cardiac, to induce complete AV block 38212-01 [665], would seem to allow us to use this code for any type of catheter ablation, but if so, should the code title be changed?

2. What are the codes 38287-00 [601] *Ablation of arrhythmia circuit or focus involving one atrial chamber* and 38290-00 [601] *Ablation of arrhythmia circuit or focus involving both atrial chambers* for? Is this for an 'open heart' procedure rather than a catheter procedure? This block has an 'excludes' note for 'radiofrequency ablation via EPS'. Should this be any type of catheter ablation? If so, could the 'excludes' note be amended and 'via catheter' added to the index to avoid confusion?

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

The NCCH agrees that there are currently no specific procedure codes for EPS with cryotherapy or microwave ablation but advises that the most appropriate code at present is **38212-01 [665] 'Cardiac electrophysiological study with radiofrequency ablation'**.

The NCCH agrees that there is ambiguity with regards to the codes in **[601] Destruction procedures on atrium** but as stated above catheter based cardiac ablations should at present be assigned to **38212-01 [665] Cardiac electrophysiological study with radiofrequency ablation** which is excluded in block 601.

These codes are currently the subject of a public submission and will be reviewed for a future edition of ACHI.

#2205 Coding of carcinoma post resection

Patient has a planned admission for closure/reversal of a colostomy 3 months post resection of carcinoma. The patient has no known metastases and is not receiving any ongoing treatment for the cancer. Do we still code the cancer for this case? Is it still part of the cancer care/treatment? Or would you just code the cancer history?

If not, does it make any difference if the patient had metastases but does not require any treatment for it during this episode. Or must the cancer always meet the criteria for an additional diagnosis?

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

The NCCH advises that the closure/reversal of a colostomy 3 months post resection can be considered part of the ongoing treatment/care for the cancer (effectively the last part) and that the cancer should be coded as an additional diagnosis.

The VICC advises that if metastases are present that these should also be coded.

#2236 Programming of Cardiac Pacemaker

Please provide advice re coding of the insertion of a dual chamber pacemaker that was programmed to VVI (single chamber) mode.

The patient was admitted for a routine pacemaker replacement. The original pacemaker was dual chamber with atrial and ventricular leads and programmed to DDD mode. The new dual chambered replacement was inserted, a new ventricular lead inserted, the existing atrial lead connected, and the replacement was programmed to VVI mode. I consulted the pacemaker technician, who assured me that dual chamber devices may be programmed to single chamber modes.

Should the pacemaker insertion be coded to 38281-02 [650] *Insertion of permanent single chamber pacemaker, VVI* to reflect the programming mode? I am at a loss to know how to code a dual chambered device without an appropriate dual chamber mode.

This should be coded to dual pacemaker insertion because it is the device's capability even though it is not being used as this in this scenario. Therefore the correct codes to assign are:

38281-10 [651] Insertion of permanent dual chamber pacemaker, DDD

38278-01 [648] Insertion of permanent single chamber transvenous electrodes

38281-12 [655] Removal of permanent dual chamber pacemaker

#2241 Main bronchus sleeve resection

Procedure coding for (L) main bronchus sleeve resection of malignancy and reconstruction of neo secondary carina using sutures (as specifically stated on operation report), via thoracotomy (other procedures performed include radical excision of lymph nodes, division of mediastinal adhesions and muscle flap - not part of query):

The procedure codes available relate to endoscopic, not open, procedures. Block 537 relates to trachea, not bronchus.

Is it appropriate to code the resection and reconstruction to 38456-04 (547)?

VICC agrees with the enquirer's code **38456-04 [547] Other procedures on bronchus, intrathoracic approach** because the procedure performed is a resection of the bronchus.

#2242 Pasteurella mutocida

What is the correct code for Pasteurella mutocida? I have used A28.0 Pasteurellosis which is the default using the 3M encoder.
The patient has a wound infection from a dog bite.
This record has been queried by DHS notifiable edit 358 Area code restraint.

Pasteurella mutocida is a systemic infectious disease, however in the case cited it is the bacteria causing a localised bacterial infection of the open wound. Therefore the correct codes to assign are:

Open wound code

T89.02 *Open wound with infection*

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

W54.0 *Bitten by dog*

Place of occurrence code

Activity code

This is supported by the 'excludes' note at the start of Chapter 1, which says 'Excludes: certain localised infections – see body system-related chapters'.

Further information about coding organisms can be found in the February 2002 ICD Coding newsletter coding feature 'Coding organisms'.

#2246 Definition of Post-Term Delivery

According to ACS 1527 *Post term delivery* a delivery is regarded as "post-term" at or after 42 weeks gestation.

The ACHS define it as 41 weeks as does the Perinatal Data Collection Unit.

I was wondering why they differ? It would make sense to me that the ACS changes it's definition to be in line with others. Is this possible?

The VICC cannot comment on the reason why **ACS 1527 Post-term delivery** differs from the ACHS and the Perinatal Data Collection Unit but notes that if there is documentation of post term in the clinical notes, then it can be coded as such. The VICC will forward this query to the NCCH for comment but you may also wish to consider submitting a public submission to the NCCH in regard to the ACS.

#2247 Fluid overload

Patient admitted for a total hip replacement. During stay has acute fluid overload that requires Lasix. On summary written as 'diastolic heart failure in the setting of fluid overload'. Do we code out I50.9 *Heart failure, unspecified* and E87.7 *Fluid overload* or just one or the other (and which one)?

Patient admitted with acute fluid overload, has a past history of Chronic Cardiac Failure (CCF) is treated with Frusemide. Do we code out both again or just the CCF or just the fluid overload?

Patient with End Stage Renal Failure (ESRF) admitted with acute fluid overload for dialysis. Is this part of the ESRF? Is this an acute condition in conjunction with the ESRF? Do we code the overload and the ESRF? What would be the principal diagnosis if we had to code both?

The VICC cannot answer each scenario specifically without access to the whole medical record, but note the following points for consideration when coding these scenarios:

- Fluid overload is a separate condition in its own right
- Fluid overload may or may not be linked to an underlying condition
- Potentially both conditions could be coded but ACS 0001 and criteria in ACS 0002 should be applied to determine whether to code one or both and the sequencing.

With respect to fluid overload and CCF, Coding Matters Volume 7 No 3 under Congestive heart failure advises it is not necessary to code fluid overload in a patient with CHF. However if a patient has a history of CCF, it does not mean that they have it now.

With respect to fluid overload and ESRF, there are circumstances in which fluid overload would be coded separately. Refer to Coding Matters Volume 5 No 3 which provides an example of a patient admitted to hospital with fluid overload due to missed dialysis and the principal diagnosis is *E87.7 Fluid overload* and the additional diagnosis is ***N18.0 End-stage renal disease***.

Coders should therefore refer to the Coding Matters advice and compare with the documentation in the medical record to determine whether the fluid overload should be coded.

#2248 Rotational vacuum extraction

Can you please advise on the best code to use for a patient who delivers via rotational vacuum extraction. This is a common procedure carried out in this hospital, usually performed in emergency situations where a woman requires instrumental assistance during labour (for example non-reassuring CTG, decreased maternal effort).

During this procedure the rotation is carried out using a ventouse device with no mention of forceps rotation of fetal head (documented as Ventouse rotation).

Currently we code this procedure to 90469-00 [1338] *Vacuum extraction*, following the index pathway: Delivery (spontaneous) (vertex) 90467-00 [1336]

vacuum extraction (Ventouse) 90469-00 [1338]

--with

---forceps rotation of fetal head 90468-04 [1337]

The code 90468-04 [1337] *Forceps rotation of fetal head with delivery*, includes delivery via vacuum and forceps. However we don't feel that this code is appropriate because it clearly specifies rotation of fetal head via forceps.

Could you please clarify what procedure code we should use to accurately code this procedure.

Research undertaken by VICC indicates that there is an element of rotation in all vacuum extractions. Therefore, in this scenario the appropriate code to assign is:

90469-00 [1338] *Vacuum extraction*

Forceps rotation of fetal head should not be coded unless documented.

#2252 Unhealthy placenta

Should we be coding 'unhealthy placenta' and if so does it get coded to 043.9 *Placental disorder, unspecified*?

This query was raised after the directive in the 1st quarter 05/06 coding newsletter stated to not code gritty placenta as it is not significant. We'd been previously advised by an external auditor in April 2005 to code both unhealthy placenta and gritty placenta.

The suggested pathway was:

Disease, placenta, complicating pregnancy or childbirth.

The VICC note that the advice in the 1st Quarter 2005-06 ICD Coding Newsletter supersedes the auditor advice; therefore gritty placenta should not be coded as it is of no clinical importance. However, all other placental abnormalities should be coded in accordance with **Vic 0002 Additional diagnoses**. The VICC suggest following index entry Abnormal, placenta and assign:

043.1 *Malformation of placenta*

#2253 Post chroming

A 15 year old female admitted into A&E with a diagnosis of Post- chroming.

Her symptoms (documented by the Clinician in the notes) include seeing things/ monsters after chroming, SOB, chest tightness, sore eyes, nausea, and abdominal cramps.

She has a history of Chroming, marijuana and IV drugs use (Speed and Ice)

Codes assigned:
T59.8 *Other specified gases, fumes and vapours*
Y17.8 *Poisoning by and exposure to other specified gas or vapours, undetermined intent* (Includes: carbon monoxide, lacrimogenic gas [tear gas], nitrogen oxides, sulfur dioxide)
Note: undetermined intent was used as documentation in the notes supports the use of this code.
Appropriate Place of Occurrence and Activity codes

Can you advise if the above codes are correct or do we need to assign code(s) from Chapter V, F10-F19 *Mental and behavioural disorders due to psychoactive substance use* instead (or as an additional diagnosis to the T code)?

The VICC agrees that this scenario should be coded to poisoning because it involves improper use.

A code from F10-F19 cannot be assigned unless there is documentation in the medical record of an appropriate lead term such as addiction.

#2257 Calcification of the placenta

Am interested to know if the committee considers calcification of the placenta to be an abnormality and should we be coding it as such?

Research obtained by VICC indicates that calcification of the placenta is linked to maternal smoking and has an effect on the fetus.

As per **Vic 0002 Additional diagnoses** all placental abnormalities should be coded (except for gritty placenta as advised in the 1st Quarter 2005-06 ICD Coding newsletter).

The VICC suggest following index entry Abnormal, placenta and assign:

O43.1 Malformation of placenta

Clarification of previously published ICD-10-AM coding queries

As a result of feedback received following publication in previous ICD Coding Newsletters, both of these queries have a revised response. Query 2042 was originally published in the 4th quarter 0506 newsletter and query 2221 was originally published in the 3rd quarter 0506 newsletter. These have now been superseded by the responses printed below.

#2042 Conditions arising in the perinatal period

Would the committee please advise on the correct coding/use of ACS in the following scenarios? My difficulty arises with the definitions contained in the ACS, Chapter 16 Certain conditions originating in the perinatal period. ACS 1605 gives the definition of the perinatal period 'Commencing at 20 completed weeks and ends at 28 completed days after birth'. ACS 1607 gives a definition for the neonatal period, as defined in Australia, which is similar to the perinatal period, in that it ends at 28 completed days after birth.

Infants who are still technically 'premature', who are over 28 days of age, as in the examples below, would seem to be excluded from the definitions within this chapter. Also ACS 1615 Specific Interventions for the Sick Neonate states 'These standards will provide a valuable body of data which will assist in improving AR-DRG classification of neonatal conditions'. All the scenarios listed below group to 'neonatal' DRGs, should the criteria listed in ACS 1615 apply in these cases, as they are not classified as neonates. Also some conditions are not 'arising in the perinatal period', therefore should they be coded to P codes or not?

1. Infant transferred to our hospital at 30 days of age for ongoing care of prematurity. Admission weight 1789 grams. (Ex 27 week premature birth weight 700 grams., so now technically only 32 weeks). Infant documented as developing jaundice of prematurity, treated with phototherapy for 11 hours overnight. Codes assigned P07.22, P07.02, P59.0 and 90677-00 [1611]. (Following ACS 1618)
2. Infant transferred to our hospital at 63 days of age for ongoing care of prematurity, required one gavage feed only, then quickly progressed to bottle feeds. Admission weight 2081 grams. (Ex 26 week premature twin one, birth weight 880 grams. so now technically 35 weeks gestation) Codes assigned P07.22, P07.03 and 96202-07 [1920]. (Following ACS 1615)
3. Infant transferred to our hospital for ongoing care at 38 days of age from interstate, admission weight 1230 grams. (Ex 26 week premature triplet three, birth weight 706 grams. so now technically 31 weeks gestation). Problem list on discharge 1. Anaemia of prematurity - required top up transfusion. 2. Apnoea of prematurity. 3. Hyponatraemia - treated with IV infusion of electrolytes. 4. Oral candidiasis. Codes assigned P07.22, P07.02, P61.2, P28.41, E87.1, B37.0, 13706-02 [1893] and 96199-08 [1920].

The VICC referred this query to the NCCH who provided the following response:

The NCCH agrees with the VICC that the codes for neonates still apply to babies >28 days for babies who are still in the birth episode / continuous from birth.

For patients who have been discharged (home) and then readmitted, neonatal codes may be assigned, if documentation indicates that their condition originated in the perinatal period. This is supported by advice in **ACS 1605 Definition Of Conditions Originating In The Perinatal Period**: 'Most conditions originating in the perinatal period disappear after a short time. Some, however, can persist throughout life and should be classified to the codes in this chapter (16) regardless of the patient's age'.

The NCCH will consider amendments to the standards in **Chapter 16 Certain Conditions Originating In The Perinatal Period** of the ACS to clarify the above advice.

VICC members noted that as per **ACS 1615 Specific interventions for the sick neonate**, the codes for jaundice and phototherapy in scenario 1 should not be assigned, and the code for gavage feed in scenario 2 should not be assigned.

#2221 Islet cell transplantation

Please advise us the procedure code to be used for Islet cell transplantation. This process involves isolated islet cells from donor pancreas and injecting them into the liver of patients with Type 1 diabetes.

We code E10.9 *Type 1 diabetes mellitus without complication* as the principal diagnosis and 14203-01 [1906] *Direct living tissue implantation*. We looked up transplantation, pancreatic tissue. This groups to K06Z *Thyroid Procedures*. This DRG does not relate to the procedure being performed.

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

- adrenal
- thyroid
- cartilage
- pancreas
- parathyroid

The DRG allocation reflects the tissue that was used when this procedure was first developed. The Committee will refer this to the Commonwealth for consideration of allocating the procedure code to **DRG K09Z Other endocrine nutritional & metabolic OR procedures**.



Coding Corkboard

Victorian ICD Coding Committee activities

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

Victorian Clinical Coders contact list

To have your details updated or your name added to our contact list, simply complete the form on our web site at: <http://www.health.vic.gov.au/hdss/icdcoding/index.htm> and email to jennie.shepherd@dhs.vic.gov.au or fax (03) 9096 7743.

Victorian Queries Database

The queries and responses currently published quarterly in the ICD Coding Newsletter will soon be made available as a database that will be downloadable from the DHS website. This will necessitate a review of our newsletter format. Any suggestions are welcome and can be addressed to Carla Read at carla.read@dhs.vic.gov.au

Victorian ICD Coding Committee members as at October 2006

Jennie Shephard	Department of Human Services (Chair)
Carla Read	Department of Human Services (Convener, Secretary, Victorian CSAC representative)
Rhonda Carroll	The Alfred Hospital (VACCDI representative)
Annette Gilchrist	Royal Melbourne Hospital
Andrea Groom	HMA
Sonia Grundy	St Vincent's Hospital
Lauren Hancock	The Austin Hospital
Susan Peel	Southern Health
Maree Thorp	Peninsula Health
Kathy Wilton	3M
Diana Cheng	La Trobe University representative
Kylie Holcombe	Ballarat Health Services
Hayley O'Meara	The Royal Children's Hospital
Pamela Williams	Eastern Health

Victorian ICD Coding Committee meeting dates

21 November 2006	DHS, 09:30am, 18 th floor 50 Lonsdale Street, Melbourne
19 December 2006	DHS, 09:30am, 18 th floor 50 Lonsdale Street, Melbourne

Abbreviations

ACBA	Australian Coding Benchmark Audit
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
ADRG	Adjacent Diagnosis Related Group
ADx	Additional Diagnosis
AIHW	Australian Institute of Health and Welfare
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CC	Complication or Comorbidity
CCCG	Clinical Classification and Coding Groups
CCL	Complication or Comorbidity Level
CSAC	Coding Standards Advisory Committee
DHS	Department of Human Services
DRG	Diagnosis Related Group
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
ICD-10-AM	International 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