ICD Coding Newsletter
February 2002

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The ICD Coding Newsletter supports the clinical coding function performed in Victoria by Health Information Managers and Clinical Coders, by providing relevant information for these professionals 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
- 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 queries or comments regarding the *ICD Coding Newsletter*, contact the HDSS Help Desk:

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Notify a change of address or a request regarding the mailing list to any of the above contacts.

HDSS's web site is:

http://hdss.health.vic.gov.au

An electronic coding query form can be completed at:

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

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Coding Features

Coding Organisms

Irene Kearsey, DHS

The National Centre for Classification in Health (NCCH) will make a change to ACS 0010 *General abstraction guidelines* for the 3rd edition of ICD-10-AM: it incorporates advice already published in NCCH's query database (NCCH # 1421). The advice relates to the coding of organisms noted in a microbiology report and the related infection documented in the patient's medical record.

Because the revised advice is already published in NCCH's query database, it is acceptable for Victorian coders to apply it immediately, if they wish, rather than wait until 1 July 2002 when 3rd edition is implemented.

In the past, coders were instructed to code the organism related to an infection only if the clinical notes documenting the infection also noted the cultured organism. Coders were not permitted to make a link between the documented infection and the cultured organism noted only in a microbiology report.

NCCH's advice in query 1421 and in third edition ACS 0010 indicates that coders are now permitted to make this connection *provided the following conditions are met*:

- The infection has been documented in the clinical notes (ie, the coder is not making the diagnosis from a microbiology report).

- The microbiology specimen is relevant to the documented condition (eg, where a UTI is documented, the relevant organism is that cultured from the urine sample).

- If more than one organism has been cultured, clinical interpretation is sought to identify which is significant.

The following are circumstances where an organism would *not* be coded:

- Where an organism is documented as a contaminant.

- Where an organism is *normal* flora for that specimen (eg, it would be normal for E.coli to be cultured in faeces).

- If an organism is grown but sensitivities are not done, then the organism is unlikely to be clinically relevant.

Coders were not permitted *and are still not permitted* to code a 'diagnosis' when the only documentation is a microbiology report noting the cultured organism with *no* mention of a condition in the clinical notes.

Coding NHT patients

Irene Kearsey, DHS

This provides advice on coding episodes where the patient has been designated Nursing Home Type (Care Type 1 in PRS/2); it includes previously published advice on coding such patients.

Definition

A Nursing Home Type (NHT) patient is one who no longer needs to be in a hospital and could be cared for in a nursing home but no nursing home bed is available. As stated in Section 2 of the *PRS/2 Manual*, a NHT patient is defined in section 3 of the *Health Insurance Act* 1973 (Commonwealth): after 35 days continuous hospitalisation, the patient is classified as a NHT patient unless a medical practitioner certifies under section 3B that the patient is in need of acute care.

Reasons for needing continued acute care would include, for example:

- Professional attention for an acute phase of the patient's condition.
- Active rehabilitation.
- Continued management, for medical reasons as an admitted patient.

A patient cannot be designated NHT before 35 days continuous hospitalisation (with a maximum break of seven consecutive days) even if an approved NH5 form *Application for Nursing Home Admission* has been signed. In this context, 'hospitalisation' means in *any* hospital (not just this one) and in *any* Care Type (NHT, Rehabilitation, etc, as well as Acute).

Abstracting problems

Because, by definition, a patient designated 'nursing home type' no longer needs to be in hospital, assigning diagnosis codes can be difficult, particularly the selection of principal diagnosis. In addition, from the clinical point of view, there is no distinguishing point between the acute and the NHT periods of care: the change of Care Type is purely an administrative process. Therefore the clinical documentation may present problems:

- Clinical documentation may not easily be separated into what was written before and what was written after the change of Care Type (an 'artificial' event with little relevance clinically).

- Clinical documentation for the NHT period may be sparse (but note it is permissible to refer to documentation recorded during earlier episodes, including the preceding acute episode, for further detail of a condition that was treated during the NHT period).

Principal Diagnosis

In ICD-10-AM 2nd edition, the final paragraph of ACS 2105 *Long term/nursing home type inpatients* covers the assignment of principal diagnosis; however, this Standard is written for jurisdictions that do not use the 'episode of care' concept (the 3rd edition will make some revision to the ACS to clarify this).

In Victoria, the principal diagnosis for the nursing home type episode will be:

Z75.x *Problems related to medical facilities and other health care*

(The ICD-9-CM code specified in query 1277 *Nursing Home Type statistical separations*, *ICD Coding Newsletter*, April 1997 maps to Z75.x as confirmed in *ICD Coding Newsletter*, February 2000) This rule is in keeping with the logic applied to rehabilitation episodes as specified in ACS 2104 *Rehabilitation*.

PRS/2 Editing

When you follow this coding advice, you will (until 1.7.2002) receive a Warning from PRS/2 (edit 355 *Invalid Principal Diagnosis - Warning*). **When the episode's Care Type is 1 NHT**, ignore this edit. HDSS will investigate a way to adjust this edit for separations on or after 1.7.2002, so PRS/2 does not apply it to Care Type 1 episodes

Additional Diagnoses

In considering whether to assign an additional code for a condition, apply ACS 0002 *Additional Diagnoses* in the normal way: *during the NHT period* did that condition meet any of the criteria for being coded? If a condition does justify coding, information recorded during preceding episodes may provide further specificity for code assignment. The reason the patient was in acute care preceding this NHT episode is *not* necessarily coded as an additional diagnosis: a NHT patient is not the same as an aftercare patient as covered in ACS 2103 *Admission for Convalescence/Aftercare*. If an injury justifies coding as an additional diagnosis, refer to 'External Cause' below.

External Cause

A NHT patient might suffer an injury during a NHT episode: unless the injury is very minor, it would generally cause the patient's Care Type to be changed to 4 *Acute*. For the NHT episode, the injury and its accompanying External Cause would be added to the string of diagnosis codes in the usual way (it would not be Principal Diagnosis, having occurred *during* the episode).

It is possible (but unlikely) that a NHT patient will still be receiving treatment for an injury sustained before the NHT episode began: it is more likely that the patient would remain Care Type 4 *Acute* until that treatment is complete. However, if a patient *is* designated NHT *during* treatment for an injury, you would need to review the record carefully: is treatment still for the injury or for a residual effect of the injury? If anything being treated requires an External Cause code, add that code.

Coding the Acute episode *preceding* a NHT episode

When coding the acute episode that *preceded* the nursing home type episode, consider whether the length of stay was extended by the lack of nursing home facilities or by extension of the acute stay to exceed 35 days of hospitalisation. If this applied, assign Z75.1 *Person awaiting admission to adequate facility elsewhere* as an additional diagnosis in the acute episode.

Coding the Acute episode *preceding* a transfer to another facility

When coding an acute episode that *preceded* a transfer to another health facility of any kind, if it meets the criteria outlined in ACS 0012 *Suspected Conditions* (Transferred to another hospital) or ACS 2107 *Respite Care*, assign a code from Z75.- *Problems related to medical facilities and other health care*.

Coding* Radiological Investigations**

Irene Kearsey, DHS

* Coding for the purpose of this article means 'reporting to DHS via PRS/2'. You could assign a code *outside* the following rules so long as the code is not transmitted via PRS/2.

**Radiological investigations/medical imaging (radiology) include CT scans, nuclear medicine scans, MRIs, x-rays, etc.

Coding becomes ever more complex: the coder needs to consider more than clinical aspects in assigning codes. One increasingly complex area involves services that were once staffed by hospital staff using hospital-owned equipment, but are now privatised. Many on-site radiology practices in Victorian public hospitals are now privatised.

In the Victorian *ICD Coding Newsletter* of April 1996, basic advice was 'where a procedure is performed at another facility under private arrangements (that is, the other facility bills the patient directly) then the procedure should not be coded'. This paper deals with the problem in more detail.

In deciding whether to code a radiological investigation, the first decision is:

- Do I code this type of procedure in light of ACS 0042 *Procedures normally not coded*?

If ACS 0042 does not rule out coding the procedure, the next decision is:

- Do I code this particular procedure in this patient's circumstance?

The following are circumstances where the funding arrangement is not straightforward:

1 When radiology is performed at another site's radiology facility (eg, rural hospital sending patient to base hospital for radiology).

2 When radiology is performed at another campus of a Metropolitan Health Service (eg, CT scanning available at only one campus of a multi-campus MHS).

3 When radiology is performed on-site, but at the public hospital of co-located public/private hospital.

4 When radiology is performed on-site but the radiology is a private practice (many on-site radiology practices are now privatised).

5 When radiology is performed on-site in theatre but the radiology is a private practice.

In all the above cases, the procedure is coded only if this hospital pays for it (ie, the procedure is performed *under contract* at the other hospital or if the hospital pays the private practice).

The procedure is not coded:

- If this hospital does not pay the providing hospital for the procedure (in examples 1, 2 and 3, this hospital may not pay the providing hospital)

- If the patient pays for the procedure directly (in examples 4 and 5, the patient may pay directly)

If the procedure is carried out by another hospital under contract, refer to the *PRS/2 Manual* for full instructions regarding reporting.

Coding Tip

Hypertension

Recent audit results have highlighted that the following coding convention sometimes gets overlooked.

Under two commonly used blocks in Chapter IX *Diseases of the circulatory system* (Volume 1, ICD-10-AM), there is a note as follows:

The note: *'Use additional code to identify presence of hypertension'*

The location: Ischaemic heart disease (I20 – I25)

Cerebrovascular diseases (I60 – I69)

Following this convention, coders must assign an additional code for hypertension, if it exists in the patient, when they are assigning a code from the blocks nominated above. The hypertension does not need to meet additional diagnosis criteria.

List of Selected ICD-10-AM Coding Queries

The ICD Coding Committee is an advisory body to Victorian clinical coders and the Department of Human Services. The Committee does not have the authority to establish coding standards but offers advice, based on the combined knowledge and experience of the members and/or the NCCH, in response to individual coding queries. The Committee's advice printed in this section of the newsletter can be adopted immediately unless an introduction date is stated. The implementation of this guidance is advisable as it sets a precedent for good coding practice. Unless otherwise stated, there is no expectation that coders should go back to similar episodes already coded differently and change the coding. It is acknowledged that this might result in a year's data containing episodes coded in a non-standard way.

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#1629 Failed spinal anaesthesia

A spinal anaesthetic was administered to a patient undergoing a TURP. This failed and a general anaesthetic (IV & Inhalation) was given. Should these be coded separately:

18209-08 [36] ***Spinal injection of local anaesthetic, combined preoperative, intraoperative and postoperative***

and

92502-02 [1910] ***Intravenous and inhalational general anaesthesia.***

Or should the following combined code be used?

92502-03 [1910] ***General anaesthesia combined with major regional anaesthesia***

NCCH was consulted (NCCH #1407) and advised that the issue of failed anaesthesia had been discussed at the Anaesthetics Classification Update Forum. The Committee agreed on the following advice:

> A failed anaesthetic should be coded as the anaesthetic that was intended. In this instance, the anaesthetic was considered 'failed' because it was actually given but did not provide sufficient pain relief.

In this case, a pair of codes would be assigned:

18209-08 [36] ***Spinal injection of local anaesthetic, combined preoperative, intraoperative and postoperative***

92502-02 [1910] ***Intravenous and inhalational general anaesthesia***

#1656 Diabetes with cataracts

Do we still code diabetes with cataracts when the cataracts were removed earlier?

NCCH was consulted and provided the following, to which the Committee has added some text [in square brackets]:

NCCH response #1479:

> The following guideline is based on information received from the NCCH's Consultant Endocrinologist and will be included in ACS 0401 *Diabetes Mellitus And Impaired Glucose Regulation* for the Third Edition of ICD-10-AM:

When a complication of diabetes has been eradicated, often as a result of surgery, assign an 'other specified complication' code from the appropriate diabetic section. Do not assign the specific code for the *manifestation* as it has been eradicated [although the *disease process* still continues].

Example 1:

A patient with a history of Type 2 diabetes mellitus with nephropathy treated by kidney transplantation [is no longer in renal failure but the *disease process* affecting the kidney still continues]

E11.29 *Type 2 diabetes mellitus with other specified renal complications*

Z94.0 *Kidney transplant status*

Example 2:

A patient with a history of Type 1 diabetic cataract previously removed and synchronous insertion of intraocular lens (IOL) [no longer has the manifestation of cataract but still has the disease process affecting the eye]

E10.39 *Type 1 diabetes mellitus with other specified ophthalmic complication*

Z96.1 *Presence of intraocular lens*

#1674 I23 Current complications following AMI

When can we assign the codes listed in:

I23 ***Certain current complications following acute myocardial infarction***

We had a patient who had an AMI and ruptured the wall of the ventricle: how do we reflect this?

Is the exclusion note on I23 a Type 2 Exclusion?

NCCH response #1419:

Codes from category I23 *Certain current complications following acute myocardial infarction* should be assigned only if the complications classifiable to this category occurred following AMI and are still current. In these cases, codes from category I23 *Certain current complications following acute myocardial infarction* may be

assigned in the same episode as I21.- *Acute myocardial infarction* or I22.- *Subsequent myocardial infarction*.

The exclusion note at category I23 *Certain current complications following acute myocardial infarction* is a Type 1 Exclusion note which is used for single condition coding (see ACS 0033 *Conventions used in the tabular list of diseases*). This means that codes from this category may be assigned in addition to codes from I21 *Acute myocardial infarction* to fully describe the diagnostic statement.

#1678 Abdominal apron or abdominal overhang

Patients (varied ages, usually female) admitted with either abdominal apron or abdominal overhang listed as their diagnosis. The usual procedures are liposuction, radical abdominoplasty or lipectomy.

There are no codes for either of these diagnoses. Suggestions include:

Z41.1	***Other plastic surgery for unacceptable cosmetic appearance***
E65	***Localised adiposity***
E88.1	***Lipodystrophy, not elsewhere classified***

The Committee agreed that ACS 1204 *Elective Plastic Surgery* does not provide an adequate answer, and forwarded the query to NCCH.

NCCH response #1420:

Lipodystrophy is a metabolic disorder of unknown cause. It may be a side effect experienced by HIV-positive patients who are on protease inhibitors and is also associated with insulin resistance. In the cases cited, 'abdominal apron' or 'abdominal overhang' refers to localised adiposity and should be assigned E65 *Localised adiposity*. When the reason for surgery (eg, localised adiposity) is documented, code this condition as the principal diagnosis even if the procedure performed is of a cosmetic nature. When it is documented that the surgery is being undertaken for cosmetic reasons, Z41.1 *Other plastic surgery for unacceptable cosmetic appearance* should be assigned as an additional diagnosis. When a condition is not specified, or is a term not recognised by ICD-10-AM, assign the Z code as the principal diagnosis.

The Committee accepted this answer (published in September 2001 *Coding Matters*) but noted it pre-empts the 3rd edition revision of ACS 1204 *Elective Plastic Surgery*.

#1745 Ventilation post transfer

In ACS 1006 *Respiratory Support*, there is instruction on coding ventilation for a patient who had surgery, stating they must be ventilated for more than 24 hours post surgery for ventilation to be coded. There is also an instruction for coding a patient who is an inwards transfer, already ventilated, to count from time of arrival at the hospital.

What do we do for a patient who is transferred in, having had surgery at another hospital? Does the 24-hour rule still apply or does the fact that they are an inwards transfer override this?

The section of ACS 1006 being referred to reads:

> 'The ventilatory support that is provided to a patient during surgery is associated with anaesthesia and is considered an integral part of the surgical procedure and therefore ventilation of ≤24 hours should not be coded in these cases. However, CVS initiated during surgery and continuing for greater than 24 hours should be coded with duration beginning at the time of intraoperative intubation.'

If a patient is transferred in post surgery, and no surgery will be performed at your hospital, the 24-hour rule does not apply. The ventilation procedure code should be assigned, even if less than 24 hours.

The 'rule' in the ACS is to differentiate between those patients whose Continuous Ventilatory Support (CVS) is associated with anaesthesia and is an integral part of surgery, from those whose CVS is not associated with surgery. In this query, the CVS the receiving hospital is providing is not associated with surgery, therefore start counting from the time of arrival at your hospital.

#1746 Implanted contraceptive

Patient admitted for termination of pregnancy. During the procedure, a slow release contraceptive known as 'Implanon Implant' is placed subdermally. This contraceptive can remain under the skin for up to three years and be effective.

We have been coding this to:

Z30.1 *__Insertion of (intrauterine) contraceptive device__*

14203-00 [1906] *__Direct hormone implantation__*

Full coding for this episode, of course, requires codes for termination of pregnancy (both diagnosis and procedure): the termination of pregnancy will be principal diagnosis.

The Committee obtained the following clinical advice regarding the Implanon implant:

> These are contraceptive devices in the form of rods [matchstick-length]. These rods are inserted subcutaneously into the arm and the rods release progesterones to prevent pregnancy.

The Committee therefore agreed with the diagnosis and procedure code suggested by the enquirer for the Implanon implant:

Z30.1	***Insertion of (intrauterine) contraceptive device***
14203-00 [1906]	***Direct hormone implantation***

#1750 Respiratory failure

A patient admitted with 'respiratory failure secondary to deteriorating chronic obstructive airways disease (COAD), congestive cardiac failure (CCF) and sleep apnoea'.

Should the respiratory failure be coded as principal, followed by the COAD or should it be assumed as continuation of the disease, or as an acute exacerbation of the disease?

Committee members studied a number of sources of information containing advice about respiratory failure coding:

- NCCH query (11/06/98) #255 *COAD with respiratory failure*
- NCCH query (14/04/99) #943 *Nocturnal respiratory failure*
- *Geriatric Medicine* specialty booklet (NCCH, 1997)
- *General Medicine* specialty booklet (NCCH, 1998)
- *Respiratory Medicine* specialty booklet (NCCH, 2000)
- *ICD-9-CM Coding Handbook, with Answers*, 'Respiratory failure', (Faye Brown, 1996)
- Just Coding, 'Respiratory Failure -Proper Sequencing Is Crucial' (website article, October 2001)
- *Introduction to coding with ICD-10-AM*, 'Respiratory Failure, NEC (J96)' (Terrie Knuckey, CCS, 2nd ed, HIMAA, 2000)

Having considered this material, the Committee agreed that coders should first apply the principal diagnosis definition. Because respiratory failure would very rarely be the only condition treated, the COAD or other condition would generally be the principal diagnosis, with respiratory failure sequenced as an additional diagnosis. Coders should keep in mind NCCH query #255 *COAD with respiratory failure*: '… generally, but not exclusively, respiratory failure should be assigned as an additional diagnosis code to COPD'.

#1752 Use of multiple diabetes codes

If a NIDDM patient has a complication such as peripheral vascular disease and also has hypertension or obesity, do we need to attach the I10 *Hypertension* or E66.9 *Obesity, unspecified* code to:

E11.9	*Type 2 diabetes mellitus with unspecified complication*

Or do we just add the I10 or E66.9 after the complicated diabetes code such as:

E11.51	*Type 2 diabetes mellitus with peripheral angiopathy, without gangrene*

The Committee agreed the relevant code I10 or E66.9 should be added after the E11.51 (or other complicated diabetes code). E11.9 must not be used with any other diabetic code.

#1753 Acute on chronic renal failure in diabetic patient

Patient admitted with acute on chronic renal failure and diabetes (Type 2).

Not sure how to code this or how to sequence codes. Is either of these strings correct?

E11.29	***Type 2 diabetes mellitus with other specified renal complication***
N17.9	***Acute renal failure, unspecified***
E11.23	***Type 2 diabetes mellitus with end-stage renal disease [ESRD]***
N18.90	***Unspecified chronic renal failure***

Or:

E11.23	***Type 2 diabetes mellitus with end-stage renal disease [ESRD]***
N17.9	***Acute renal failure, unspecified***
N18.90	***Unspecified chronic renal failure***

The Committee agreed that, assuming there is no separate specific cause of the patient's acute renal failure, and following the disease index, the first string of codes suggested by the enquirer is correct (the two pairs):

E11.29	***Type 2 diabetes mellitus with other specified renal complication***
N17.9	***Acute renal failure, unspecified***
E11.23	***Type 2 diabetes mellitus with end-stage renal disease [ESRD]***
N18.90	***Unspecified chronic renal failure***

#1757 Diabetes with arteriosclerosis or atherosclerosis

A 71 year old patient complaining of claudication at 200 metres presents for Lumbar Aortogram Bilateral Femoral Angiogram (LABFA).

History: Type 2 diabetes mellitus, ex-smoker.

Result of LABFA: Infrapopliteal occlusive disease secondary to atheroma.

Please advise which codes to use for principal diagnosis:

E11.51	***Type 2 diabetes mellitus with peripheral angiopathy, without gangrene***

Or:

E11.59	***Type 2 diabetes mellitus with other specified circulatory complication***
I70.21	***Atherosclerosis of arteries of extremities with intermittent claudication***

Vol.2 lists E11.59 if you look up Diabetes with arteriosclerosis or Diabetes with atherosclerosis.

Although the index leads to E11.59, depending on the terms used to locate the code, to capture more fully the clinical statement, code:

E11.51	***Type 2 diabetes mellitus with peripheral angiopathy, without gangrene***
I70.21	***Atherosclerosis of arteries of extremities with intermittent claudication***

Coders should use the following look-up:

Diabetes

- with

- - angiopathy, peripheral (without gangrene) E1-.51

The Index to the 3rd edition resolves this potential confusion.

#1759 Palliative Care

Should the principal diagnosis in the following scenario be either of the listed reasons for admission (pneumonia or CVA) or the diagnosis resulting in a shortened prognosis (pancreatic cancer)?

Diagnoses:

1. Right lower lobe pneumonia
2. CVA/Right hemiparesis
3. Carcinoma of pancreas

Patient admitted with worsening dyspnoea over several days and right sided weakness. She had undergone a palliative surgical bypass procedure in February 2001 and initially had done well; however, in the weeks leading up to admission, her mobility and appetite had been poor. Upon arrival she was drowsy, and in respiratory distress and rapid atrial fibrillation. She had a dense right hemiparesis, clinical signs of left ventricular failure and right lower lobe pneumonia, subsequently confirmed on chest x-ray. Her right calf appeared swollen and extensive subcutaneous bruising was present on both legs distal to the knees and this was associated with a serous discharge.

In view of her very poor prognosis, palliative treatment was undertaken with intravenous fluids and adequate analgesia. She died peacefully at 4.00am [3 days after admission].

Patient was admitted in an acute setting with pneumonia and CVA. No treatment was initiated due to poor prognosis and admission was for palliative care only.

We read ACS 0224 *Palliative Care* and Query #1663 *Palliative Care* in the June 2001 *ICD Coding Newsletter* and are still unsure.

The Committee agreed that this was an acute admission where, after investigation and consideration, a decision was made to treat palliatively, therefore the principal diagnosis should be one of the acute conditions (selection to depend on the documentation). Add a code for the cancer only if it meets the criteria for ACS 0002 *Additional diagnoses*. This is not a palliative care *admission* therefore ACS 0224 *Palliative care* does not apply and Z51.5 *Palliative care* would *not* be added.

 May be reproduced

#1763 UTI as complication of urethra graft

21 year old male. Previous hypospadias repair and failed skin graft to urethra (skin graft subsequently removed and debridement performed). [This would have been as a baby when there is only a small amount of scrotal tissue available for use in the graft.] Now presents with 'multiple UTIs' attributed to previous surgery for peno-scrotal hypospadias with urethra now hair bearing, due to previous repair. (Documentation provided).

Cystoscopy, urethroscopy with plucking of hairs performed under GA; coding the procedures is not the problem.

Possible coding solutions for diagnoses with include:

First set of possible codes

N39.0	*Urinary tract infection, site not specified*
T83.8	*Other complications of genitourinary prosthetic devices, implants and grafts*
N36.8	*Other specified disorders of urethra*
Y83.2	*Surgical operation with anastomosis, bypass or graft*
Y92.22	*Health Service Area*

Second set of possible codes

T83.5	*Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system*
T83.8	*Other complications of genitourinary prosthetic devices, implants and grafts*
N36.8	*Other specified disorders of urethra*
Y83.2	*Surgical operation with anastomosis, bypass or graft*
Y92.22	*Health Service Area*

Third set of possible codes

N39.0	*Urinary tract infection site not specified*
T98.3	*Sequelae of complications of surgical and medical care, not elsewhere classified*
Y88.3	*Sequelae of surgical and medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure*
Y92.22	*Health Service Area*

Searching the NCCH database revealed query #687 *Intraurethral hair growth and removal*. This provides N36.8, but does not account for hair being due to skin graft/repair and does not address UTI problem as a result of this:

> **NCCH #687 *Intraurethral hair growth and removal***
>
> **Query**: How do you code intraurethral hair growth for diagnosis? I coded it to L68.2. How do you code removal of hair in distal urethra?
>
> **Response**: ACS 0013 *'Other' and 'Unspecified' codes* provides guidance in the selection of codes for terms that cannot be located in the ICD-10-AM Index (Vol 2). For intraurethral hair growth assign N36.8 *Other specified disorders of urethra*. For the procedure, assign 37318.00 [1113] *Endoscopic removal of foreign body from urethra*. Based on the evidence that you have provided, the diagnosis L68.2 *Localised hypertrichosis* is not appropriate, as it is not supported by the documentation on the operation report and discharge summary. Hypertrichosis is a skin disorder and is defined as the growth of terminal hair from vellus hair at sites not normally hairy, such as the forehead, back and extremities and this hair growth is excessive given the person's age, sex or race.

The Committee agreed that the third set of possible codes is incorrect because ACS 1904 *Procedural complications*, 'Sequela', defines 'sequela of a complication' as a current condition that is a result of a previously occurring postprocedural complication.

The Committee considered the first set of proposed codes were the basis of correct coding except that the UTIs would be coded only if they meet ACS 0002 *Additional diagnoses* and, even if coded, would not be the principal diagnosis: T83.8 would be the principal diagnosis. Therefore coding would be:

T83.8 ***Other complications of genitourinary prosthetic devices, implants and grafts***

N36.8 ***Other specified disorders of urethra***

Y83.2 ***Surgical operation with anastomosis, bypass or graft***

Y92.22 ***Health Service Area***

If meeting ACS 0002 *Additional diagnoses*:

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

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#1765 Intravenous (only) General Anaesthetic

For cases such as cardioversion, performed in CCU with an anaesthetist performing an **intravenous** general anaesthesia (GA) only, should we use:

92502-00 ***Intravenous general anaesthesia***

Or the default GA code as advised in the June 2001 *ICD Coding Newsletter*:

92502-02 ***Intravenous and inhalational general anaesthesia***

Assign the default code, as specified in the June 2001 *ICD Coding Newsletter*:

92502-02 ***Intravenous and inhalational general anaesthesia***

#1767 Hyperlipidaemia in diabetes

How do we code hyperlipidaemia in a patient with Type 2 diabetes?

E11.72 ***Type 2 diabetes mellitus with features of insulin resistance***

and

E78.5 ***Hyperlipidaemia, unspecified***

The Committee noted that the terms 'hyperlipidaemia' and 'dyslipidaemia' appear to be used interchangeably in ACS 0401 *Diabetes*. However, the classification box on page 82 of this ACS details dyslipidaemia as 'elevated triglycerides and depressed HDL-cholesterol'. Thus, features of insulin resistance should be coded only when these criteria are met for dyslipidaemia.

E11.72 ***Type 2 diabetes mellitus with features of insulin resistance***

A code should also be used to show the nature of the features of insulin resistance.

E78.8 ***Other disorders of lipoprotein metabolism***

If the episode does not meet the criteria for 'features of insulin resistance', code the diabetes to:

E11.9 ***Type 2 diabetes mellitus without complication***

The hyperlipidaemia can be coded as an associated condition if it meets ACS 0002 *Additional Diagnoses*.

The 3rd edition resolves this potential confusion.

#1769 Anxiety during pregnancy/delivery

An obstetric patient suffering from anxiety ceased medication when she found she was pregnant. During the delivery episode, she was referred to the social worker because of history of anxiety attacks. Can we code the anxiety as a complication of the delivery? We have discussed allied health interventions in relation to ACS 0002 *Additional diagnoses*.

As the patient has a history of anxiety attacks, rather than current anxiety attacks, this should be coded:

Z86.5	***Personal history of other mental and behavioural disorders***

The fact that the social worker was involved justifies the coding of the personal history.

#1773 Unspecified Injury Coding

S09.9	***Unspecified injury of head***

My understanding is that we use the above code as a last resort, when there is no further information on the type of injury.

Scenario 1:

Patient admitted with final diagnosis of 'Nose injury following alleged assault'. Examination revealed swelling tender area of nose and abrasion. There was no septal haematoma and CT head excluded fracture of nose. Would the correct codes be:

S00.31	***Superficial injury of nose, Abrasion***
S00.38	***Superficial injury of nose, Other***

Or only:

S09.9	***Unspecified injury of head***

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Scenario 2:

Patient admitted with final diagnosis of 'foot injury' and examination revealed swelling and abrasion of foot after kicking into glass door, should we code:

S90.81 ***Abrasion of ankle and foot***

S90.88 ***Other superficial injuries of ankle and foot***

Or only:

S99.9 ***Unspecified injury of ankle and foot***

Does ACS 1905 *Closed Head Injury/Loss of Consciousness/Concussion* only apply to Closed Head Injury, or could it be interpreted to cover other conditions that are coded to S09.9?

Could you clarify the following section of the ACS 'coders should check the record for a more specific diagnosis'. Does this include coding of conditions such as contusions, abrasions, open wounds, even if the clinician records the diagnosis as ' Head Injury'.

As there are specific injuries documented, for example swelling and abrasion, these should be coded rather than a non-specific injury code. As investigation has ruled out other, more severe injuries, only the superficial injuries can be coded.

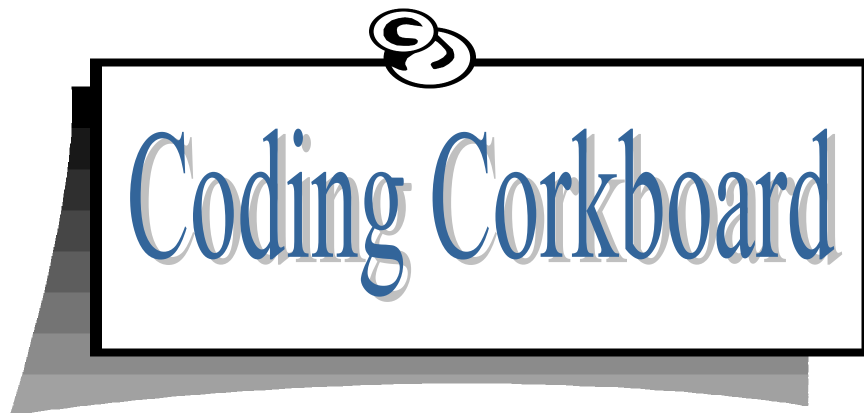
1778 Suppressed lactation

A patient decided to suppress lactation because she had grazed, very sore nipples. ACS 1539 *Suppressed lactation* states you assign a code for therapeutic suppression:

O92.5 ***Suppressed lactation***

ACS 1539 gives examples of reasons for suppressing lactation, where patients are on drugs contraindicating breast-feeding. Is the taking of contraindicating drugs the only scenario in which you can use O92.5-?

As the suppression is the patient's choice rather than a therapeutic suppression, do not apply ACS 1539 *Suppressed lactation*, which refers only to therapeutic suppression of lactation. In this case, you should code the condition of the breasts/nipples.



NCCH ICD-10-AM query database

The most recent posting of queries to the NCCH database was 24 January 2002. Coders have three options for viewing queries:

- downloading the searchable database in Microsoft Access 97 format
- viewing the whole database online
- searching the database online

Coding Matters

The December edition of *Coding Matters* concentrates on injury coding and includes several articles by users of coded data. There are a number of international reports together with regular features.

Current and previous editions of *Coding Matters* can be viewed and/or downloaded from the NCCH's website http://www.cchs.usyd.edu.au/ncch

ICD 10

For the first time, the 10th Revision of ICD is available from the World Health Organisation on CD-ROM. For this and other WHO publications, contact:

Hunter Publications

58a Gipps Street, Collingwood, Vic 3066

Telephone (03) 9417 5361 Fax (03) 9419 7154

Email jpdavies@ozemail.com.au Web site http://www.hunter-pubs.com.au

Websites

If you've found some useful sites, send details to: PRS2.Help-Desk@dhs.vic.gov.au

Private Health Insurance Administration Council	Need to check out the name of a health fund? Need contact details for a fund? http://www.phiac.gov.au/
Day Only Procedures Manual	Find the Commonwealth's list of day only procedure codes at: http://www.health.gov.au/privatehealth/providers/dayonly/daymbs_nov2001.htm (It can be slow to load)
Victorian legislation	Need to check a Victorian Act or Statutory Rule? http://www.dms.dpc.vic.gov.au/ (When you get to the Disclaimer page, you need to scroll down to progress further)
Hazard	Monash University Accident Research Centre's publication uses accident data from VAED and VEMD: http://www.general.monash.edu.au/muarc/hazard/hazidx.htm
ABC radio and TV health news/features updates	To subscribe to a weekly email listing health-related items, with a hyperlink for each to the ABC web site, go to: http://www.abc.net.au/health/subscribe.htm
Anti-Cancer Council of Victoria	A range of information (including job ads): http://www.accv.org.au
Australian Society of the History of Medicine	Interested in the history of medicine and health care? http://www.cshs.unimelb.edu.au/ashm/

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Information Update

ICD-10-AM Library File: tell us the problem edits!

Irene Kearsey, DHS

From 1 July 2002, Victoria will change to a new ICD-10-AM Library File: this File will include the revisions relevant to the 3rd edition (including an extensive revision to the Morphology codes). It is also an opportunity to revise any edits that are causing problems in hospitals.

This is your opportunity to let HDSS know of any edits that cause you problems. Please clearly identify the code(s) caught by the edit, the edit number, and for what sort of patient the edit should *not* apply. For example, you might think that the edit should not apply to patients under such and such an age, or not apply to male patients. We can't promise to make adjustments for every request but we're open to suggestions!

Work will begin very shortly on revisions to the File to have it available to suppliers and hospitals in good time so **let us know ASAP of problems you have found**. Email the details to:
Irene.Kearsey@dhs.vic.gov.au

What's on HDSS 'Clinical Coding' web site

How long since you checked out the 'Clinical Coding' section of HDSS's web site?

Go to:
http://hdss.health.vic.gov.au/icdcoding/index.htm

Currently, this site provides:

- Additional Diagnoses Queries & Responses
- ICD Coding Committee - background
- ICD Coding Committee Query Form
- ICD Coding Newsletters (issues since May 1999)
- ICD-10-AM Library File
- Performance Indicators for Coding Quality (PICQ) and Australian Coding Benchmark Audit (ACBA) software - how Victorian hospitals can access these products
- Summary - ICD Coding and DRG Grouping Systems used in Victoria (calendar)
- Summary - ICD Coding Editions used in Victoria (calendar)
- Victorian Additions to Australian Coding Standards - effective 1 July 2001
- Victorian Additions to Australian Coding Standards - effective 1 July 2000

Have you suggestions for other Victorian material that might be useful to coders that we could include on our site? Suggestions to:
PRS2.Help-Desk@dhs.vic.gov.au

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Data Quality

PRS/2 edit 412

The 'Remedy' for edit 412 has been revised in light of *Coding Matters* December 2001. The following could be pasted into your *PRS/2 Manual* at page 8-153:

412 Adm Wt 1000-2499g, No Matching Dx Code

Effect

Warning

Problem

The X2 Diagnosis Record's Admission Weight is 1000-2499 grams yet none of the following ICD-10-AM, 2nd Edition diagnosis codes is present in the X2/Y2:

- P07.1 *Other low birth weight (1000-2499g)*
- P07.3 *Other preterm infants (28-37 weeks gestation)*
- P05.x *Slow fetal growth and fetal malnutrition*
- P96.4 *Termination of pregnancy, fetus or newborn*
- P01.8 *Fetus and newborn affected by other maternal complication of pregnancy (includes spontaneous abortion)*

Remedy

Coding Matters (December 2001) advised that low birth weight is coded *only* when documented. Therefore, check the Admission Weight, the clinical documentation and the coding:

- If the Admission Weight is incorrect, correct it and re-transmit the X2/Y2.
- If the documentation supports a low birth weight code, assign one and re-transmit the X2/Y2.

Coding *Transfusions* becomes important!

ACS 0302 *Blood Transfusions* instructs that blood transfusions and infusions of blood products should be coded **whenever** performed. Multiple transfusions of the same blood product within the same episode need only one code; however, when more than one type of blood product is transfused, assign a code for each different product.

The Department is starting a review of the broad picture of the use of blood and blood products and its funding. The VAED will be a major component of the research therefore it is vital that every episode that involved a blood transfusion or infusion of blood products is appropriately coded.

We will analyse VAED data to assess current practice and will provide information to hospitals. In the meantime, please assess your hospital's coding performance against data in your hospital's blood bank: how close is your hospital to complete coding?

Quality Information consolidated

In July 2001, DHS published *Quality Framework: Business Rules 2001/2002* which consolidates a range of previous documentation covering quality funding performance and requirements for reporting of quality performance to DHS. This publication draws together indicator definitions and describes the ways in which performance against specific indicators will relate to bonus funding and identifies which health services are expected to report against particular indicators.

The information complements the relevant sections of *Victoria - Public Hospitals Policy and Funding Guidelines 2001-2002*.

You can find these publications at:

Quality Framework: Business Rules 2001/2002:
http://www.dhs.vic.gov.au/ahs/pfg2001/qfbizrules.pdf

Note that there is also an addendum to the above (relevant to Waiting Lists):
http://www.dhs.vic.gov.au/ahs/quality/dosa.pdf

Victoria - Public Hospitals Policy and Funding Guidelines 2001-2002:
http://www.dhs.vic.gov.au/ahs/pfg2001/index.htm

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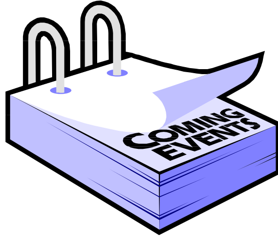

Coding Calendar of Events

Date	Event	Details
7-8 June 2002	**Canadian Health Records Association Annual Conference 2001**	http://www.chra.ca/news-content/conference.html Halifax, Nova Scotia, Canada
4-8 August 2002	**Combined HISA/HIMAA Conference**	http://www.himaa.org.au Melbourne
25-29 August 2002	**European Conference on Health Records Dublin 2002**	Email: info@conferencepartners.com Dublin
1-4 September 2002	**Casemix Conference**	http://www.health.gov.au/casemix/conf.htm casemix_conf@health.gov.au Melbourne
21-26 September 2002	**National Convention, American Health Information Management Association**	http://www.ahima.org/convention/ San Francisco
March 2003	**NCCH 8th Biennial Conference**	Details later, from: http://www.cchs.usyd.edu.au/ncch/ Victoria

For a comprehensive list of health information events, see:
http://www.himaa.org.au/Calendar.html

Victorian ICD Coding Committee

VICC's new Secretary

We are delighted to announce the Coding Committee has a new Secretary: Jenny Wischer. On a part-time basis, Jenny will manage the query process from receipt to response and publication, and will provide secretarial and research services to the Committee. Jenny brings to the task current coding expertise from her other work as a coder at Monash Medical Centre. We are *very* grateful to Sara Harrison for holding the fort since the resignation of Nicolette Thein.

Members as at 1 February 2002

Irene Kearsey	Convener (Department of Human Services)
Lisa Basile	Peninsula Health
Moira Cameron	Cabrini Hospital
Rhonda Carroll	The Alfred Hospital
Andrea Groom	Southern Health
Sonia Grundy	St John of God, Geelong
Kylie Holcombe	St Vincent's Hospital
Susan Peel	Healesville and District Hospital
Evelyn Robinson	Peninsula Health
Fiona Rounds	Ballarat Health Services
Ruth Rundell	Barwon Health - The Geelong Hospital
Jennie Shepheard	La Trobe University representative
Kathy Wilton	Royal Children's Hospital
Jenny Wischer	Secretary (Southern Health)

Committee's representative on VACCDI: Pauline Cripps, Box Hill Hospital

Future Meetings

Tuesday 16 April DHS, 10.00 am, 555 Collins Street, Melbourne

Tuesday 21 May	DHS, 10.00 am, 555 Collins Street, Melbourne

On a Lighter Note

This Newsletter has been remiss in not bringing to your attention before now information about an important series of international prizes awarded for a range of scientific achievements including medicine: the *Ig Nobel* Prizes.

> 'The *Ig Nobel* Prizes honor people whose achievements "cannot or should not be reproduced". Ten prizes are given to people who have done remarkably goofy things – some of them admirable, some perhaps otherwise. The *Igs* are intended to celebrate the unusual, honor the imaginative – and spur people's interest in science, medicine, and technology'.

The 2001 *Ig Nobel* Medicine prize was awarded for a paper, 'Injuries due to falling coconuts', written after the author served as director of a rural New Guinea hospital where 'one in every 40 patients who presented had serious injuries caused by coconuts'. [The Victorian Coding Committee doesn't get a lot of coding queries about falling coconuts. The Editor.]

Find the complete list of *Ig Nobels* on:

http://www.improbable.com/ig/ig-pastwinners.html

Sadly, the paper that won the 1999 Medicine prize does not appear to be available in translation: the winner, from Norway, carefully collected, classified and contemplated which kinds of containers his patients chose when submitting urine samples. [Surely not even the most obsessive clinical coder would go that far…The Editor]

If you wish to avoid the common cold, consider the 1997 Medicine prizewinners who discovered that listening to elevator Muzak stimulates production of immunoglobulin A and thus may help prevent the common cold. [Before you spend your lunch times riding the lift, note that one author works for Muzak Ltd. The Editor]

The 1995 Medicine prize may be relevant to those who have been *unsuccessful* in avoiding the common cold: the authors made an invigorating study entitled 'The Effects of Unilateral Forced Nostril Breathing on Cognition'.

The 1993 Medicine prize was for a paper on acute management of [deleted – we've had complaints about making light of this topic before. The Editor].

Do not limit your review to the Medicine awards; other prizes cover health-related topics. For example, the Statistics prize for 1998 was awarded to a carefully measured report, 'The Relationship Among Height, Penile Length, and Foot Size'. The 1996 economics

prize went to the discoverer that ‘financial strain is a risk indicator for destructive periodontal disease’.

Alphabetic Index to Victorian ICD-10-AM Coding Advice

Looking for the Index? We're moving it to the HDSS web site. This will:

- reduce the size of the newsletter as email attachment
- save paper when you/we print a copy of the newsletter and
- provide a single place of reference

This is part of an on-going program of making the web site more useful (see page 30).

The index will be updated for each edition and posted shortly after the Newsletter is issued. When the update for this issue is ready, you will find it at:

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

Each time the index is revised, you can refer to it on the web or download it to a folder to your PC for speedy reference.

Abbreviations

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
DHS	Department of Human Services
ESIS	Elective Surgery Information System
HDSS	Health Data Standards and Systems
HIMAA	Health Information Management Association of Australia
HMA	Healthcare Management Advisors Pty Ltd
ICD-9-CM	International Classification of Diseases - 9th Revision – Clinical Modification
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
IFHRO	International Federation of Health Records Organizations
NCCH	National Centre for Classification in Health
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee