

The **10-AM** Commandments

Diastasis of Recti Abdominal Muscle (DRAM) in pregnancy or delivery

A query was received by NCCH about assigning M62.08 *Diastasis of muscle in addition to O71.8 Other specified obstetric trauma for diastasis of recti abdominal muscle in pregnancy or delivery*. ACS 0027 *Multiple coding* states that multiple codes may be assigned to reflect the various components of a disease and to ensure that the entire medical concept is captured by the codes.

Classification

When coding DRAM occurring in pregnancy or delivery, the following codes should be assigned:

O71.8 *Other specified obstetric trauma*
M62.08 *Diastasis of muscle, other*

The NCCH will consider amendments to the classification to clarify the coding of this condition.

Ultrasound guided compression of a false femoral artery aneurysm

Ultrasound guided compression of a false femoral artery aneurysm, also known as duplex-guided compression therapy, is a relatively new method of treating pseudoaneurysms (Burnett, nd). 'During the procedure, the neck or tract of the pseudoaneurysm is compressed by an ultrasound transducer until there is no blood flow detected in the pathway. Compressions, lasting up to one hour, are usually applied in ten minute time intervals. Colour flow imaging confirms compression of the neck and patency of the artery and vein' (James, 2002).

Classification

In cases where ultrasound guided compression of a false femoral artery aneurysm is documented, assign 55238-00 [1946] *Duplex ultrasound of arteries or bypass grafts in lower limb, unilateral*.

According to ACS 0042 *Procedures normally not coded*, ultrasound is not normally coded. However, in this case, it is integral to the procedure.

Cancelled procedures

The NCCH was requested to provide further clarification about what code should be assigned as the principal diagnosis when a procedure is cancelled. The query specifically related to cases where a Z code would normally be assigned to capture the reason for hospitalisation. Examples are: admission for elective sterilisation (Z30.2) or same day chemotherapy (Z51.1).

The guidelines in ACS 0011 *Admission for surgery not performed* should be applied in these circumstances. Where an admission is affected by the cancellation of a procedure, the principal diagnosis code should be the same as it would have been had the procedure been performed.

Classification

Example 1

Patient admitted for same day chemotherapy for neoplasm, patient was dehydrated and the procedure was cancelled.

Code

Z51.1 *Pharmacotherapy session for neoplasm*

Appropriate neoplasm codes

Z53.0 *Procedure not carried out because of contraindication*

E86 *Volume depletion*

Example 2

Admission for creation of arteriovenous fistula, procedure cancelled due to unavailability of surgeon.

Code

Z49.0 *Preparatory care for dialysis*

Z53.8 *Procedure not carried out for other reasons*

Appropriate additional diagnoses codes

Example 3

Patient admitted for elective sterilisation, the procedure was cancelled due to lack of OT time.

Code

Z30.2 *Sterilisation*

Z53.8 *Procedure not carried out for other reasons*

Appropriate additional diagnoses codes ►►

The NCCH will consider an addition to ACS 0011 *Admission for surgery not performed* to include the above advice in a future edition of the Australian Coding Standards.

Incisional hernia

The NCCH received a query regarding the assigning of a code from category Y83 *Surgical operation and other surgical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure* as an additional code to K43 *Ventral hernia* for incisional hernias.

Incisional hernia is defined as a protrusion of a portion of an organ or tissue through the abdominal wall where scar tissue formed after surgery has become thin or weakened. 'Risk factors for incisional ventral hernia include: wound infection, abdominal distension, pulmonary complications, male gender, age, obesity, emergency procedures, early re-operation, jaundice, underlying disease process, type of closure, suture material used in closure and choice of original incision. They can also be a result of too much tension with the initial closure of the abdominal incision, which creates poor healing, swelling and wound separation' (ASERNIP-S 2005).

Classification

As there are other factors that may contribute to incisional hernia apart from the procedure itself, the decision to assign of a code from Y83 as an additional diagnosis code should be made on a case by case basis. If a causal link is documented between a previous surgical procedure and an incisional hernia, assign Y83.- as an additional code to complete the clinical picture.

Post transfusion hepatitis

The NCCH was requested to provide further clarification on code assignment for post transfusion hepatitis, particularly in cases where the underlying cause of hepatitis is not known.

The index pathways in the Alphabetic Index are as follows:

Hepatitis K75.9

- from injection, inoculation or transfusion (blood) (other substance) (plasma) (serum) (see also Hepatitis, viral, type B) B16.9
- post-transfusion (see also Hepatitis, viral, type B) B16.9

Therefore, the default for post transfusion hepatitis is B16.9 *Acute hepatitis B without delta-agent and without hepatic coma*.

Clinical advice received by NCCH confirms that the default to hepatitis B is outdated. In Australia, improvements in the detection of hepatitis B in blood donors have prevented its transmission via this method. Conversely, many people have contracted hepatitis C via transfusion as the screening test for this type of hepatitis has only become available recently. As a consequence, hepatitis C is currently the most common cause of post transfusion hepatitis in Australia. The NCCH will consult with the WHO Update Reference Committee before any changes can be made to the default code.

In the meantime, where post transfusion hepatitis is documented in the clinical record, coders should seek advice from the treating clinician and assign a code for the underlying cause of the hepatitis, that is, the relevant type of hepatitis virus. If the relevant type of hepatitis is unable to be determined, the Alphabetic Index of Diseases should be followed.

Unicompartmental knee replacement

The NCCH received a query questioning the assignment of procedure codes for unicompartmental knee replacement. The knee joint is made up of three compartments, the patellofemoral joint, the medial compartment and the lateral compartment. Unicompartmental knee replacement is suitable for osteoarthritis limited to only one compartment of the knee. It is a less invasive procedure involving the replacement of the affected parts of the knee joint (Orthosports.com, nd).

Classification

Unicompartmental knee replacement should be assigned 49517-00 [1518] *Hemiarthroplasty of knee*.

The NCCH will consider the addition of index entries for unicompartmental knee replacement to a future edition of ACHI.

References

Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (2005). Laparoscopic ventral hernia repair. Accessed June 2005:
<http://www.surgeons.org/asernip-s/procedures3e.htm>

Burnett A (no date) Australasian Society for Ultrasound in Medicine. How to successfully compress femoral false aneurysms. Accessed 13 June 2005:
<http://www.asum.com.au/open/papers/burnett.html>

James B (2002) Coosa Valley Technical College. Pseudoaneurysm. Accessed 7 June 2005:
http://test.cvtcollege.org/Ac_Programs/dms_vascular/studentbrandie.html

Orthosports.com (no date) Minimally invasive unicompartmental knee replacement. Accessed 1 June 2005:
<http://www.orthosports.com.au/ukr.html>

Asthma study

Historically, ICD-10-AM, like its parent classification ICD-10, has described asthma with terms such as intrinsic (non-allergic) and extrinsic (allergic). A public submission received by NCCH recommended changes to the asthma classification to incorporate terms for pattern and severity of asthma. Consequently, NCCH undertook a review of asthma terminology used in a representative sample of hospital records with a principal diagnosis of asthma to assess:

- whether patterns of asthma are used widely and regularly documented in hospital records
- whether severity is regularly documented
- other common asthma terms in hospital records
- whether the terminology supports the current classification

There was little support for the introduction of pattern terminology into the asthma classification. In addition, pattern terminology varied significantly by state, hospital type, and age group with 5 to 15 year olds in children's hospitals having the highest rate of pattern documentation. Severity levels were commonly documented in hospital records, however, there was significant variation by state, locality, hospital type and age group. When severity was documented in hospital records the occurrence of multiple severity levels was common.

The study identified four main categories of asthma terms including exacerbation terms, viral terms, symptom terms, and asthma history terms; and there was evidence that the asthma terminology in ICD-10-AM is outdated and not used clinically. There was an overall lack of documentation to support the assignment of J46 *Status asthmaticus* using the current classification terminology.

NCCH would like to acknowledge the cooperation and support of state, territory and New Zealand CSAC representatives and health authorities, and especially health information managers and clinical coders in participating hospitals, for their contribution to the study. The NCCH will be circulating study results more widely amongst key stakeholders in the asthma field so that experts in asthma research and clinical care can assist in deciding the next steps in relation to the classification and clinical documentation of asthma.

Full details of the study are included in a paper titled *Asthma terminology and classification in hospital records* which has been accepted for publication in the *Health Information Management Journal* 34(2): July 2005.

PICQ 2004

incorporating
PICQ indicators for
ICD-10-AM
Fourth Edition

Performance Indicators for Coding Quality (PICQ) is an electronic application that provides a series of indicators to analyse admitted patient morbidity data coded with ICD-10-AM. It is based on Australian Coding Standards (ACS) and coding conventions

PICQ 2004 contains a number of enhancements:

- 111 new indicators
- Upgraded internal data specifications for some indicators in PICQ for ICD-10-AM Third Edition
- Indicators to check code edits, completeness, redundancy, specificity and sequencing
- New and improved PICQ user guide

For further information and to order:
NCCH Sydney
Phone: + 61 2 9351 9461
Email: ncchsales@fhs.usyd.edu.au

10 good reasons to use PICQ

- Identify actual coding errors and possible coding problems
- Identify specific records for correction, if necessary
- Suggest possible problem causes
- Suggest possible corrections
- Measure data accuracy against particular indicators
- Measure data quality over time
- Provide continuous review and amendment of coded data
- Provide feedback to individual coders and assist coder education
- Benchmark results with similar hospital or health organisation
- Complement existing coding audit activities

Coding quality analysis:

respiratory disorders

Keeping with the respiratory theme (the recently completed study of asthma terminology documented in clinical records also appears in this edition) the following results present the outcomes of a recent analysis of respiratory disease coding quality. Source data for the analysis are the AIHW national hospital morbidity data set 2002–2003. Data from Tasmania were not available.

ACS 1008 Chronic obstructive pulmonary disease (COPD)

As stated in the standard:

The term COPD (synonyms: chronic airway limitation (CAL), chronic obstructive airway disease (COAD)) is used to describe a condition of chronic bronchitis with obstruction possibly due to chronic asthma and/or emphysema or chronic tracheobronchitis

Further, chronic bronchitis, asthma or emphysema which is documented with COPD should be assigned a code from J44 *Other chronic obstructive pulmonary disease* only. The analysis examined coder practice relating to the application of ACS 1008 *Chronic obstructive pulmonary disease*, specifically, the exclusion of a code for chronic bronchitis, asthma or emphysema when a COPD code was present in the diagnosis code string. The COPD dataset contained 107,441 records with a COPD (J44) code in the diagnosis code string. Figure 1 presents a comparison of COPD codes assigned as principal diagnosis (PDx) and additional diagnosis (ADx). A small number of records were found to contain duplicate codes in the code string.

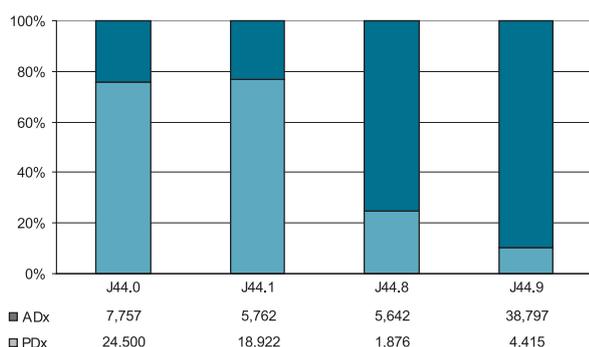


Figure 1 Comparison of COPD codes by diagnosis category

Code descriptions from ICD-10-AM tabular

- J44.0 *Chronic obstructive pulmonary disease with acute lower respiratory infection*
- J44.1 *Chronic obstructive pulmonary disease with acute exacerbation, unspecified*
- J44.8 *Other specified chronic obstructive pulmonary disease*
- J44.9 *Chronic obstructive pulmonary disease, unspecified*

Asthma was more likely to be coded with COPD than emphysema or chronic bronchitis. In total, 1,830 records (1.7%) contained both a code for COPD and a code for chronic bronchitis, asthma or emphysema; with asthma accounting for greater than 50% of these cases (see Figure 2 for further information).

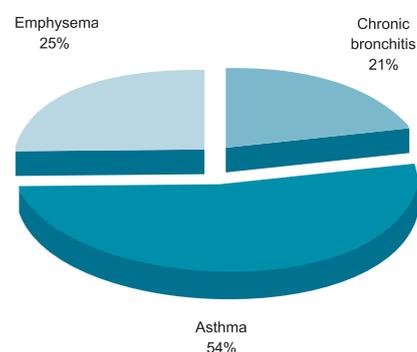


Figure 2 Comparison of conditions incorrectly coded with COPD

Further analysis revealed that J45 *Asthma* accounted for 91% of asthma cases coded with COPD; and J40 *Bronchitis, not specified as acute or chronic* accounted for 76% of chronic bronchitis cases (see Figure 3 for further information).

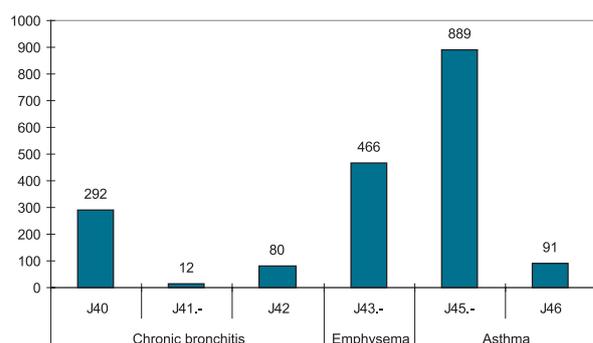


Figure 3 Comparison of codes within conditions incorrectly coded with COPD

Code descriptions from ICD-10-AM tabular

- J40 *Bronchitis, not specified as acute or chronic*
- J41 *Simple and mucopurulent chronic bronchitis*
- J42 *Unspecified chronic bronchitis*
- J43 *Emphysema*
- J45 *Asthma*
- J46 *Status asthmaticus*

ACS 1004 Pneumonia

The NCCH Education Division suggested that there may be some confusion among coders regarding coding of lobar and lower lobe pneumonia. The standard states:

The inflammatory process may involve all or part of a lobe; all or parts of more than one lobe; and lobes in different lungs. Note that pneumonia described as 'lower lobe' does not necessarily mean that the pneumonia is 'lobar'. Lobar pneumonia means consolidation of the entire lobe and is rarely seen. However, the term 'lobar' may be used loosely to mean involvement of part of a lobe(s). Therefore, when this term is used it should be clarified with the clinician before assignment of code J18.1 *Lobar pneumonia, unspecified*.

To review coding practice the frequency of coding J18.1 *Lobar pneumonia, unspecified* was compared to coding of J18.0 *Bronchopneumonia, unspecified*. The default code for pneumonia, J18.9 *Pneumonia, unspecified*, was not included in the analysis as it would be expected to skew the data. The analysis of 8,406 records revealed the frequency of coding J18.0 *Bronchopneumonia, unspecified* was more than three times higher than J18.1 *Lobar pneumonia* (see Figure 4). NCCH believes this result is a good outcome, and would like to remind clinical coders to continue to clarify any documentation of 'lobar' with the treating clinician so that the correct code is assigned.

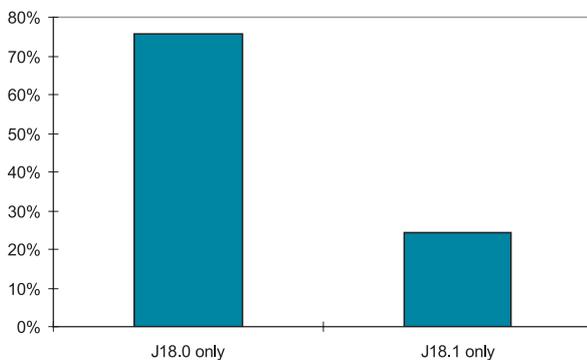


Figure 4 Comparison of coding of lower lobe and lobar pneumonia

ACS 1011 Chronic bronchitis in children

The standard states:

The diagnosis of chronic bronchitis in children (< 12 years) is not an acceptable diagnosis and should therefore be queried with the treating clinician.

A review of the data found 125 cases where J42 *Unspecified chronic bronchitis* was in the code string and age was less than 12 years. By comparison, there were 692 cases of J20.9 *Acute bronchitis, unspecified*, which is the default code for bronchitis under 15 years of age, where age was less than 12 years (see Figure 5). Clinical coders should be diligent about assigning J42 *Unspecified chronic bronchitis* to children under the age of 12 years and query the diagnosis of chronic bronchitis with the treating clinician.

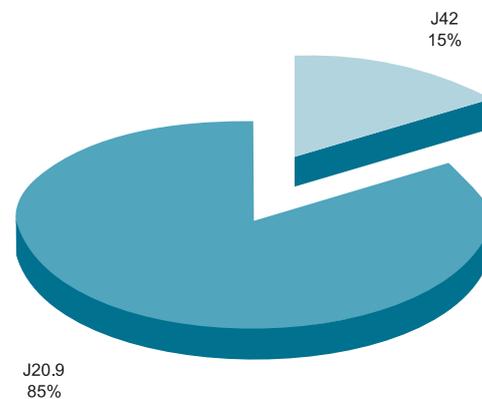


Figure 5 Coding of chronic bronchitis in children < 12 years

Fifth Edition is coming...

More information in Coding Matters December 2005 edition

Does Lorenzo's oil really work?

The 1992 film *Lorenzo's Oil* tells the story of the Odone family and their quest to find a treatment for son Lorenzo's X-linked adrenoleucodystrophy (X-ALD).

X-ALD is characterised by the breakdown of nerve fibres' myelin sheaths. The disease is most common in boys aged between 4 and 8 years, and about 40% of diagnoses are of the cerebral type that destroys brain tissue. Principal symptoms are aphasia and loss of muscular coordination leading to body function breakdown. Treatments have included bone marrow transplants and the drug lovastatin, which is more commonly used as a cholesterol-lowering agent.

Augusto and Michaela Odone created Lorenzo's oil which they derived from fats found in olive and canola oils. Lorenzo's oil is thought to normalise the concentrations of long-chain fatty acids.

In a paper published in *Archives of Neurology* Dr Hugo Moser of Baltimore's Kennedy Krieger Institute reports the results of a clinical study of 89 boys, aged 7 or younger, who have been diagnosed as having the abnormal X-ALD gene, but who were not showing symptoms. They received daily oral doses of Lorenzo's oil and their diets were moderated for the types of fats ingested. The results indicate that 74% of the boys had no indications of advancement of symptoms.

Lorenzo Odone, although severely disabled, has survived and is now 27 years old.

Source

Lorenzo's oil really works. Reuters: Tuesday 12 July 2005. Reported in: News in Science. http://www.abc.net.au/cgi-bin/common/printfriendly.pl?/science/news/health/HealthRepublsh_1412121.htm



Australian Government - Department of Health and Ageing

AR-DRG Development

This is to advise that the next version of the Australian Refined Diagnosis Related Groups will be a minor release, AR-DRG v5.2. This will be launched at the Casemix Conference in October 2006.

The cut-off date for submissions which propose a required change to the AR-DRG will be 30 November 2005. Submissions are categorised as either a major or minor update. Submissions that are received after 30 November will be deferred until the next release of the AR-DRG. Those submissions with a category of major will be included in the AR-DRG v6.0

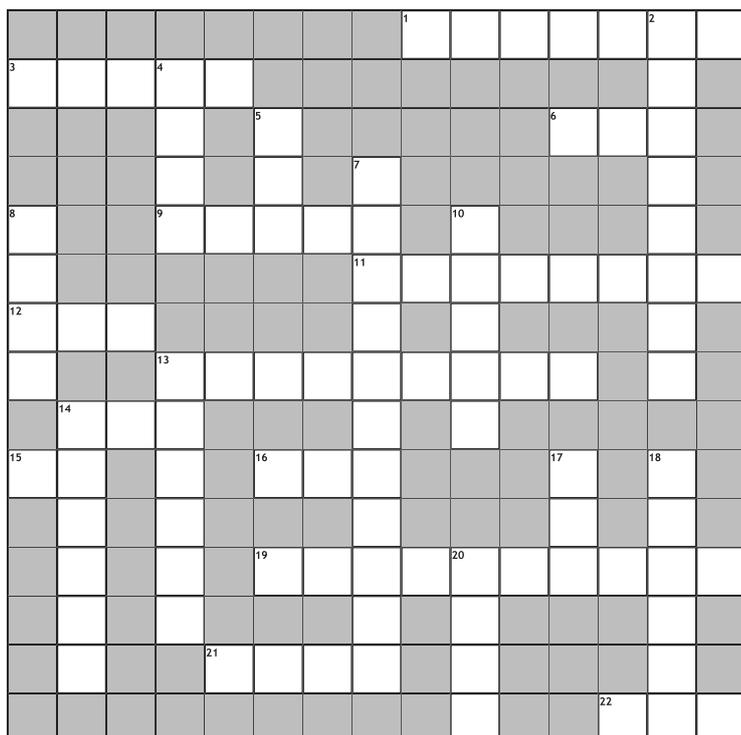
Submissions can be lodged via the public submission form on the Department of Health and Ageing internet site. The address is www.health.gov.au/casemix or mail/fax/email to

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NCCH crossword



Across

1. contagious skin disease
3. pertaining to sheep
6. no added bruits (abbrev)
9. a ridge or fold of a body structure
11. increased excretion of urine
12. rapid eye movement (abbrev)
13. red green colour blindness
14. cancer potential index (abbrev)
15. hiatus hernia (abbrev)
16. honorary medical officer (abbrev)
19. surgical incision into the perineum
21. hydatid complement fixation test
22. balloon catheter angioplasty (abbrev)

Down

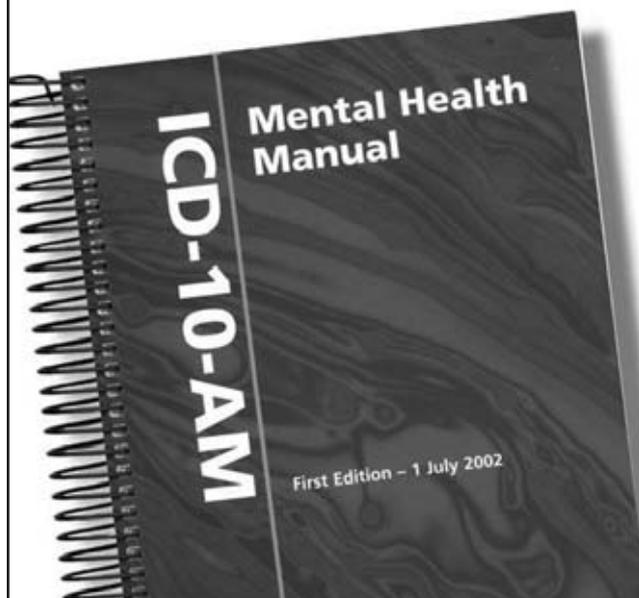
2. sudden blocking of artery
4. non invasive blood pressure (abbrev)
5. no pathogens isolated (abbrev)
7. radiology specialist
8. end stage renal failure (abbrev)
10. pertaining to gold
13. remote
14. any funnel shaped cavity
17. direct Coombs test (abbrev)
18. pertaining to a limbus
20. intrapartum anoxia and trauma (abbrev)

ICD-10-AM Mental Health Manual

The ICD-10-AM Mental Health Manual is a classification of mental and behavioural disorders with glossary descriptions and diagnostic guidelines based on ICD-10-AM Third Edition.

The Manual is a diagnostic and coding tool that offers a common morbidity data language between the acute and community health sectors.

Available **NOW**



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CONFERENCES 2005

SEPTEMBER

30 August – 2 Sept	8th Australian Palliative Care Conference 2005	Sydney	www.pallcare.org.au/pca_conference.html
2 – 4 September	6th International Mental Health Conference	Gold Coast	www.gcimh.com.au/conference/
4 – 7 September	Endocrine Society of Australia ASM	Perth	www.esa-srb.org.au/
5 – 7 September	Australian Diabetes Society ASM	Perth	www.ads-adea.org.au/
8 – 10 September	The 7th Annual SNOMED® International Users Group	Chicago, IL USA	www.snomed.org/education/usersgroups.html
22 – 24 September	10th International Symposium on Health Information Management Research (ISHIMR 2005)	Thessaloniki/Greece	www.seerc.info/ishimr2005
24 – 27 September	Australian Society of Anaesthetists 64th national congress	Gold Coast	www.asa.org.au/
25 – 28 September	36th Public Health Association of Australia annual conference	Perth	www.phaa.net.au/conferences/Perth/Perthconfront.htm
29 Sept – 2 Oct	Australasian College of Dermatologists spring conference	Cairns	www.dermcoll.asn.au/main.asp
29 Sept – 2 Oct	RACGP 48th Annual Scientific Convention	Darwin	www.racgp.org.au/document.asp?id=15589%20

OCTOBER

2 – 6 October	Divisions of General Practice Network Forum	Perth	www.adgp.com.au
5 – 8 October	Patient Classification Systems /International (PCS/I)	Ljubljana/Slovenia	www.pcse.org
6 – 9 October	Royal Australian and NZ College of Radiologists ASM	Sydney	www.raNZcr.edu.au
10 – 11 October	25th Annual APHA National Congress	Melbourne	www.apha.org.au/media_files/2378040505
22 – 26 October	XIII Cochrane Colloquium	Melbourne	www.cochrane.org.au/colloquium/
22 – 26 October	AMIA 2005 Annual Symposium	Washington DC	www.amia.org/meetings/annual/current

NOVEMBER

3 – 4 November	5th National Indigenous Environmental Health Conference	Terrigal, NSW	www.health.nsw.gov.au/public-health/ehb/aborig/conference/2004/
5 – 11 November	18th World Congress of Neurology ASM	Sydney	www.wcn2005.com/
6 – 9 November	Royal Australian and New Zealand College of Ophthalmologists ASM	Hobart	www.raNZco.edu
20 – 25 November	Australasian College for Emergency Medicine	Melbourne	www.waldronsmith.com.au/acem05/

DECEMBER

4 – 7 December	10th World Congress Internet in Medicine	Prague, Czech Republic	www.medinfo.cz/MedNet2005/index.php
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Conference information is also published at the NCCH web site <http://www3.fhs.usyd.edu.au/ncch/2.4.htm>

Next edition: December 2005

- What's in Fifth Edition? A summary of changes
- Intraoperative radiotherapy in early stage breast cancer
- International – clinical classification systems go global: Turkey, Jordan, Samoa...and more