

The **10-AM** Commandments

Nuclear medicine red cell scan

The NCCH received a query regarding the correct code to use for a labelled red cell scan/study, performed for the following admissions:

- 'PR bleeding +++' in a patient with pancreatic carcinoma, plus liver and spleen metastases
- 'PR bleeding since yesterday' in a patient who had a small bowel resection 10 days previously and was being treated with Warfarin for atrial fibrillation

Red cell scans are nuclear medicine procedures. Nuclear medicine procedures in ICD-10-AM are classified as either 'imaging' or 'non-imaging'. With imaging procedures, radioactive elements are introduced into the patient, and then an image is traced and recorded. Non-imaging procedures also include the insertion of radioactive elements, but it is the body specimens (blood, urine, faeces and so forth) that are examined at a later date.

Classification

Documentation of red (blood) cell scan to determine the cause of gastrointestinal bleeding, should be coded as 61364-00 [2007] *Bowel haemorrhage study*, indexed as:

- Nuclear medicine
- imaging (study)
- - bowel haemorrhage 61364-00 [2007]

Spinal cord compression secondary to neoplasm

The NCCH was asked to comment on the classification of spinal cord compression secondary to a neoplasm. The inquirer suggested G99.2* *Myelopathy in diseases classified elsewhere* should be used as an additional diagnosis to indicate that spinal cord compression has occurred as the result of a coexisting neoplastic condition, for example, rectal carcinoma. The NCCH agrees with this logic.



Spinal cord compression is a type of myelopathy, that is, functional disturbance or pathological change in the spinal cord. However, since G99.2* is a general, unspecified code, an additional code should also be assigned to specify the type of myelopathy.

Classification

Where spinal cord compression is documented as occurring as the direct consequence of a neoplastic condition, the following codes should be assigned to complete the clinical picture:

G99.2* *Myelopathy in diseases classified elsewhere*

G95.2 *Cord compression, unspecified*

Use of documentation from previous episodes in the clinical record

The use of relevant information abstracted from previous episodes of care in the clinical record is a well recognised coding practice. The purpose of this practice is to provide specificity for code selection where documentation in the current episode is inconsistent, insufficient or conflicting.

Support for this practice may be found in a number of sources. The introduction to the Australian Coding Standards advises that "analysis of the entire clinical record is performed before code assignment". Appendix C, Code of Ethics for Clinical Coders reiterates the need for "...abstracting diagnoses and procedures using the entire clinical record". Similar advice has been given in specific *Coding Matters* articles and standards. Health Information Management Association of Australia Ltd education material and Clinical Coder Competencies also encourage the use of the entire clinical record. The 'entire clinical record' should be interpreted as meaning all episodes of care and any other relevant documents within the record, such as outpatient notes.

Important points to remember when applying this advice include: >>>

- only abstract information that is **relevant** to the current episode of care and which meets the criteria for principal diagnosis or additional diagnosis
- review previous episodes of care to provide **further specificity** for code selection when documentation in the current episode is deficient. That is, previous episodes may be referenced in order to **clarify** information in the current episode
- never abstract information from a subsequent episode to retrospectively code a previous episode of care

Coders are **not** expected to routinely access previous episodes of care in order to code **every new** episode of care.

Example

Day only admission for intraocular lens extraction for cataract (no further information).

Documentation in eye clinic notes (one month previous) states 'cataracta brunescens, booked admission for extraction in one month'.

Principal diagnosis H25.1 *Senile nuclear cataract*

This example demonstrates the use of relevant documents within the clinical record that provide further specificity to a non-specific diagnosis in the current episode of care. H25.1 *Senile nuclear cataract* (cataracta brunescens is an inclusion term) is a more specific code than H26.9 *Cataract, unspecified*. Australian Coding Standard 0701 *Cataract* states, "Unless the cataract is specified as senile, traumatic, drug-induced, etc assign H26.9 *Cataract, unspecified*. Attempt to obtain further specificity if possible".

Osteoarthritis

The NCCCH has investigated the possibility of changing the default code for osteoarthritis from 'unspecified' to 'primary' in the Alphabetic Index of Diseases. This follows investigation of a proposal that was sent to the WHO Update Reference Committee in late 2003. Work continues in this area and no final decision has been made by the WHO at this stage.

Until a decision is reached by WHO, documentation of 'arthrosis', 'osteoarthrosis' or 'osteoarthritis' with no underlying condition identified as the cause, should be assigned the relevant code for 'primary'.

L55 Sunburn

If the percentage of body surface area is documented with sunburn, assign T31.- *Burns classified according to extent of body surface involved* in addition to a code from L55.- *Sunburn*.



Note that the external cause is inherent in L55.- *Sunburn* and therefore the assignment of an external cause code is unnecessary (see ACS 2001 *External cause code use and sequencing*). However, if T31.- *Burns classified according to extent of body surface involved* is assigned, X32 *Exposure to sunlight* must also be assigned (with appropriate place of occurrence and activity codes).

Banding of haemorrhoids

External haemorrhoids are aggregations of congested external perianal vascular plexus covered by perianal skin. External haemorrhoids are more correctly termed 'skin tags' or 'peri-anal haematomas'. They are acutely sensitive and are covered by anoderm (modified skin).

Internal haemorrhoids are vascular cushions originating from the subepithelial plexus of the anal canal above the dentate line. Internal haemorrhoids are covered by mucosa and are not sensitive.

Surgical treatment of haemorrhoids includes sclerotherapy, destruction (cauterisation, cryotherapy, and infrared therapy), excision (haemorrhoidectomy) or rubber band ligation.

Rubber band ligation is a procedure applied to internal haemorrhoids only. A proctoscope is used for visualisation and the haemorrhoid is grasped with forceps, and then passed through a banding tool with which it is possible to apply a rubber band. The procedure is never performed on external haemorrhoids, as the banding would be extremely painful.

Classification

When a procedure for banding/ligation of haemorrhoids is performed with no documentation regarding the type of haemorrhoids, assign a diagnosis code to indicate that the procedure has been performed on internal haemorrhoids (see Alphabetic Index of Diseases: Haemorrhoids, internal). Assign as the procedure code 32135-00 [941] *Rubber band ligation of haemorrhoids*.

Bibliography

Orlay G (2003) Haemorrhoids – a review. *Australian Family Physician* 32(7): 523–526.

Drug administration

With the introduction of the new codes for drug administration in ICD-10-AM Fourth Edition, clinical coders should still follow coding convention and only assign the new codes in block [1920]

Pharmacotherapy when directed by relevant coding standards or if they meet the criteria in ACS 0016 *General procedure guidelines* and ACS 0042 *Procedures normally not coded*.

At the recent workshops the following guidelines were outlined regarding the classification of multiple drug administration:

Multiple drugs given at the same administration

When a patient receives multiple drugs at the **same administration** (via the same route of administration) the following guidelines should be used to determine which code extension to be assigned from block [1920] *Pharmacotherapy*:

- Code the individual drugs administered as directed by a specialty Australian Coding Standard

For example: Australian Coding Standard 1615 *Specific interventions for the sick neonate* provides guidance on the appropriate procedure codes to be assigned, such as antibiotics, electrolytes and so forth

- Assign the extension that indicates the **main intent** of the pharmacotherapy

For example: If a patient is admitted for pharmacotherapy for treatment of a neoplasm and is given a cytotoxic drug together with an antihypercalcaemic, such as Zometa (for hypercalcaemia), at the same administration, assign extension -00 *Antineoplastic agent*, as the main intent of the pharmacotherapy is for treatment of the neoplasm

- If the main intent of the pharmacotherapy is unknown, assign the code highest in the hierarchy (that is, the lowest number).

For example: If a patient is given an anti-infective together with a steroid at the same administration, assign extension -02 *Anti-infective*.

Multiple administrations of the same drug

When a patient receives multiple administrations of the same drug by the same route, within the one episode of care, assign the pharmacotherapy code once only.

Clarification of the use of Z51.1 *Pharmacotherapy session for neoplasm*

Z51.1 *Pharmacotherapy session for neoplasm* is assigned as PDx for same day episodes of care for chemotherapy for a neoplasm or a neoplasm-related condition. If the pharmacotherapy is for treatment of a condition that is a result of the chemotherapy treatment, then Z51.1 *Pharmacotherapy session for neoplasm* is not assigned. For these cases follow the advice in ACS 0044 *Chemotherapy for same day episodes of care for chemotherapy for conditions other than neoplasms*.

For multi-day episodes of care for chemotherapy the assignment of Z51.1 *Pharmacotherapy session for neoplasm* as an additional diagnosis code is unnecessary as the procedure code indicates that chemotherapy was performed.

Clarification of the use of extension -00 in block [1920] *Pharmacotherapy*

Patients receiving pharmacotherapy for treatment of a neoplasm or a neoplasm-related condition should have the appropriate code from block [1920] *Pharmacotherapy* assigned with the extension -00 *Antineoplastic agent*.

Patients receiving pharmacotherapy such as chemotherapy for a condition related to the treatment of their neoplasm or neoplasm-related condition, should have the appropriate code from block [1920] *Pharmacotherapy* assigned with the appropriate extension. The extension -00 *Antineoplastic agent* should not be used in these cases as the pharmacological agent is not for treatment of the neoplasm or neoplasm-related condition but rather the treatment-related condition.

Example 1:

A patient was admitted as a same day for IV antibiotics for mucositis due to previous chemotherapy treatment. (See also Australian Coding Standard 0042 *Procedures normally not coded*, point 5.)

In this scenario a procedure code from block [1920] *Pharmacotherapy* should be assigned with extension -02.

Example 2:

A cancer patient is receiving day therapy of IV injection of intragam for hypogammaglobulinaemia due to chemotherapy treatment.

In this scenario a procedure code from block [1920] *Pharmacotherapy* would be assigned with extension -05.

Activity codes

Activity codes in ICD-10-AM are for use with categories V01-Y34 to identify the activity of the injured person at the time the event occurred. These are to provide hospitals and epidemiologists with more useful statistics for injury prevention and control.

'Sport' overlaps with 'leisure' and most activities specified in the U50–U71 activity codes are commonly recognised as sport; however, they can also be classed as leisure activities. When both a sport (U50–U71) and leisure (U72) code apply, assign the activity code for sport.

There is also a recognised overlap between some sport codes and transport external cause codes. The external cause code for the transport accident will identify (in most circumstances) what the person was doing at the time the injury occurred. Following a review of the application of the activity codes the following guideline has been developed:

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

Example 1

A 17 year-old male sustained a fractured femur when, whilst riding his bike on the street, he collided with a pick-up truck.

Codes:

S72.9	Fracture of femur, part unspecified
V13.4	Pedal cyclist injured in collision with car, pick-up truck or van, driver injured in traffic accident
Y92.40	Place of occurrence, roadway
U73.9	Unspecified activity

Example 2

A 46 year-old male sustained a closed dislocated shoulder when he fell from his horse in a paddock on a farm.

Codes:

S43.00	Dislocation of shoulder, unspecified
V80.00	Rider injured by fall from or being thrown from horse in noncollision accident
Y92.7	Place of occurrence, farm
U73.9	Unspecified activity

Hint: In both these cases there is no documentation of the patient playing a sport, doing a leisure activity or working for an income when the injury occurred, therefore assign a code for unspecified activity.

Example 3

While delivering mail on bicycle, a 49 year-old postman sustained a lacerated wrist with tendon damage, when he was attacked by a pit bull terrier.

Codes:

S66.9	Injury of unspecified muscle and tendon at wrist and hand level
S61.9	Open wound of wrist and hand part, part unspecified
W54.0	Bitten by dog
Y92.9	Unspecified place of occurrence
U73.08	While working for an income, other specified work for an income

NCCH quality services and products

The NCCH quality services division has recently relocated to the Sydney office. For all quality issues, products, services and advice, please contact

NCCH Sydney
Ph 02 9351 9461
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e-mail s.wood@fhs.usyd.edu.au

Performance Indicators for Coding Quality **FAQs**

Neonatal complications

PICQ indicator 100284 *Newborn affected by complication of labour and/or delivery without code indicating effect* has a fatal indicator degree, indicating that there is definitely an error. ICD-10-AM Fourth Edition rationale for this indicator is that:

This indicator identifies records containing a 'fetus and newborn affected by other complications of labour and/or delivery' code but no other diagnosis code to indicate the newborn's problem. ACS 1609 *Newborn affected by maternal causes and birth trauma* states that only when the newborn is affected in some way by a complication of labour and/or delivery should the '...fetus and newborn affected by other complication of labour and delivery...' code be used. If the newborn is observed after the complication but in fact suffers no effect, use 'health supervision and care of other healthy infant and child' code or 'observation and evaluation of newborn for suspected condition not found' code.

Analysis of Australian Institute of Health and Welfare data indicates that between July and December 2000, there was a national error rate of approximately 79.89% for this indicator. This is an extremely high error rate for a fatal indicator.

ACS 1609 *Newborn affected by maternal causes and birth trauma* provides the logic for this indicator.

Codes in categories P00–P04 *Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery* should only be used to indicate that a newborn has been **affected** by a maternal condition.

There must be documentation linking the cause — a maternal condition or a complication of pregnancy, labour or delivery — and the effect — the newborn's problem — to assign one of the codes from category P00–P04 *Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery*.

Therefore, there will always be two codes: the effect (problem) and the cause. Always sequence the code for the effect first, followed by the code for the cause.

Example

Diagnosis — cephalhaematoma due to forceps delivery (single liveborn)

Effect is cephalhaematoma; cause is forceps delivery

Diagnosis codes assigned:

P12.0 *Cephalhaematoma due to birth trauma*

P03.2 *Fetus and newborn affected by forceps delivery*

Z38.0 *Singleton, born in hospital*

If the mother has a condition or complication of labour or delivery that does not cause any adverse effect to the baby, a code from P00–P04 is **not** assigned on the baby's record.

Example

Diagnosis — forceps delivery (single liveborn)

No effect is documented therefore, no cause can be coded

Diagnosis code assigned:

Z38.0 *Singleton, born in hospital*

Babies are sometimes admitted to special care nurseries for observation, because of a maternal condition or a complication of pregnancy, labour or delivery. In this instance, the cause has necessitated provision of more health services than is usual for a newborn. In these cases, it may be appropriate to assign Z76.2 *Health supervision and care of other healthy infant and child* (for example, in the case of post-caesarean observation) or Z03.7 *Observation and evaluation of newborn for suspected condition not found*.

Urethrocele, cystocele, enterocele and rectocele and uterine prolapse

PICQ indicator 101637 *Urethrocele, cystocele, enterocele, rectocele code with prolapse of uterus code* has a fatal indicator degree, indicating that there is definitely an error. The rationale for this indicator is that:

This indicator identifies records containing an urethrocele, cystocele, enterocele or rectocele code and a prolapse of uterus code. The urethrocele, cystocele, enterocele and rectocele codes exclude when with prolapse of uterus.

Analysis of Australian Institute of Health and Welfare data indicates that between July and December 2000, there was a national error rate of approximately 5.2% for this indicator. This is a high error rate for a fatal indicator.

The logic for this indicator comes from excludes notes in block N81 *Female genital prolapse* in the Tabular List of Diseases. The codes for female urethrocele (N81.0), cystocele (N81.1), vaginal enterocele (N81.5) and rectocele (N81.6) all contain the note:

Excludes: (condition) with prolapse of uterus (N81.2–N81.4).

This means that a combined code for uterovaginal prolapse (N81.2–N81.4) should be assigned for documentation of urethrocele, cystocele, enterocele or rectocele with prolapse of uterus.

Non-infectious gastroenteritis in children

A query relating to *Performance Indicators for Coding Quality (PICQ)* indicator 100196 *Non-infectious gastroenteritis code in children* has been received. PICQ Indicator 100196 *Non-infectious gastroenteritis code in children* has a warning indicator degree, indicating that there is possibly an error. The rationale for this indicator is that:

This indicator identifies records where the patient's age is less than 16 years with a non-infective gastroenteritis code. ACS 1120 *Gastroenteritis* states that, where gastroenteritis in adults is not specified as infectious, it should be coded as non-infective. Gastroenteritis in children, aged less than 16 years, should be presumed infectious unless documented as non-infectious.

Analysis of Australian Institute of Health and Welfare data indicates that between July and December 2000 there was a national error rate of approximately 11.49% for this indicator, and that variation in jurisdictions ranged from 1.94% to 15.14%. It appears that differences in the indicator rates are not due to clinical differences across jurisdictions.

The logic of this indicator has been questioned; as the codes listed in ACS 1120 (both A09 and K52.-) apply to diarrhoea as well as gastroenteritis.

NCCH advises that diarrhoea should be coded in the same way as gastroenteritis in ACS 1120 *Gastroenteritis*. (Reference: NCCH Query database #492).

PICQ 2002 indicators invalid for ICD-10-AM Fourth Edition

PICQ 2002 indicator 100135 *Rejection/failure of corneal graft code without additional diagnosis* is **not** recommended for use with ICD-10-AM Fourth Edition coded data because changes to the classification rules have required deletion of the indicator.

Several other indicators have had changes in PICQ 2004 to improve their functionality. These indicators are still valid to use in their current form.

Note that PICQ 2002 indicator 100368 *External cause code required but not present with chapter 19 code* excludes cases with rehabilitation care type. This exclusion has been deleted in PICQ 2004 because all States and Territories now require external cause codes for rehabilitation care type. In the meantime, this indicator will fail to identify rehabilitation cases missing these codes.

Note: It is recommended that if PICQ 2002 is used to process ICD-10-AM Fourth Edition coded data those data are re-run through PICQ 2004 when it becomes available. This will allow the improved indicators, as well as the new indicators, to examine your data.

4 August 2004

The Good Clinical Documentation guide

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coding matters



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CONFERENCES 2004

7-11 September	Medinfo 2004	San Francisco, CA USA	www.medinfo2004.org/
22-24 September	SNOMED International Users Group Meeting	Phoenix AZ USA	www.snomed.org/
26 Sept-1 Oct	HL7 18th Plenary and Annual Working Group Meeting	Atlanta GA USA	meetinginfo@hl7.org
30 Sept - 3 Oct	RACGP 47th Annual Scientific Convention: celebrating diversity in general practice	Melbourne	
1-2 October	The Critical Early Childhood Years — Rethinking current interventions and strategies	Melbourne	www.qec.org.au
9-14 October	International Federation of Health Records Organizations Congress: Sharing Solutions in the Global Community	Washington DC USA	http://cop.ahima.org/COP/Public/Events/
10-13 October	Health Care in Focus 15th Casemix Conference in Australia	Sydney	www.health.gov.au/casemix/conf.htm
11-12 October	Australian Private Hospitals Association National Congress 2004	Gold Coast	apha@consec.com.au
13-17 October	WONCA 2004	Orlando FL USA	www.wonca2004.org/
15-17 October	Trauma Care 2004	Sydney	www.traumacare2004.com
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30 Nov-3 Dec	Asia Pacific Academic Consortium of Public Health	Brisbane	www.apacph.org/conf2004.asp
6-7 December	National Health Information Summit	Melbourne	ahic.secretariat@health.gov.au
13-15 December	International Conference on Knowledge Management	Singapore	www.icKM2004.org

Conference information is also published at the NCCH web site www.fhs.usyd.edu.au

Coding rules

9th NCCH conference
Perth, Western Australia
16-18 March 2005

Features include

- an optional full day post ICD-10-AM Fourth Edition implementation coding workshop
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More information

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