

The **10-AM** Commandments

Intraperitoneal port and catheter for chemotherapy

What is the correct procedure code to assign for the insertion of an intraperitoneal port and catheter for chemotherapy?

Intraperitoneal chemotherapy is the administration of pharmacological agents directly into the peritoneal cavity via a catheter.

The correct code assignment for insertion of an intraperitoneal catheter is 90331-00 [I004] *Other procedures on abdomen, peritoneum or omentum* with an additional code for laparoscopy if performed.

The NCCH is considering the creation of a new code for this procedure for a future edition of ACHI.

KTP bladder neck vaporisation

What is the correct code to assign for KTP bladder neck vaporisation?

KTP (potassium-titanyl-phosphate) is a specially designed high-powered laser used to vaporise tissue. Vaporisation involves tissue ablation in which the structural components of the tissue are carbonised and the water component is vaporised at tissue temperatures exceeding 100° C.

The correct code to assign for KTP vaporisation of the bladder neck is 36840-01 [I096] *Endoscopic laser destruction of a single lesion of bladder lesion ≤ 2cm or tissue of bladder*.

Improvements to the index and tabular list for KTP bladder neck vaporisation will be considered for a future edition of ACHI.

Patient remaining in hospital receiving care whilst awaiting transport back to a remote community

What is the correct code to assign to classify the above scenario?

The correct code to assign for this scenario is Z59.8 *Other problems related to housing and economic circumstances* following the index pathway:

Isolation, isolated
- dwelling Z59.8

or

Problem
- housing
-- isolated Z59.8

Stones spilling from the gallbladder during cholecystectomy

When stones spill from the gallbladder during cholecystectomy, should this be coded as a complication or misadventure?

During either open incision or laparoscopic cholecystectomy procedures, stones can spill into the patient's peritoneal cavity. This occurs during surgical decompression or as a result of unintentional tears.

Surgical decompression occurs when the gallbladder is intentionally perforated to extract fluid so that the gallbladder can be removed through an exit port when the procedure is performed laparoscopically.

A common decompression method involves using an aspirating needle attached to a 35 mL syringe or low pressure suction tip. If the fluid or bile is thick, the gallbladder is incised a few millimetres to accommodate a small open-ended suction tip. Small stones and fluid are removed by suction before the gallbladder is extracted through an exit port. Surgical decompression can result in minor spillage of stones which doesn't necessarily cause a problem and is not considered a



misadventure.

If an adverse effect of stone spillage due to surgical decompression of the gallbladder is documented and it meets the criteria in ACS 0002 *Additional diagnoses*, refer to the guidelines in ACS 1904 *Procedural complications* under the heading *Classification of procedural complications (diagnosis codes)* and *Classification of external causes of procedural complications (external cause codes)* for code assignment.

Unintentional tear of the gallbladder is the most common reason a stone is lost. Perforations or tears occur during sharp or blunt dissection, electrosurgery, instrument malfunction or tissue resistance. When this happens, gallbladder contents spill into the peritoneal cavity. If the gallbladder is inflamed, purulent discharge can also spill into the cavity, increasing the potential for postoperative infection.

Where there is documentation of unintentional tear/rupture of the gallbladder, which may or may not result in spillage of stones, and it meets the criteria in ACS 0002 *Additional diagnoses*, assign:

T81.2 *Accidental puncture and laceration during a procedure, not elsewhere classified*

S36.17 *Injury of gallbladder*

Y60.0 *Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, During surgical operation*

Y92.22 *Health service area*

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ICD-10-AM/ACHI/ACS Sixth Edition

education program

Workshops

ICD-10-AM/ACHI/ACS Sixth Edition workshops in 2008 were held over two days due to the large number of complex changes made to the classification. As in previous years, the workshops were offered as an optional education activity following the completion of the pre-workshop education material. The workshops focused on the more complex changes made to the classification which the NCCH thought would be beneficial to discuss in a workshop situation. Practical exercises and a quiz were offered to help apply and comprehend the changes.

A total of 35 two day workshops were held nationally for 1,183 participants between April–June 2008. 1,401 people registered for the web-based training via a PDF document, 42 requested the CD-ROM version and 78 a hardcopy. Completion of the pre-workshop education material was mandatory for coders attending the workshops.

Breakdown of workshop participants by State/Territory

State/territory	Workshops	Participants
NSW	13	373
Victoria	6	228
Queensland	6	237
South Australia	4	148
Western Australia	3	123
Tasmania	1	34
ACT	1	27
Northern Territory	1	13
TOTAL	35	1,183

The workshop sizes varied from 15 people (some rural centres) up to a maximum of 50 people in most capital cities. The inclusion of graphic material to highlight clinical information was well received with coders indicating that these diagrams helped improve their coding knowledge. The support and comments regarding the changes to Sixth Edition were excellent as can be seen in *Figure 1* which illustrates the total number of responses received regarding the pre-education material, workshop content, presentations etc.

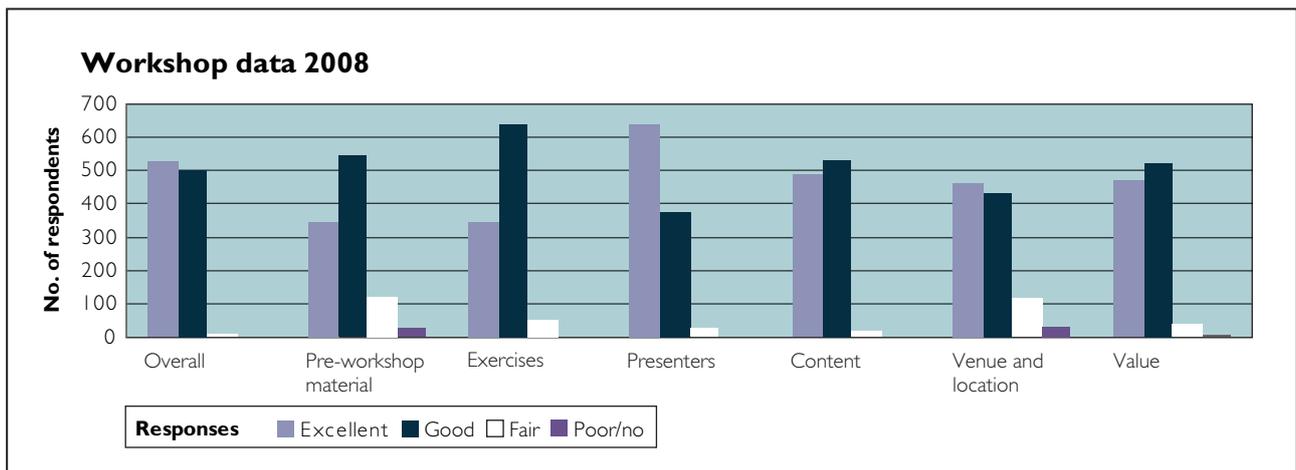


Figure 1 – Evaluation form responses.

Of the 1,183 attendees at the workshops, 1,041 evaluation forms were completed giving an 88% completion rate. From the results the majority of coders who completed the evaluation forms indicated that the pre-education material and workshops were either excellent or good with only a small percentage in each category indicating fair or poor. Overall this illustrates the benefit of the education programs for the continuing education of clinical coders on a national basis.

Workshop comments

Some comments about the workshops from participants include:

- Coding workshops are an important event for people in rural areas especially if you are an isolated coder.
- Good that questions raised were repeated for the benefit of entire room. Visual explanation of procedures was good.
- Presenters were very 'in touch' with the practical decision making involved in being a hospital coder and particularly worked well under pressure as were challenged.
- Several issues raised which were NOT readily identifiable from pre-workshop material provided and which impacted on current coding practice e.g. coding of diabetes based on BSL.
- Two days better not so rushed.
- Would prefer to have exercises immediately following each specialty to reinforce changes. Please do difficult topics at beginning of day.
- Sixth Edition seems much more sensible, clarified and consistent than previous editions. Good that trying to remove some ACS and instead build everything into index/tabular books – coders have enough additional reference material that they must often refer to.
- Found it helpful to see pictures of devices etc e.g. Port-A-Cath. Sometimes it's good to actually see the devices, instrument etc to get a good picture in your head and that will help me to code more efficiently.
- The two day course has been planned with a great deal of thought by the presenters. The content of the workshop was of good quality and the topics covered was evenly spread out between the two days. I did not find it mentally draining.
- The workbook was more like a reference document. Suggestion for next time is that the workbook should be a subset of the total and should only include important material and exclude the listing of index changes as coders will come across these once they start using the new edition.
- There was some very realistic observation regarding the practice of coding and how variable it can be. It was good to see this flexibility of thought as when one is actually working at the 'coal-face' this is commonly needed. Congratulations.

The Good Clinical Documentation guide

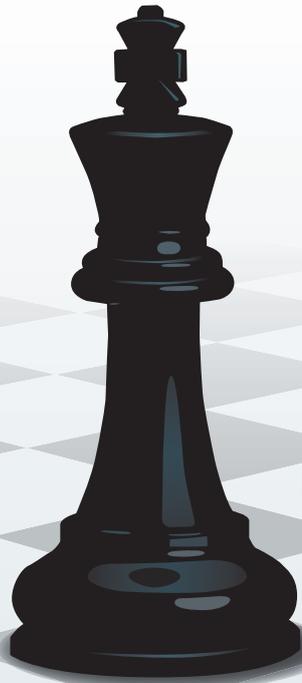
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Frequently Asked Questions

– Part I

This is the first of a two part series on FAQs which were asked at the recent ICD-10-AM/ACHI/ACS Sixth Edition education workshops. For this article the FAQs have been grouped by specialty. The standard abbreviation of 'ACS' has been used throughout for 'Australian Coding Standard'.

Principal/Additional diagnoses

1. **Q:** Patient admitted for breast lumpectomy histopathology pending and patient was discharged. Findings showed cancer. What is coded as the principal diagnosis, the breast lump or the cancer?

A: As per ACS 0010 *General abstraction guidelines – Test results*, the histopathology result is providing further specificity to an already documented condition. In this scenario the patient was admitted for the removal of a breast lump and the histopathology confirmed that the lump was cancerous; therefore, the cancer would be coded as the principal diagnosis.

2. **Q:** If a patient is admitted with chest pain and there is documentation of risk factors such as hypertension, family history of IHD etc and tests such as scans are performed for the risk factors, should the risk factors be coded?

A: As per ACS 0002 *Additional diagnoses – Risk factors*, these factors should only be coded if they meet the additional diagnosis criteria or another standard indicates they should be coded, i.e. if the tests are performed for the hypertension, family history of IHD etc, these conditions would then meet the additional diagnosis criteria for code assignment.

3. **Q:** In day only dialysis admissions, should codes be assigned for any additional diagnoses, e.g. CKD, diabetes etc?

A: As most day only dialysis admissions are autogenerated, it is difficult to assign additional diagnosis codes when the full record is not available at the time of the coding process. Therefore, for day only admissions for dialysis, only assign Z49.1 *Extracorporeal dialysis* for extracorporeal dialysis or Z49.2 *Other dialysis* for peritoneal dialysis together with the appropriate procedure code. Additional diagnosis codes should only be assigned if the conditions meet ACS 0002 *Additional diagnoses*.

Diabetes

1. **Q:** If you have hypercholesterolaemia documented in the clinical record and the test results indicate increased triglycerides and decreased HDL, can this be used to assign a code for dyslipidaemia?

A: Yes, test results can be used to confirm an already documented condition as per ACS 0010 *General abstraction guidelines – Test results – Findings that provide more specificity about a diagnosis* and ACS 0401 *Diabetes mellitus and impaired glucose regulation – Dyslipidaemia* which indicates that:

The characteristic pretreatment dyslipidaemia attributed to insulin resistance features elevated fasting triglycerides and depressed HDL-cholesterol fraction.

Hypercholesterolaemia is a type of dyslipidaemia and therefore more information can be obtained from the test results to be able to code the characteristic dyslipidaemia which meets the criteria for insulin resistance.

2. **Q:** If ↑ Lipids is documented with diabetes, and the diabetes meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*, what codes should be assigned?

A: Documentation in the clinical record of hyperlipidaemia/↑ Lipids **alone** does not equate to features of insulin resistance in a patient with diabetes. The patient has to have 'characteristic dyslipidaemia (elevated fasting triglycerides and depressed HDL-cholesterol)' as per ACS 0401 *Diabetes mellitus and impaired glucose regulation – Dyslipidaemia*, for features of insulin resistance to be coded.

As coders are required to check the pathology results to ensure the patient has 'characteristic dyslipidaemia' the note indicating that 'these criteria are for use by clinicians, not clinical coders' will be removed in a future errata, (see over).



ICD-10-AM/ACHI/ACS
Sixth Edition

ICD-10-AM/ACHI/ACS Sixth Edition is now available in printed volumes and as eCompress@desktop software. For further information and to order: NCCH Sydney
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Diagnostic Criteria for Dyslipidaemia

Triglycerides (mmol/L)	≥ 2.0
	AND
HDL-Cholesterol (mmol/L)	≤ 1.0

Note: These criteria are for use by clinicians, not clinical coders.

In the case cited, assign E1.-. *Diabetes mellitus and E78.5 Hyperlipidaemia, unspecified.

3. **Q:** Does I10 Essential (primary) hypertension need to be assigned if a patient has hypertensive kidney disease (I12) or hypertensive heart and kidney disease (I13) and Type 2 diabetes mellitus, when the diabetes meets ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses?

A: In this scenario, as there is a causal relationship documented between the chronic kidney disease and hypertension etc, a code from I12.- Hypertensive kidney disease or I13.- Hypertensive heart and kidney disease should be assigned as per ACS 0913 Hypertensive kidney disease (I12), ACS 0927 Hypertensive heart and kidney disease (I13) and ACS 1438 Chronic kidney disease. This patient also meets the criteria for insulin resistance, therefore, E11.72 Type 2 Diabetes mellitus with features of insulin resistance is assigned and it is not necessary to assign I10 Essential (primary) hypertension as the 'hypertension' has already been captured in I12.-.

Correct code assignment for the scenario when diabetes meets ACS 0001 Principal diagnosis would be:

E11.72 Type 2 Diabetes mellitus with features of insulin resistance
I12.- Hypertensive kidney disease or
I13.- Hypertensive heart and kidney disease, and
E11.22 Type 2 Diabetes mellitus with established diabetic nephropathy

Obstetrics/Gynaecology

1. **Q:** Does anaemia and pre-existing anaemia need to meet ACS 0002 for the combined code to be assigned?

A: For a code to be assigned from category O99.0- Anaemia complicating pregnancy, childbirth and the puerperium, the 'anaemia' firstly needs to meet ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses. However, as per the ICD-10-AM index:

Anaemia D64.9

- complicating pregnancy, childbirth or puerperium O99.00
- - antepartum NEC O99.01
- - - with mention of pre-existing anaemia O99.02
- - childbirth and the puerperium NEC O99.03
- - - with mention of pre-existing anaemia O99.04
- - postpartum NEC O99.03
- - - with mention of pre-existing anaemia O99.04

Once it has been determined that anaemia requires coding in accordance with ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses, the 'pre-existing

anaemia' component only needs to be 'mentioned' and therefore does not itself have to meet ACS 0001 or ACS 0002 for the appropriate fifth character code to be assigned.

2. **Q:** Why wasn't 'postpartum' removed from I6564-00 Postpartum evacuation of uterus by dilation and curettage and I6564-01 Postpartum evacuation of uterus by suction curettage in block [1345] given that the diagnostic detail was removed from the other D&C codes?

A: The term 'postpartum' could not be removed from the above codes in block [1345] as these are specific procedures which are performed in the postpartum period for retained products of conception and need to be distinguished from other evacuation of uterus codes in block [1265].

Perinatal

1. **Q:** Premature baby is re-admitted 3 weeks after initial episode of care for continuing UTIs. Should this be coded using the P or N codes?

A: As per ACS 1605 Conditions originating in the perinatal period:

Codes from ICD-10-AM Chapter 16 Certain conditions originating in the perinatal period:

- will still apply for infants > 28 days who are still in the birth episode and
- will still apply for infants > 28 days who are discharged and subsequently readmitted with a condition **documented** as originating in the perinatal period.

Therefore, in this scenario, as the UTI originated in the perinatal period, assign P39.3 Neonatal urinary tract infection.

Chronic kidney disease

1. **Q:** If assigning Z99.2 Dependence on kidney dialysis, ACS 1438 Chronic kidney disease – Kidney replacement therapy indicates to also assign N18.5 but isn't this implied that the patient has CKD stage 5 as they are dependent on dialysis?

A: Yes, you are correct, this will be fixed in a future errata.

2. **Q:** If a patient is admitted with acute on chronic kidney disease and is transferred to another hospital still in the acute phase, how is the chronic component coded?

A: In this scenario, assign N18.9 Chronic kidney disease, unspecified for the chronic component of the disease as the eGFR cannot be used as it won't be a true indicator of the underlying level of kidney function. However, if 'end-stage' is documented or the patient is on ongoing haemodialysis or peritoneal dialysis, then N18.5 Chronic kidney disease, stage 5 would be assigned.

3. **Q:** Should renal bone disease be included in ACS I438 Chronic kidney disease and indexed in ICD-10-AM?

A: Renal bone disease, or renal osteodystrophy, is a feature of chronic kidney disease with the same risk factors. Both conditions are due to an underlying cause. Renal bone disease is classified to N25.0 Renal osteodystrophy following the index pathway Osteodystrophy, renal. On consultation with the clinicians it was felt this condition did not warrant inclusion in the current standard.

4. **Q:** If the specific type of anaemia is documented with chronic kidney disease, can an additional code be assigned to specify the **type of anaemia** in addition to D63.8 Anaemia in other chronic diseases classified elsewhere?

A: It is not necessary to assign another code from ICD-10-AM Chapter 3 Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism in addition to D63.8 to indicate the type of anaemia, as the anaemia has already been captured in this code assignment.

However, if the patient has a neoplasm, CKD and anaemia and all three conditions meet either ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses and following the dagger/asterisk convention, both *D63.0 Anaemia in neoplastic disease and *D63.8 Anaemia in other chronic conditions classified elsewhere would be assigned to capture the anaemia 'in neoplastic disease' as well as 'other chronic conditions'.

The issue of assigning additional diagnosis codes to reflect the 'type' of anaemia in chronic diseases is being reviewed for a future edition of the classification.

Ventilation

1. **Q:** If a paraplegic/quadruplegic patient with tracheostomy goes into ICU with his own machine, usually admitted with UTI for cystoscopy, do you code the ventilation in this instance?

A: As this type of patient is using a ventilator (as opposed to a CPAP machine) it would be expected that there would be sufficient documentation in the clinical record indicating increased resources are being used for the assignment of the ventilation codes. If not, assign Z93.0 Tracheostomy status or Z99.1 Dependence on respirator as appropriate.

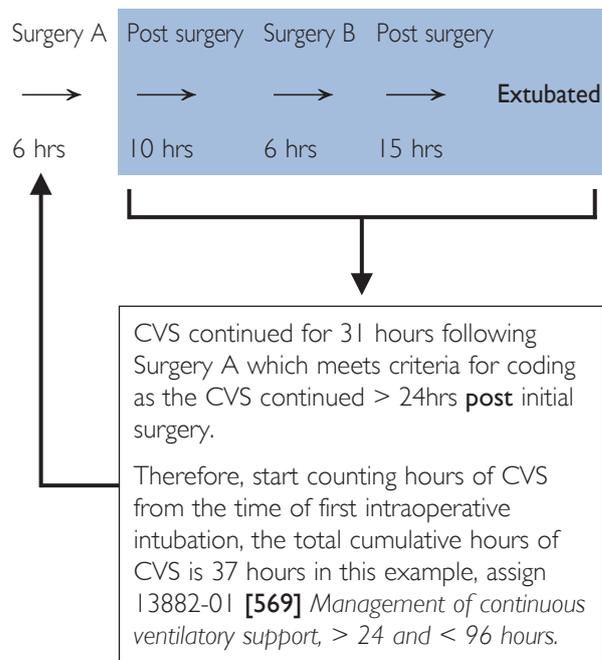
2. **Q:** If a patient is ventilated for surgery for 6 hrs – ICU 10 hrs – back to theatre 6 hrs – ICU 15 hrs and is then finally extubated, how is this type of scenario coded?

A: As per ACS I006 Respiratory support point 1 f, even though the ventilation was originally initiated for surgery, if it continues for >24 hours **post** surgery (including subsequent surgical episodes) then it should be coded with the duration beginning from the time of the first intraoperative intubation. Minor errata changes will be made to this section of the standard.

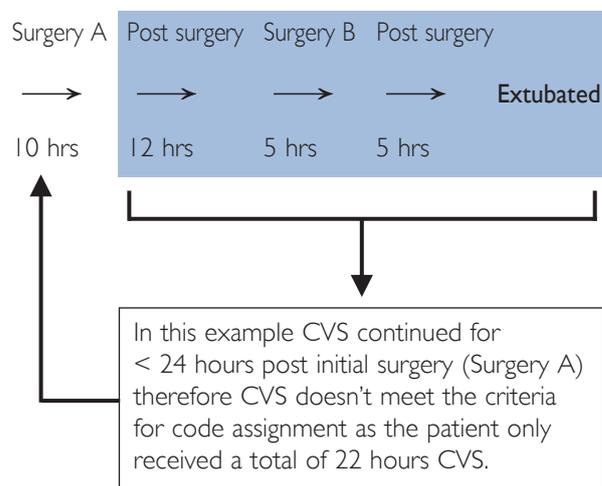
In the scenario cited, CVS continued for 31 hours (10+6+15=31) **post** the original surgery; therefore, count the number of hours of CVS from the time of initial intubation = 37 hours ventilation, assign I3882-01 [569] Management of continuous ventilatory support, > 24 and < 96 hours).

The following examples help illustrate code assignment in these types of scenarios when CVS is continued for subsequent surgery.

Example 1



Example 2



3. **Q:** If NETS (Newborn & paediatric Emergency Transport Service) team (a medical retrieval service for critically ill newborns, infants and children) is called in to intubate and ventilate patients before transfer to another hospital, should this be coded?

A: No, the NETS team stabilise the patient using their own equipment prior to transferring the patient; therefore, this should not be coded as part of the hospital care episode. The NETS team maintain their own records on the care provided.

Pharmacotherapy

1. **Q:** *Should Z45.1 Adjustment and management of drug delivery or implanted device be assigned when a patient is admitted as a day only for loading of a CADD for treatment of their neoplasm?*

A: No, assign Z51.1 *Pharmacotherapy session for neoplasm* as the loading of these devices is considered to be chemotherapy treatment as per ACS 0044 *Chemotherapy*:

Same-day episodes of care for chemotherapy for neoplasm

For episodes of care for chemotherapy for a neoplasm or neoplasm related condition, where the patient is discharged on the same day as the admission, assign:

- Z51.1 *Pharmacotherapy session for neoplasm* as principal diagnosis
- a code for the neoplasm being treated as the first additional diagnosis (see also ACS 0236 *Neoplasm coding and sequencing*)
- additional diagnosis code(s) for any neoplasm related condition(s) being treated
- the appropriate procedure code.

The following excludes note has been added at Z45.1 to help with code assignment:

Excludes: that for pharmacotherapy for neoplasm (Z51.1)

2. **Q:** *Is a Hickman's catheter considered to be a vascular access device (VAD)?*

A: For classification purposes, a Hickman's catheter does not meet the definition of a vascular access device in ACHI as it does not have a reservoir attached. A Hickman's catheter is classified in ACHI as a venous catheter.

3. **Q:** *When a VAD is flushed and a heparin lock is given, should the maintenance code be assigned as well as a code for the infusion of the drug?*

A: No, flushing and a heparin lock is part of the infusion procedure and therefore a maintenance code will only be assigned if no infusion is given as per the following excludes note:

I3939-02 [1922] Maintenance (alone) of vascular access device

...

Excludes: that:

- for vascular catheter without reservoir attached (92058-00 [1890])
- with administration of pharmacotherapy (96199 [1920])

4. **Q:** *Is a permacath a VAD?*

A: A permacath is classified in ACHI as a venous catheter.

5. **Q:** *If a patient is admitted for insertion of a Port-A-Cath, should Z45.2 Adjustment and management of vascular access device be assigned as the principal diagnosis or the reason for the insertion i.e. cancer codes?*

A: As per ACS 0002 *Additional diagnoses*:

The national morbidity data collection is not intended to describe the current disease status of the inpatient population but rather, the conditions that are significant in terms of treatment required, investigations needed and resources used in each episode of care.

If the admission is only for the insertion of a Port-A-Cath then Z45.2 is assigned as the principal diagnosis. Additional diagnosis codes for the neoplasm are only assigned if the condition meets ACS 0002 *Additional diagnoses*, i.e. if treatment of the neoplasm commences during the episode of care.

6. **Q:** *If admission is for removal of Port-A-Cath, should the neoplasm codes be assigned as additional diagnosis?*

A: To assign a code for the neoplasm, this condition needs to meet the criteria in ACS 0002 *Additional diagnoses* (refer also to question 5 above).

7. **Q:** *Which ICD-10-AM/ACHI codes are assigned for a CADD disconnection only?*

A: Assign Z45.1 *Adjustment and management of drug delivery or implanted device* and I3942-02 [1922] *Maintenance (alone) of drug delivery device*.

8. **Q:** *What ICD-10-AM/ACHI codes are assigned for an admission for port flush only?*

A: Assign Z45.2 *Adjustment and management of vascular access device* and I3939-02 [1922] *Maintenance (alone) of vascular access device*.

Bilateral/multiple procedures

1. **Q:** *If skin lesions are removed from both the left and right ear, how many ACHI codes are assigned?*

A: In the scenario, cited assign 31230-02 [1620] *Excision of lesion(s) of skin and subcutaneous tissue of ear* ONCE only. The term 'lesion' has been made plural in ACHI Sixth Edition to reflect that multiple lesions have been excised. The 'bilateral' nature of the procedure in the example should be disregarded and the point 5 in the ACS followed.

ACHI also provides some site specific codes for the removal of skin lesions, and where these exist, they may be assigned.

2. **Q:** Patient admitted for diathermy of endometriosis of multiple sites, e.g. fallopian tube, omentum, ovary etc. Is a procedure code assigned to reflect each site that is diathermied?

A: No, only one procedure code is assigned as per ACS 0020 *Bilateral/multiple procedures – Multiple procedures classification point 2:*

The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions

Assign one code for these procedure types.

There are ACHI index entries to specify the different sites. However, as the same code is allocated for each of these sites the code should only be assigned once.

Refer to Q3 below which covers the scenario where the codes are different.

3. **Q:** If a repair is done via the same approach on multiple, (e.g. two flexor and extensor) tendons of the right hand, what codes are assigned?

A: As ACHI provides separate procedure codes for each site (lesion), in this scenario one code would be assigned for each site, i.e. the flexor and extensor tendon as per ACS 0020 *Bilateral/multiple procedures – Multiple procedures classification point 3:*

46420-00 [1466] Primary repair of extensor tendon of hand

46432-00 [1466] Primary repair of flexor tendon of hand, distal to A1 Pulley

4. **Q:** If an angioplasty is performed on both the right and left renal arteries at one operative episode, should this be coded once or twice since there are two kidneys?

A: An angioplasty can be performed on one or both renal arteries. If the angioplasty is performed on both renal arteries with separate entry points, within the one operative episode, the following guidelines should be followed in ACS 0020 *Bilateral/multiple procedures – Multiple procedures classification point 4:*

The SAME PROCEDURE repeated during a visit to theatre involving MORE THAN ONE ENTRY POINT/APPROACH and more than one non-bilateral site

Assign a code for each procedure as there is a separate entry point/approach for each one.

5. **Q:** Egg retrieval from each ovary via laparoscope for IVF. Should this be coded once or twice?

A: As per ACS 0020 *Bilateral/multiple procedures – Multiple procedures classification point 2:*

The SAME PROCEDURE repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and similar/same lesions

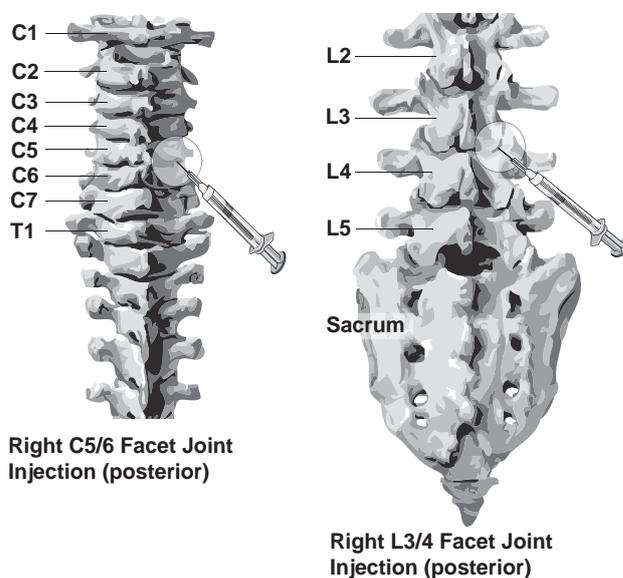
Assign one code for these procedure types.

6. **Q:** If a patient has three skin grafts to the nose, how many codes are assigned?

A: If there are separate incisions/entry points for each of the three grafts, then three codes would be assigned.

7. **Q:** A patient is admitted for facet joint injections at L2/L3 and L3/L4, how many codes would be assigned?

A: In a facet nerve block injections are performed using x-ray guidance. A local anaesthetic is used to numb the area before starting. A small diameter spinal needle is guided into the joint and then a small volume of local anaesthetic mixed with steroid is injected. Single joints or groups of joints are usually injected in the same episode of care. The following diagrams illustrate cervical and lumbar facet joint injections:



For the case cited, two ACHI codes would be assigned to reflect the different entry points per level, i.e.

L2/L3 = 1 code

L3/L4 = 1 code

8. **Q:** How many ACHI codes would be assigned for the following scenarios:

- If liposuction on multiple sites, e.g. thigh and stomach, would a code be assigned for each separate entry point?
- Botox injections to right and left thigh muscles – two entry points therefore two codes?

A: In both scenarios two ACHI codes would be assigned as there are separate entry points for each procedure as per ACS 0020 *Bilateral/multiple – Multiple procedures classification point 4.*

Pacemakers

1. **Q:** Can the specific pacemaker/defibrillator electrode codes be assigned if documentation indicates what the electrodes are being used for, i.e. to either shock, pace or defibrillate?

A: As per ACS 0936 Cardiac pacemakers and implanted defibrillators regarding coding of insertion of the electrodes:

The code(s) should be assigned based on the type of electrode (pacemaker or defibrillator) and the route (transvenous, epicardial etc) regardless of how, or if, they are subsequently used.

Therefore, if a defibrillator is inserted then the code(s) for the defibrillator electrode(s) should be assigned regardless of what they are used for.

Condition onset flag

1. **Q:** Patient is admitted with impaired glucose regulation and is diagnosed with diabetes mellitus during the episode of care, which condition onset flag is assigned?

A: Assign a code for the diabetes as per the excludes note at E09 Impaired glucose regulation and the

condition onset value of 2 – Condition not noted as arising during the episode of admitted patient care as the condition was present on admission.

2. **Q:** Some coders felt that condition onset for jaundice in a preterm infant should be 2 because the jaundice is related to the prematurity and you would be assigning P59.0 Neonatal jaundice associated with preterm delivery. Is this correct?

A: No, the prematurity is present on admission, i.e. the baby was born prematurely, and not all premature babies develop jaundice. Jaundice **may** be associated with a preterm baby; however, the jaundice doesn't arise until a few days after birth and is therefore assigned a condition onset flag of 1 – Condition with onset during the episode of admitted patient care.

3. **Q:** Is there a guideline for assigning condition onset for dagger and asterisk conditions?

A: Yes, follow ACS 0048 Condition onset flag – Guide for use point 8:

When a condition requires more than one disease code to describe it, it is possible and allowable, that each disease code can have a different condition onset flag value.

Attention!

Health Information Managers and Clinical Coders

The NCCH needs case scenarios or clinical record abstracts for possible use in future education workshops!

If you have a case that can be used, please either send a *de-identified* copy to the NCCH or summarise the case and email it...

E-mail:
m.cumerlato@usyd.edu.au

Address:
NCCH
The University of Sydney
PO Box 170 Lidcombe NSW 1825

10-AM Commandments Sixth Edition online now

10-AM Commandments Sixth Edition published in *Coding Matters* can now be viewed on the NCCH website. The commandments are conveniently displayed by title and can be expanded and collapsed as you browse.

10-AM Commandments Sixth Edition may also be viewed using the *Coding Matters* index and newsletter PDF documents also available on the NCCH website. The ICD-10-AM/ACHI/ACS Sixth Edition software version includes the Commandments using active hyperlinks to the relevant sections of the classification.

Visit ICD-10-AM Sixth Edition Commandments online at: www.fhs.usyd.edu.au/ncch

CONFERENCES 2008

Sept 25-26	HIMAA Symposium 2008	Canberra, ACT	www.himaa.org.au/2008/default.htm
Oct 2-5	WONCA 2008 Asia Pacific Regional Conference combined with the RACGP 51st Annual Scientific Convention 2008	Melbourne, VIC	www.racgp.org.au/asc2008
Oct 8-11	24th PCS International Working Conference	Lisbon, Portugal	www.pcsi2008.org/en/welcome/
Oct 15-17	HINZ08 - Health Informatics: Improving and Exploiting our Health Information	Rotorua, NZ	www.hinz.org.nz/content/view/177/1/
Oct 26-28	APHA 28th National Congress	Adelaide, Australia	http://congress.apha.org.au/
Oct 25-31	WHO-FIC Meeting	New Delhi, India	www.who.int/classifications/en/
Nov 4-6	World of Health IT Conference and Exhibition	Copenhagen, Denmark	www.cfp.worldofhealthit.org/
Nov 8-12	AMIA 2008 Annual Symposium	Washington, DC, USA	www.amia.org/meetings/f08/
Nov 12-13	Inaugural National Allied Health Conference 2008	Auckland, NZ	www.healthsectorconferences.org.nz/Site/Future_Workforce/HSC/Upcoming-events.aspx
Nov 16-19	Casemix Conference 2008	Adelaide, SA	www.casemixconference2008.com.au
Nov 24	5th Annual Understanding Mortality Data Workshop	Brisbane, QLD	www.fhs.usyd.edu.au/ncch
Dec 8-10	4th Annual World Healthcare Innovation and Technology Congress	Washington, DC, USA	www.worldcongress.com/events/HT08010/index.cfm?confCode=HT08010
Mar 11-13 2009	11th NCCH Conference and Workshop	Sydney, NSW	www.fhs.usyd.edu.au/ncch
April 4-8 2009	HIMSS'09 Annual Conference and Exhibition	Chicago, USA	www.himssconference.org
April 14-16 2009	6th Annual World Health Care Congress	Washington, DC, USA	www.worldcongress.com/events/HR09000/index.cfm?confCode=HR09000
May 5-7 2009	HIMSS MiddleEast09	Manama, Bahrain	www.himssme.org/09/

Conference information is also published at the NCCH website www.fhs.usyd.edu.au/ncch



CODING rules
11th NCCH Conference 2009
11-13 March 2009, Dockside, Cockle Bay, Sydney

Call for papers
deadline now extended to 17 October 2008

Correction:

The NCCH would like to acknowledge the following error published in *Coding Matters* Volume 15 Number 1 (June 2008).

The article titled '**ACS 1618 Low birth weight and gestational age – the use of Z51.88 Other specified medical care**' contained a typographical error. The section relating to the previous advice in ACS 1618 should have read as follows:

However, if the infant is > 28 days old and ≥ 2500g on admission...

The NCCH apologises for any inconvenience caused by this error.




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National Centre for Classification in Health

NCCH (Sydney)
Faculty of Health Sciences, The University of Sydney
PO Box 170 ph: 02 9351 9461
Lidcombe NSW 1825 fax: 02 9351 9603
Australia e-mail: r.bernard@usyd.edu.au

NCCH (Brisbane)
School of Public Health, QUT
Victoria Park Rd ph: 07 3138 5809
Kelvin Grove QLD 4059 fax: 07 3138 5515
Australia e-mail: ncch.brisbane@qut.edu.au

Editor: Rodney Bernard
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CASEMIX EVOLUTION

extending the boundaries

Casemix-based funding is the dominant form of funding of public hospitals in most states and territories in Australia. Casemix aims to fund on individual outcomes, rather than on a historical level of funding.

From 16th to 19th November 2008, the Department of Health and Ageing will host Casemix Evolution: *extending boundaries*, which aims to view casemix in a holistic manner, across acute, sub-acute and non-acute sectors, including:

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- > **Steve Sutch**, Sutch Consulting International Ltd, United Kingdom
- > **Jason M. Sutherland** PhD, Assistant Professor, Center for Health Policy Research, The Dartmouth Institute for Health Policy and Clinical Practice in Hanover, New Hampshire, USA
- > **Assoc Prof Theo Vos**, Director of the Centre for Burden of Disease and Cost-Effectiveness, School of Population Health, University of Queensland, Australia.

Invited Speakers

- > **Jim Birch** AM, Lead Partner, Health & Human Services, Ernst & Young
- > **Marie Gertz** RN, BN, A&E Cert, GDAET, PhD
- > **Claude Grealy**, Manager, National Casemix Programme, Ireland
- > **Dr Ric Marshall**, OAM, PhD, Health Service Management Information Specialist Infrastructure Development for Strengthening and Restructuring of Health Services' Financial Management Project, Turkey
- > **Dr Tony Sherbon**, CEO, Department of Health, South Australia
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