Government of Western Australia
Department of Health

WACCA coding queries
6 September 2024

Queries received by WACCA from 1 June 2023

Queries to be discussed by the WA Clinical Coding Technical Advisory Group

WACCA's unanswered IHACPA queries

IHACPA query responses

WA Clinical Coding Authority
Purchasing and System Performance Division

Contents

Ministroke

Liver transplant complication

February 2024
PELVIS syndrome

January 2024
Postoperative blood loss anaemia during admission & chronic anaemia

Same-day chemotherapy cancelled or abandoned after pre-medication

Femoral osteochondroplasty

Endoscopic administration of agent into lesion of stomach or duodenum

December 2023
Piriformis syndrome

Documentation of deconditioning by physiotherapists

Principal diagnosis selection: Gastroenteritis versus syncope

Adenoid hypertrophy grades

Radiology report indication as principal diagnosis

November 2023
Schimmelpenning Feuerstein Mims Syndrome

Reconstruction following mastectomy for breast cancer

October 2023
Acute on chronic anaemia

Arthroscopic reconstruction of knee with meniscectomy, indexing anomaly

Mitomycin intravascular chemoembolisation (MICE) for lipid keratopathy

Primary Ciliary Dyskinesia (Immotile-Cilia Syndrome)

Condition Onset Flag (COF) for diabetes mellitus with hypoglycaemia during admission

Assigning 96273-00 [1866] Testing for severe acute respiratory syndrome coronavirus …

Postoperative pain

September 2023

Wiedemann-Steiner syndrome

Clarification of TN1601 Twelfth Edition FAQ: Personal history of coronavirus disease …
Wrong intraocular lens inserted requiring return to theatre for lens exchange
Perinephric haematoma due to a kidney transplant procedure
Performance of inappropriate operation
Is 'clinically dry' synonymous with dehydration?
Condition Onset Flags (COFs) for conditions occurring in ED
Principal diagnoses for COVID-19 patients
Pascal technique for autologous augmentation of buttocks and body lift
Same-day intravenous Bevacizumab for Hereditary Haemorrhagic Telangiectasia
Documentation for Supplementary (U) codes for chronic conditions
Cerebral infarction with haemorrhagic transformation

August 2023

Viral-induced wheeze with multiple viruses including COVID
Cerebral hypoperfusion
Excision of osteophytes
vNotes Vaginal Natural Orifice Transluminal Endoscopic Surgery
Uveitis-glaucoma-hyphema (UGH) syndrome due to iris prosthesis requiring removal
Gastroscopy with adjustment of gastric pigtail stent

July 2023

Haematological malignancy so described
Principal diagnosis in Rehabilitation episodes
Aspiration pneumonia with identification of microorganisms
Intraoperative 3D imaging systems
Contracted Care Flags, Hospital A, Diabetes
Documentation of ESBL producing organism
Typhilitis and normal neutrophil count
Manifestations of COVID-19
COVID-19 vaccination under anaesthesia
Clarification of Example 3 in ACS 0236 *Pharmacotherapy for neoplasms*
Atrial fibrillation as indication for sleep study
Assigning multiple COVID-19 codes

Viral-induced wheeze due to COVID-19

June 2023
Remplir collagen nerve wrap to tethered median nerve

Pseudomeniscus post total knee replacement

Extra-adrenal paraganglionoma of bladder

Seizures, brain tumour, ACS 0001, significant problems in own right

May 2023
P24 Neonatal aspiration syndromes

Oxygen desaturations in neonate or intrauterine

Emotionally unstable personality disorder, unspecified

April 2023
COF assignment for DM with hypoglycaemia (E1-.64) in unstable or poorly controlled DM

Pelvic venous hypertension

Urinary traction infection (UTI) post insertion of indwelling catheter (IDC)

Ketosis and other transient conditions

COF assignment for pressure injury when skin redness is present on admission

February 2023
Barth syndrome

January 2023
Referrals for admission for assignment of supplementary U codes

Complete hydatid mole with lung metastases

December 2022
Ketotic hypoglycaemia in a non-diabetic patient

November 2022
Delirium in a patient with diagnosis of Dementia with Behavioural Disturbance

Anaemia in pregnancy

October 2022
Supportive (not antineoplastic) pharmacotherapy for neoplasm

September 2022
Admission for pain management, without management of underlying condition

Changing the documented principal diagnosis

Breast Implant Associated Anaplastic Large Cell Lymphoma (ALCL)

July 2022
Bartholin's cyst complicating pregnancy

Malignant behaviour documented but no corresponding code available in ICD-10-AM

April 2022
Pneumonitis due to vaping

Clarification of Q3669 Nonmalignant neoplastic polyps detected during …

January 2022
Bacteraemia

ACS 0604 Cerebrovascular Accident (CVA)

Reticulohistiocytoma morphology

Chapter 15 codes to add specificity to O08 *Complications following …*

Palmar space abscess

Pre 2022
Shockwave intravascular lithotripsy/lithoplasty

Flexible Endoscopic Evaluation of Swallowing (FEES) performed by speech pathologist

Postpartum haemorrhage (PPH) with anaemia or low haemoglobin

Spondylosis unspecified

Multistage external ear reconstruction

Closure of postoperative urethrocutaneous fistula

Subconjunctival blocks administered for cataract extraction

Neoplasms of transplanted organs

Catatonia due to mental disorder other than schizophrenia

Retrograde double balloon enteroscopy with ileal biopsy and colonic polypectomy

Triplegic spastic cerebral palsy

User Guide

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024035
QUERY TITLE	**Rezum procedure of prostate**
QUERY SPECIALTY	GEUR - Diseases of the genitourinary system
DATE QUERY RECEIVED	05/08/24
DATE QUERY RESPONDED TO	05/08/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How is Rezum therapy of prostate coded?

RESPONSE

Clinical information

Rezum therapy is a minimally-invasive procedure utilising radiofrequency-generated water vapour (steam) to destroy prostatic tissue in benign prostatic hypertrophy. The steam is delivered through a handheld device via cystoscopy, administering thermal energy to the prostatic tissue. Over the subsequent weeks and months the body absorbs the treated prostatic tissue, shrinking the prostate.

Classification

Rezum therapy is akin to other minimally invasive destruction procedures on the prostate such as transurethral needle ablation (TUNA) which administers radiofrequency heat to the prostatic tissue.

Rezum therapy is classified to 37224-00 [1162] *Endoscopic destruction procedures on prostate* via Index pathway:

Destruction (ablation) (cauterisation) (coagulation) (cryotherapy) (diathermy) (HIFUS) (irreversible electroporation) (laser) (microwave) (radiofrequency) (thermotherapy)
…
- prostate
--endoscopic (transurethral) 37224-00 [1162]

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024034
QUERY TITLE	**Trial of void**
QUERY SPECIALTY	ACSD - General standards for diseases
DATE QUERY RECEIVED	02/08/24
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What code should be assigned as principal diagnosis for an admission for trial of void, where the trial of void fails, and a replacement catheter is inserted?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024033
QUERY TITLE	**Malnutrition versus inadequate/suboptimal oral intake**
QUERY SPECIALTY	ACSD - General standards for diseases
DATE QUERY RECEIVED	01/08/24
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What should be coded in each of the following Dietetics documentation examples — malnutrition or inadequate oral intake?

Examples to follow.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024032
QUERY TITLE	**Breast dysphoria in transgender patient**
QUERY SPECIALTY	ACSD - General standards for diseases
DATE QUERY RECEIVED	12/08/24
DATE QUERY RESPONDED TO	02/09/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What is the code assignment when a bilateral mastectomy is performed for the indication '*breast dysphoria / transgender patient'*? Would code assignment differ if *'transgender patient'* was documented first? Does a query need to be sent to the clinician to determine the principal diagnosis?

RESPONSE

Clinical information

The term **'transgender'** refers to a person whose sex assigned at birth (i.e., the sex assigned at birth, usually based on external genitalia) does not align with their gender identity (i.e., one's psychological sense of their gender). 'Transgender' is not considered a mental health disorder. Some people who are transgender will experience **'gender dysphoria',** which refers to the psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Gender dysphoria is considered a mental health disorder.

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* provides the criteria for diagnosis of gender dysphoria. These include:

- **A strong desire to be rid of one's primary and/or secondary sex characteristics** because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary and/or secondary sex characteristics of the other gender

Not all transgender people experience gender dysphoria.

Some transgender people want surgery to change the physical features of their body. This is gender affirming surgery (GAS). GAS is often referred to as: 'top' surgery - chest surgery, 'bottom' surgery - genital removal and/or creation. In female-to-male transgender individuals pursuing GAS, the first surgical procedure is usually **chest wall masculinisation**, also known as transmale top surgery. It is sometimes the only surgical step undertaken during transition.

Several techniques have been described for chest wall masculinisation surgeries. The goal of transmale top surgery includes the complete or partial removal of breast tissue and skin excess, minimisation of chest-wall scars, and appropriate reshaping and positioning of the nipple-areola complex (NAC).

For further information see:

- Psychiatry.org - What is Gender Dysphoria?
- Nipple-areola complex reconstruction in transgender patients undergoing mastectomy with free nipple grafts: a systematic review of techniques and outcomes - Bustos - Annals of Translational Medicine (amegroups.org)

Clinical documentation abstraction

Operation report
Indications: Breast dysphoria / transgender patient
Procedure: Bilateral mastectomy with free nipple areolar complex (NAC) graft

Classification

In this episode of care, a transgender patient has presented for chest masculinisation (bilateral mastectomy) surgery due to the psychological distress (dysphoria) from feminine appearing breasts. That is, the patient is having excision of their secondary sexual characteristic – breasts, due to gender dysphoria.

Follow

- IHACPA Coding Rule Q3527 *Chest masculinisation surgery for gender dysphoria* (Published 18/12/2020. Updated 15/12/2023). When a patient is admitted with gender dysphoria for a bilateral mastectomy and nipple graft (i.e., chest masculinisation surgery), assign Z41.1 *Other plastic surgery for unacceptable cosmetic appearance as the principal diagnosis* and F64 *Gender incongruence*.

to assign

- The unacceptable cosmetic appearance of feminine breasts as principal diagnosis

- the gender dysphoria as an additional diagnosis

  Follow the ICD-10-AM Alphabetic Index:
  Surgery
  - plastic
  - - cosmetic **Z41.1** ***Other plastic surgery for unacceptable cosmetic appearance***

  Dysphoria
  - gender **F64** ***Gender incongruence***

- 'Transgender' is a gender identity and is not a mental health disorder. 'Transgender' is not a term classifiable in ICD-10-AM. The surgeon does not need to be queried.
- Per instructions in IHACPA Coding Rule Q3841 *Genital reconfiguration surgery* (Published 15/12/2023 Current), do not assign Z41.89 *Other procedures for purposes other than remedying health state* as the principal diagnosis for chest masculinisation surgery. This code is assigned for genital reconfiguration surgery, NOT for chest masculinisation surgery.

Other comments

In responding to this query, it has been noted that the following statement in Q3527 *Chest masculinisation surgery for gender dysphoria* is incorrect.

'…gender dysphoria is not considered a mental illness or condition (Healthdirect Australia 2019)."

With the publication of DSM–5 in 2013, "gender identity disorder" was eliminated and replaced with "gender dysphoria." This change further focused the diagnosis on the gender identity-related distress that some transgender people experience (and for which they may seek psychiatric, medical, and surgical treatments) rather than on transgender individuals or identities themselves.

For further information see

- Gender incongruence | healthdirect (May 2024)
- Gender affirming surgery | healthdirect (May 2024)
- Psychiatry.org - Gender Dysphoria Diagnosis
- Table 2. [DSM-5 Criteria for Gender Dysphoria ()]. - Endotext - NCBI Bookshelf (nih.gov)

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024031
QUERY TITLE	**Removal of penetrating foreign body in lung**
QUERY SPECIALTY	RESP- Diseases of the respiratory system
DATE QUERY RECEIVED	30/07/2024
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code removal of penetrating foreign body in lung?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024030
QUERY TITLE	**Procedural anxiety or distress in the absence of a psychiatric diagnosis of anxiety**
QUERY SPECIALTY	SSAF- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
DATE QUERY RECEIVED	25/07/24
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What code is assigned for procedural anxiety or distress in the absence of a mental health disorder?

Scenario for context

Patient with distress and anxiousness related to routine medical procedures/interventions. Oral sedation administered for patient to cooperate with procedures.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024029
QUERY TITLE	**ACHI code for Aboriginal Health Liaison Officer (ALO)**
QUERY SPECIALTY	ACSI- General standards for interventions
DATE QUERY RECEIVED	15/07/24
DATE QUERY RESPONDED TO	30/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Aboriginal Health Liaison Officers are part of the Social Work service at our hospital. Should Aboriginal Health Liaison Officer (ALO) be classified to an Allied Health ACHI code such as 95550-01 [1916] *Allied health intervention, social work* or 95550-11 [1916] *Allied health intervention, other*?

RESPONSE

Classification

Allied health professionals are defined as health professionals that are not part of the medical, dental or nursing professions and who are university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses Allied health professions - Allied Health Professions Australia (ahpa.com.au).

'Allied health' is an essential modifier in most of the ACHI Index entries for block 1916 codes, including all index pathways for codes 95550-01 [1916] *Allied health intervention, social work* and 95550-11 [1916] *Allied health intervention, other.*

It is acknowledged that 95550-12 *Allied health intervention, spiritual care* is located in block 1916 even though the role does not meet the definition of Allied Health. It does, however, have an additional Index entry at lead term 'Spiritual care NEC', separate to the lead term 'Allied health'.

Aboriginal Health Liaison Officers are part of the comprehensive multi-disciplinary care received by patients, however the role does not meet the definition of Allied Health so the lead term 'Allied health' is not applicable. The role is more complex

and varied than solely providing spiritual care, so the lead term ‘Spiritual care’ is also not applicable.

Because Aboriginal Health Liaison does not have its own ACHI code/index pathway, it is currently unable to be classified.

Other comments
In Twelfth Edition a new code was created for a liaison service: 96037-01 [1824] *Consultation liaison psychiatry.* In public consultation for Thirteenth Edition, IHACPA received requests to consider creation of new ACHI codes for aboriginal and disability liaison services.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a public submission to the Independent Health and Aged Care Pricing Authority (IHACPA).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024028
QUERY TITLE	**Li- Fraumeni syndrome (LFS)**
QUERY SPECIALTY	CONG - Congenital malformations, deformations and chromosomal abnormalities
DATE QUERY RECEIVED	15/07/24
DATE QUERY RESPONDED TO	30/08/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code Li-Fraumeni syndrome in a patient with adenocarcinoma of sigmoid colon?

RESPONSE

Clinical information

Li-Fraumeni syndrome (LFS) is a type of hereditary cancer syndrome, caused by mutation in the TP53 gene.

Both children and adults with LFS are susceptible to developing various cancers. Not everyone with a TP53 gene variant will develop cancer, but the risk is substantially higher than among the general population.

The most common types of cancer associated with LFS include:

- Soft tissue sarcoma
- Osteosarcoma
- Breast cancer
- Leukemia
- Brain cancer
- Adrenal gland cancer

Other less common cancers associated with LFS include:

- Lung cancer
- Skin cancer, including melanoma
- Colon cancer

- Pancreatic cancer
- Kidney cancer
- Thyroid cancer
- Ovarian cancer
- Testicular cancer
- Prostate cancer

Classification

Li-Fraumeni syndrome is not classified in ICD-10-AM.

However, Lynch syndrome (another hereditary cancer syndrome), is Indexed in ICD-10-AM.

Lynch syndrome
- with neoplasm (M8000/3) – see Neoplasm/malignant
- screening for neoplasm – see Screening/neoplasm

The Alphabetic Index provides a 'see' cross reference which is an explicit direction to use the alternate index pathway.
Because 'syndrome' is part of the Index pathway, U91 *Syndrome NEC* is not assigned i.e., the appropriate neoplasm codes are assigned alone to classify Lynch syndrome.

Li-Fraumeni syndrome is a rare disorder, and like many rare disorders isn't specifically indexed in ICD-10-AM.

Some hereditary cancer syndromes don't have 'syndrome' in their title e.g. multiple endocrine neoplasia, which is also Indexed in ICD-10-AM:

Neoplasia
- endocrine, multiple (M8360/1)(MEN) (see also Adenomatosis/endocrine) D44.8

The intention in ICD-10-AM appears to be to classify hereditary cancer syndromes by coding the manifesting neoplasm(s) alone. This is consistent with the Orphanet nomenclature which maps Li Fraumeni syndrome to an ICD-10 neoplasm code: C97 *Malignant neoplasms of independent (primary) multiple sites.*

Despite this apparent intention, ACS 0005 *Syndromes* is applicable where syndrome is in the title of a condition, for assignment of U91 *Syndrome NEC* to flag that an individual index pathway and code for the syndrome is not available in ICD-10-AM.

For Li-Fraumeni syndrome in a patient with adenocarcinoma of sigmoid colon, follow ACS 0005 *Syndromes* to code the manifestation(s) that meet ACS 0001 or 0002 in the episode, followed by U91 *Syndrome NEC*:

C18.7 *Malignant neoplasm of sigmoid colon*
8140/3 *Adenocarcinoma NOS*
U91 *Syndrome, NEC*

Other comments

Retired national coding rule TN211 *Assignment of Chapter 17 Congenital malformations, deformations and chromosomal abnormalities codes (Q00-Q99)* as additional diagnoses advised that Q codes (e.g. Q99.8 *Other specified chromosome abnormalities*) should **not** be assigned as additional diagnoses to indicate the genetic nature of a disease in conditions such as otosclerosis, familial adenomatous polyposis (FAP) and hereditary non-polyposis colon cancer (HNPCC). This rule was retired at time of Eleventh Edition implementation because it contained an ACS 0005 *Syndromes* instruction about assignment of Q87, which was removed from ACS 0005 in Eleventh Edition. Despite the rule's retirement, its logic about not assigning Q codes to indicate the genetic nature of a disease is interpreted to still be current. In America a new code category was created in ICD-10-CM: Z15 *Genetic susceptibility to disease*, to which Li Fraumeni syndrome is indexed.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024027
QUERY TITLE	**Radical abdominoplasty**
QUERY SPECIALTY	SKSC – Diseases of skin and subcutaneous tissue
DATE QUERY RECEIVED	22/07/24
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can radical abdominoplasty be coded based on documentation of procedural components alone (without documentation of the term 'radical')?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024026
QUERY TITLE	**Haematuria secondary to traumatic indwelling catheter insertion**
QUERY SPECIALTY	INPO - Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	18/06/2024
DATE QUERY RESPONDED TO	27/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Examples of documentation:

- Patient 1: Haematuria noted from IDC likely traumatic catheterisation
- Patient 2: Haematuria secondary to traumatic IDC insertion
- Patient 3: Haematuria likely secondary to traumatic IDC insertion

Which external cause code do you assign?

RESPONSE

Clinical information

Insertion of indwelling catheter (IDC) is a procedure commonly performed in health care settings. As with all medical and surgical interventions, IDC insertion poses complication risks. Complications of IDC placement may include:

- Infection (e.g. prostatitis, epididymitis, UTI)
- Trauma/injury resulting in false tracts/passages, strictures, and bleeding/haematuria.
- Blockage
- Bypassing/leakage
- Bladder spasm

Classification

ACS 1904 *Procedural complications* states:

> An unintentional event (previously termed misadventure) is defined as injury or harm caused during medical or surgical care. An unintentional event may be identified at the time of the procedure or after completion of the procedure.

Clinical documentation such as ‘traumatic IDC insertion’ or ‘traumatic catheterisation’ infer that a trauma was caused **during** the insertion of the IDC, thereby meeting the definition of an unintentional event. 'Traumatic IDC insertion/traumatic catheterisation' can be coded as an unintentional event even without documentation of the specific anatomy that has been injured.

For haematuria from traumatic catheterisation/IDC insertion, assign:

T83.81 *Haemorrhage and haematoma following insertion of genitourinary prosthetic devices, implants and grafts* by following the Index pathway:

Complication(s) (from) (of)
- genitourinary NEC (see also Complication(s)/by site and type)
- - device, implant or graft
- - - haemorrhage (bleeding) T83.81

and an appropriate external cause code:

Y60.6 *Unintentional cut, puncture, perforation or haemorrhage during aspiration, puncture and other catheterisation*

OR

Y73.1 *Gastroenterology and urology devices associated with unintentional events, therapeutic (nonsurgical) and rehabilitative devices*
(if clinical documentation evidences that the unintentional event is due to device breakdown or malfunction)

by following the External Cause Index pathways:

Unintentional event(s)
- cut, cutting, haemorrhage, perforation or puncture (accidental) (during) (inadvertent)
- - catheterisation Y60.6

OR

Unintentional event(s)
- due to device
- - urology Y73.-

Also assign appropriate place of occurrence and activity codes.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024024
QUERY TITLE	**Iliotibial band release**
QUERY SPECIALTY	MSCT - Diseases of the musculoskeletal system and connective tissue
DATE QUERY RECEIVED	11/06/2024
DATE QUERY RESPONDED TO	27/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code iliotibial band release?

Clinical information

The iliotibial tract or iliotibial band (ITB) is a longitudinal fibre-dense tissue that runs along the outside of the thigh. The precise anatomy of this structure has been the subject of many investigations over the years and there have been differing opinions on whether the ITB is considered a tendon, ligament, or fascia.

The fascia lata is a deep fascia surrounding the thigh muscles. It begins proximally at the ilium and ends distally at the tibia. The thickness of the fascia lata varies across its length. **The thickest part of the fascia lata is the ITB**.

Iliotibial band/ITB release surgery covers various surgical techniques performed to treat conditions such as iliotibial band syndrome and external snapping hip syndrome when nonsurgical management has failed. The different techniques share a common goal of releasing or lengthening the ITB to take some of the tension out of it. These surgical techniques may include fenestrations, various types of incisions (longitudinal/vertical, transverse, cross-shaped/cruciate, elliptical, diamond-shaped) and Z-plasty/lengthening.

Classification

As the ITB is a thickening of the fascia lata, surgical procedures on the ITB should be coded as procedures on fascia. This is consistent with advice from NHS Classifications Service in the UK.

Classification of iliotibial band release is guided by documentation in the operation report.

When ITB release is performed by fenestration or incision, assign 90567-01 *Fasciotomy of the lower limb* by following the Index pathway:

Incision
- fascia — see Fasciotomy

Fasciotomy (decompression) NEC
- limb
- - lower 90567-01 **[1558]**

When ITB release is performed by Z-plasty/lengthening, assign 30238-00 *Repair of fascia, not elsewhere classified* by following the Index pathway:

Lengthen, lengthening
- fascia 30238-00 **[1574]**

When the specific surgical technique is not documented on the operation report and only 'ITB release' is documented, assign 90567-01 *Fasciotomy of the lower limb* by following the Index pathway:

Release, released
- fascia — see Fasciotomy

Fasciotomy (decompression) NEC
- limb
- - lower 90567-01 **[1558]**

See also ACS 0023 *Minimally invasive interventions* to assign applicable intervention codes when ITB release is performed via endoscopy or arthroscopy.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024023
QUERY TITLE	**Coding queries post discharge for antimicrobial drug resistance**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	06/06/24
DATE QUERY RESPONDED TO	09/08/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can a clinician query be generated post-discharge, to clarify (and potentially code) resistance to antimicrobial drugs, when resistance is only evidenced on a pathology report?

RESPONSE

The *Classification* section of ACS 0112 *Infection with drug resistant organisms* instructs Z14-Z16 codes for resistance to antibiotics and other antimicrobial drugs can only be assigned when there is documentation of 'resistance' in the episode of care. There is no specific instruction in ACS 0112 regarding a clinician query when 'resistance' is not documented but is evident from pathology report.

ACS 0010 *Clinical documentation and general abstraction guidelines* provides the below instructions:

- All information from test results should be qualified with clinical documentation within the current episode of care.
- A query to a clinician may be used where documentation in an episode of care is incomplete (e.g. lacking specificity)
- The guidelines in this ACS apply to all personnel involved in the clinical coding process, including clinical coders and clinical documentation (improvement) specialists.

IHACPA published TN1601 *Twelfth Edition FAQ: Antimicrobial drug resistance* (15 Sep 2022) to clarify their stance of not using pathology results alone for 'drug

resistance' coding. Furthermore, this instruction is due to be incorporated in the Thirteenth Edition update of ACS 0112 per below:

Note(s)
...
2. **Do not** assign codes from block Z14-Z16 based on documentation of drug susceptibility, to imply or inform the classification of drug resistance. Use the pathology results to identify the specific drug(s), but **do not** assign Z14-Z16 based on pathology results alone.

While ACS 0010 provides justification for a query to be sent for incomplete documentation, this should be considered in the context of ACS 0112 and TN 1601 which explicitly instruct that Z14-Z16 should not be assigned based on pathology results alone.

Therefore, WACCA considers it inappropriate to generate a clinician query post-discharge for clarification of antibiotic/antimicrobial resistance based on pathology results alone.

Other comments

WACCA notes that this response conflicts with that of other jurisdictions. A public submission and a coding query have previously been raised with IHACPA for the same issue and are still awaiting a decision.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024022
QUERY TITLE	**Drowsiness due to drugs in a palliative care admission**
QUERY SPECIALTY	SSAF – Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
DATE QUERY RECEIVED	28/05/24
DATE QUERY RESPONDED TO	23/08/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Should drowsiness not otherwise specified and drowsiness due to drugs be coded in a palliative care admission?

RESPONSE

Clinical information

Palliative care is care provided to patients with life-limiting or terminal illness. Palliative care aims to support patients to maximise their quality of life based on their physical, social, emotional and spiritual needs.

Palliative care manages pain relief as well as relief from other symptoms commonly occurring in the end-of-life phase such as:

- dyspnoea
- nausea and vomiting
- respiratory secretions
- delirium symptoms (confusion, agitation, drowsiness, hallucinations, etc)

Drowsiness is one of the physical changes that happen naturally as part of the dying process. However, it can also be induced by medications that are often pre-emptively prescribed to manage the above symptoms in palliative care admissions. Examples of these medications can be found in WA Cancer and Palliative Care Network- Evidence Based Clinical Guidelines for adults in the terminal phase (health.wa.gov.au).

Classification

The only specialty standard specific to palliative care is ACS 2116 *Palliative care*, which only provides classification directive for assignment of Z51.5 *Palliative care*.

Therefore, coding of all other diagnoses (including drowsiness NOS and drowsiness due to drugs) in palliative care admissions are governed by ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

In ICD-10-AM, drowsiness is classified as a symptom code. It may potentially meet the definition described in Note (f) in Chapter 18 of the Tabular List: *certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right*.

Palliative medications are often titrated to achieve pain/symptom relief balanced against side effects. This titration process is inherent in palliative care, and therefore drowsiness would generally not meet ACS 0002. However, each episode should be assessed on its merits because there may be evidence that drowsiness has required increased clinical care and meets ACS 0002 criteria for coding.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024021
QUERY TITLE	**Debridement by podiatrists**
QUERY SPECIALTY	SKSC - Diseases of the skin and subcutaneous tissue
DATE QUERY RECEIVED	15/05/2024
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code the podiatric debridement procedures in these scenarios?

Scenario 1
Plantar foot ulcer, Size: 28.6cm, Probe to bone: No, Wound base: granulating/slough/tendon, Exudate: serous moderate, Periwound: slightly macerated.

Dorsal foot ulcer, Size: 7.8cm, Probe to bone: No, Wound base: granulating/slough, Exudate: serous moderate, Periwound: slightly macerated.

Procedure: sharps debridement of devitalised soft tissue at wound bases.

Scenario 2
Plantar 5th forefoot wound, Size: 45x10x1mm, Probe to bone: No, Wound base: 60% granulating 40% sloughy, Exudate: serous, Periwound: minimal callus.

Procedure: slough removed as much as possible with tweezers and saline flushed.

Scenario 3
Plantar 5th metatarsophalangeal ulcer, Size: 0.7cm, Probe to bone: not probed today, likely still deep, Wound base: mixed granulation and slough, Exudate: joint fluid and haemoserous exudate, Periwound: mild callus.

Procedure: Tissue debridement performed using curette to remove sloughy tissue. Periwound skin debridement also performed to remove callus.

Scenario 4
Hallux amputation site ulcer, Size: 48x12x4mm, Probe to bone: No, Wound base: mixed granulation and slough, Exudate: serous, Periwound: normal.

Procedure: Amputation site tissue debridement performed using forceps to remove sloughy and devitalised tissue.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024020
QUERY TITLE	**Sedative medication on operation reports & blocks performed at the end of procedures**
QUERY SPECIALTY	ACSI – General standards for interventions
DATE QUERY RECEIVED	22/04/2024
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

1. When is it appropriate to code sedation not documented on an anaesthetic chart e.g., documentation of Midazolam in the notes on an endoscopy report or cardiac catheter report?

2. Can the logic from National Coding Advice Q3233 *TAP block performed at the end of a surgical procedure* be applied to other blocks?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024019
QUERY TITLE	**Annuloplasty in intervertebral disc herniation**
QUERY SPECIALTY	MSCT - Musculoskeletal system and connective tissue
DATE QUERY RECEIVED	03/04/2024
DATE QUERY RESPONDED TO	19/07/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

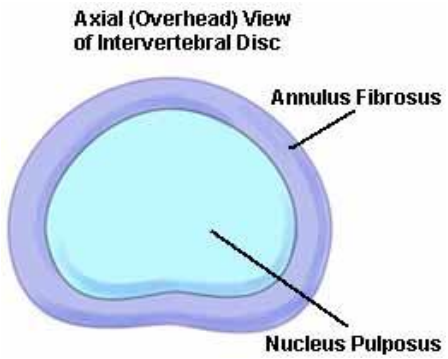
How should annuloplasty for treatment of intervertebral disc herniation be classified?

RESPONSE

Clinical information

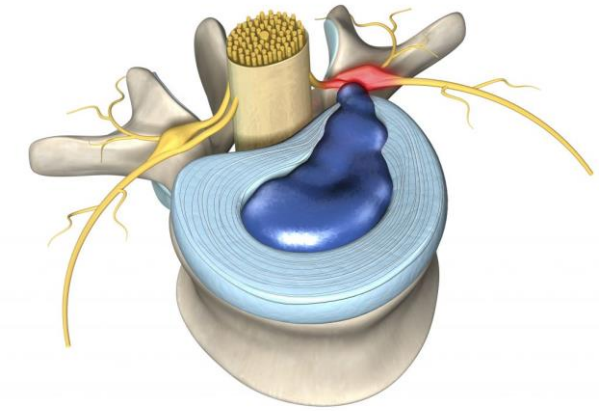
Anatomy and pathophysiology

Intervertebral discs are cushions that sit between vertebral bodies of the spine. Each disc is composed of two parts: a soft inner, jelly-like nucleus (nucleus pulposus) and a tough outer ring of collagenous tissue (annulus fibrosus).



When a tear develops in the outer ring of a spinal disc, the injury is called an annular tear/fissure. Annular tears can develop naturally (as part of degenerative aging

process) or due to an injury. Most annular tears are asymptomatic, but complications such as disc herniation and nerve compression may occur.



A herniated disc formed as the result of an annular tear.

Treatment options

Treatments of annular tears vary depending on the severity of the tear and the patient's symptoms. Treatment options include:

- painkillers and anti-inflammatory medications
- physiotherapy
- steroid injection
- intradiscal electrothermal therapy (IDET) such as thermal annuloplasty, percutaneous intradiscal radiofrequency thermocoagulation, biaculoplasty
- spinal surgery such as decompressive discectomy and spinal fusion

An annuloplasty is a minimally invasive procedure performed by inserting a catheter with an embedded temperature-controlled thermal resistive heating coil into the disc annulus or nucleus. Using radiofrequency energy, electrothermocoagulation is performed to denature collagen fibres which result in sealing the annular tears.

For a short video of this procedure, visit Annuloplasty - SpineOne Treatment for Chronic Low Back Pain

Classification

Assign 90027-00 *Intradiscal therapy* for annuloplasty following the pathway:

Therapy
-intradiscal (electrothermal catheter) (percutaneous) (radiofrequency) 90027-00 [31]

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024015
QUERY TITLE	**Bacteraemia due to specific infection/known source**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	02/04/2024
DATE QUERY RESPONDED TO	12/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What codes do you assign for this scenario?

> ***Scenario***
> Admitted for management of group G streptococcus bacteraemia secondary to pharyngitis.

a) Do you code pharyngitis alone OR both pharyngitis and bacteraemia?
b) Do you query for sepsis?
c) Do you apply National Coding Advice Q3332 *E.coli UTI and E.coli bacteraemia* to this scenario?

It's noted that WA's IHACPA coding query IHACPA0136 (Q3777) *Bacteraemia* remains unanswered.

RESPONSE

While WA's IHACPA coding query IHACPA0136 (Q3777) Bacteraemia remains unanswered, that query was based on ICD-10-AM/ACHI/ACS Eleventh Edition. Some Index pathways and ACS contents that form the basis of that query have been updated in Twelfth Edition and the classification advice below is based on Twelfth Edition.

Clinical information

Bacteraemia, in the strictest sense, is defined as the presence of viable bacteria in the blood. Patients with bacteraemia are often asymptomatic or may present with mild symptoms.

A healthy immune system usually can clear up bacteraemia before it develops into a serious illness. However, if bacteria start to multiply and establish an infection, then this is known as bloodstream infection.

Left untreated, bloodstream infection can lead to more serious complications such as:

- Sepsis
- Meningitis
- Osteomyelitis
- Infectious arthritis
- Endocarditis
- Peritonitis

Sepsis is currently defined as a **life-threatening organ dysfunction caused by a dysregulated host response to infection**.
In lay terms, sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. (The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) | Critical Care Medicine | JAMA | JAMA Network).

Classification

The terms 'bacteraemia' and 'sepsis' may be documented interchangeably by clinicians.

ACS 0110 *Sepsis and Septic shock* states:
Note that codes for terms seemingly synonymous with sepsis (eg septicaemia, bloodstream infection) are assigned as directed by the ICD-10-AM Alphabetic Index.

Group G Streptococcus bacteraemia is classified to A49.11 *Streptococcal infection, unspecified site*, per below:

Follow the ICD-10-AM Index lead term **Bacteraemia** and follow the 'see also' instruction to **Infection/bacterial/agent**:
Bacteraemia (see also Infection/bacterial) A49.9

Infection, infected (opportunistic) (see also Infestation) B99
- bacterial (unspecified agent) NEC (see also Infection/by site) A49.9
- - agent (unspecified site) — see also Infection/by type of agent

Then locate the specific type of agent (Streptococcus) in the Index:
Infection, infected (opportunistic) (see also Infestation) B99
- Streptococcus, streptococcal NEC A49.11
- - group
- - - G, as cause of disease classified to other chapters B95.42

Note: B95.42 is not applicable for bacteraemia because B95-B97 codes are only used to provide infectious agent specificity to conditions classified **outside** of Chapter 1, as per the 'Code first' instruction in the Tabular List:

B95–B97 Bacterial and viral agents as the cause of diseases classified to other chapters

Note: Assign a code from these categories if it provides specificity about the infectious agent.

Code first disease classified to other chapter.

Excludes: bacterial or viral condition classified elsewhere in Chapter 1 — see Alphabetic Index

A separate code is assigned to classify pharyngitis because it's a separate clinical concept to bacteraemia.

Final code assignment

For "group G Streptococcus bacteraemia secondary to pharyngitis", assign:
A49.11 *Streptococcal infection, unspecified site*
J02.0 *Streptococcal pharyngitis*
B95.42 *Streptococcus, group G, as the cause of diseases classified to other chapters*
This is consistent with National Coding Rule Q3222 *E.coli* UTI and *E.coli* bacteraemia and previously published decisions in QLD (Query ID 05-0216) and NSW (Query No. 4190).

Following the instructions in ACS 0010, a query for sepsis can be raised when there is ambiguous or conflicting documentation within the medical record. WACCA recommends that hospitals/HSPs conduct an investigation of clinical documentation at their sites and implement document improvement initiatives as required.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024014
QUERY TITLE	**Vaginal vault prolapse with cystocele and rectocele**
QUERY SPECIALTY	GEUR – Diseases of the genitourinary system
DATE QUERY RECEIVED	02/04/2024
DATE QUERY RESPONDED TO	05/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Are cystocele and/or rectocele coded with vaginal vault prolapse, if each condition meets ACS 0002 *Additional diagnosis* criteria for code assignment?

RESPONSE

Clinical information

The female pelvic organs include the bladder, vagina, uterus, and bowel. These organs are held in place by the pelvic floor muscles and ligaments as well as by each other. If this support system weakens, **one or more pelvic organ may prolapse** simultaneously into the vagina.

There are different types of pelvic organ prolapse. The most common ones are:

- Cystocele (anterior prolapse) – occurs when the connective tissue wall between the bladder and the vagina weakens.
- Rectocele (posterior prolapse) – occurs when the connective tissue wall between the rectum and the vagina weakens.

Vaginal vault prolapse – occurs when the top of the vagina weakens and collapses into the vaginal canal.

- Uterine prolapse – occurs when the uterus drops into the vagina.

Risk factors for developing pelvic organ prolapse include:

- Pregnancy and childbirth, especially repeated vaginal deliveries

- Menopause
- Normal weakening of tissue as part of aging process
- Obesity
- Chronic cough
- Constipation
- Hysterectomy

Classification

In ICD-10-AM, cystocele and rectocele are both classified to the **N81 Female genital prolapse** block, which has the below *Excludes* note:

N81 Female genital prolapse

Excludes:
- prolapse:
  - and hernia of ovary and fallopian tube (N83.4)
  - of vaginal vault **after hysterectomy** (N99.3)

Vaginal vault prolapse is classified to N99.3 *Prolapse of vaginal vault after hysterectomy* following the Index pathway:

Prolapse, prolapsed
- vagina, vaginal (anterior) (wall) N81.1
- - vault (posthysterectomy) **N99.3**

The Index defaults to N99.3 regardless of whether the patient has had hysterectomy performed, as 'posthysterectomy' is listed as a non-essential modifier.

In the Tabular List, the code N99.3 does not have an *Includes* note for cystocele or rectocele.

Since different types of pelvic organ prolapse can occur, multiple codes can be assigned to ensure all clinical concepts are accounted for.

Therefore, when classifying cystocele and/or rectocele in a patient who also has vaginal vault prolapse (regardless of hysterectomy status), and each condition meets ACS 0001 or ACS 0002 criteria for code assignment, assign the below codes as applicable:

N81.1 *Cystocele*
N81.6 *Rectocele*
N99.*3 Prolapse of vaginal vault after hysterectomy* with appropriate external cause codes.

Note: for the above conditions in patients who also have uterine prolapse, follow ICD-10-AM Index pathways, and instead assign the appropriate uterine prolapse code (N81.2 - N81.4).

Sequencing of the above codes are determined by the circumstances of each admission.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024013
QUERY TITLE	**Nonmalignant polyps detected during surveillance colonoscopy for history of malignancy or diverticular disease**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	02/04/2024
DATE QUERY RESPONDED TO	21/08/24
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What is the principal diagnosis when a non-malignant polyp is excised during a surveillance colonoscopy for history of malignancy or diverticular disease?

Dear Joe

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What is the principal diagnosis when a non-malignant polyp is excised during a surveillance colonoscopy for history of malignancy or diverticular disease?

RESPONSE

Clinical documentation abstraction
Example colonoscopies:

> Colonoscopy 1
> Indication: follow up post rectal carcinoma.
> Findings and interventions: Sessile polyp removed.
> Histopathology: Tubular adenoma
> Follow up: Surveillance colonoscopy in 2 years.
> **No family history** of colorectal cancer (CRC).

Colonoscopy 2
Indication: Surveillance of diverticular disease.
Findings and interventions: Scattered pan diverticulosis. Rectal stump. Diversion proctitis. Sessile polyp removed.
Histopathology: Tubular adenoma
Follow up: Surveillance colonoscopy in 5 years.
No family history of CRC

Classification

Colonoscopy 1

The rectal carcinoma under surveillance was previously treated and no recurrence was detected at colonoscopy. Therefore, follow the logic in ACS 0052 *Same day Endoscopy - Surveillance*, Classification Point ***Follow-up examination after treatment***, to assign a code from Z08.- *Follow-up examination after treatment for malignant neoplasms* as the principal diagnosis.

Assign as additional diagnoses:

- Z85.0 *Personal history of malignant neoplasm of digestive organs* per ACS 0002 Additional diagnoses section: *Family and personal history, and certain conditions influencing health status*.
- The Tubular Adenoma that was removed and meets ACS 0002 Additional diagnoses criterion*: Commencement, alteration, or adjustment of therapeutic treatment.*

This case is not a same day colonoscopic screening for family history of malignant neoplasm. The patient has had a malignant neoplasm. Therefore, do not follow the logic in Q3669 *Non-malignant neoplastic polyps detected during same-day endoscopic screening for family history of malignant neoplasm.*

Q3669 is applicable only for surveillance where there is a **family history** of malignant neoplasm, and the purpose is to screen for all the following conditions:

- malignant neoplasms.
- insitu neoplasms
- non-malignant neoplastic polyps such as tubular, tubulovillous, or villous adenomas
- benign or adenomatous polyps (neoplasm precursors).

Colonoscopy 2

The indication for this colonoscopy is “surveillance of diverticular disease”. Diverticular disease is a broad term that includes diverticulosis and diverticulitis. This case is not a same day colonoscopic screening for family history of malignant neoplasm. Therefore, do not follow the logic in Q3669 *Non-malignant neoplastic polyps detected during same-day endoscopic screening for family history of malignant neoplasm*.

Q3630 *Same-day surveillance of diverticulitis* specifically advises on code assignment for surveillance of patients with **diverticulitis** who are at increased risk of CRC. Q3630 advises that diverticulosis is a chronic incurable condition that is not routinely surveilled or regularly followed up. This would suggest that this patient had an episode of diverticulitis in the past to necessitate this colonoscopy.

Q3630 explicitly instructs to "…assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as the principal diagnosis where a patient is admitted for a same-day colonoscopy for diverticulitis surveillance and **no CRC is detected**…" No CRC was detected, so follow the logic in Q3630 to assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as the principal diagnosis.

Assign the Tubular Adenoma as an additional diagnosis as it meets ACS 0002 Additional diagnoses.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. WACCA have concerns regarding the advice in Q3630, Q3669 and other neoplasm classification decisions published by the Independent Health and Aged Care Pricing Authority (IHACPA). WACCA will send a further query to IHACPA.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

ACCD coding query response

WACCA QUERY ID NUMBER	J2024012
QUERY TITLE	**Conditions indexed with subterm 'in pregnancy'**
QUERY SPECIALTY	OBST - Pregnancy, childbirth and the puerperium
DATE QUERY RECEIVED	28/03/2024
DATE QUERY RESPONDED TO	28/03/2024
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to ACCD by a state other than Western Australia:

SUMMARISED QUERY

To follow 'in pregnancy' Index pathways, do nonobstetric conditions need to meet the criteria in ACS 1521 *Conditions and injuries in pregnancy / Nonobstetric conditions complicating pregnancy*?

Examples
Addiction -alcohol, alcoholic –in pregnancy, childbirth or the puerperium NEC O99.3
Anaemia -in pregnancy, childbirth or the puerperium O99.00
Hypertension - in pregnancy, childbirth or the puerperium NEC O16
Infection -urinary NEC –in pregnancy O23.4
Vomiting -in pregnancy NEC O21.9

RESPONSE

… when classifying a condition in (due to) pregnancy:

- refer to the ICD-10-AM Alphabetic Index (eg Pregnancy/complicated by or condition/in pregnancy or condition/in pregnancy, childbirth or puerperium)
- refer to the ICD-10-AM Tabular List
- refer to the ACS (ie general standards eg ACS 0001, ACS 0002, and specialty standards eg in Chapter 15 *Pregnancy, childbirth and the puerperium*)

Note also the following:

- ICD-10-AM Alphabetic Index Introduction states:

  The index…is intended to include most of the diagnostic terms currently in use. Nevertheless, reference should always be made back to the Tabular List

and its notes, as well as to the guidelines provided in the Australian Coding Standards, to ensure that the code given by the index fits with the information provided by a particular episode of care.

- ACS 0001 *Principal diagnosis* states:

  For general guidelines regarding assignment of additional diagnoses in delivery episodes of care, see ACS 1500 *Diagnosis sequencing in delivery episodes of care*.

  See also ACS 1521 *Conditions and injuries in pregnancy* and ACS 1548 *Puerperal/postpartum condition or complication*.

- ACS 0002 *Additional diagnoses* states:

  For general guidelines regarding assignment of additional diagnoses in delivery episodes of care, see ACS 1500 *Diagnosis sequencing in delivery episodes of care*.

  See also ACS 1521 *Conditions and injuries in pregnancy* and ACS 1548 *Puerperal/postpartum condition or complication*.

- ACS 1521 *Conditions and injuries in pregnancy* states:

  Chapter 15 *Pregnancy, childbirth and the puerperium* lists codes for conditions that:
    - exclusively or predominantly occur only in a pregnant patient (ie obstetric conditions/complications).

  Assign codes for these conditions/complications that meet the criteria for assignment as per ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses* and ACS 1500 *Diagnosis sequencing in obstetric episodes of care*.
  …

  Nonobstetric conditions are classified as complicating pregnancy when the condition meets the criteria in ACS 0001 *Principal diagnosis*, ACS 0002 *Additional diagnoses*, or ACS 1500 *Diagnosis sequencing in obstetric episodes of care* in an antepartum or delivery episode of care, and documentation specifies that the condition is complicating the pregnancy.

  In the absence of specific documentation, a nonobstetric condition is classified as complicating pregnancy as indicated by two or more of the following criteria:

- Patient is admitted to an obstetric unit
- Patient is supervised/evaluated by an obstetrician/gynaecologist (or other medical clinician responsible for obstetric care), midwife and/or neonatologist (Note: Evaluation may be performed remotely. That is, the clinician is located in another facility and consults via electronic methods (eg video/telephone conferencing))
- Fetal evaluation and/or monitoring is performed
- Patient is transferred to another facility for obstetric and/or neonatal care (see also ACS 1550 Discharge/transfer in labour).

Therefore, **assign codes for nonobstetric conditions indexed as 'in pregnancy' that meet the criteria in ACS 1521 *Conditions and injuries in pregnancy*.**

Note: This response will not be published.

Acknowledgement: the content of this query comes from the Victorian ICD Coding Committee's query database. Query number 3453. Publication date June 2019. ICD-10-AM Edition: Tenth Edition.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024011
QUERY TITLE	**Idiopathic intracranial hypertension with venous sinus stenosis**
QUERY SPECIALTY	CIRC - Diseases of the circulatory system
DATE QUERY RECEIVED	25/03/2024
DATE QUERY RESPONDED TO	18/07/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify dural venous sinus stenosis (VSS) in a patient with idiopathic intracranial hypertension (IIH) when the admission is for stenting of the VSS?

Scenario
Idiopathic intracranial hypertension secondary to stenosis in medial part of right transverse dural venous sinus. Catheter cerebral angiogram/venography and stenting of venous sinus (right transverse sinus to superior sagittal sinus).

RESPONSE

Clinical information

IIH was known as pseudotumor cerebri syndrome and benign intracranial hypertension. IIH is a disorder characterized by elevated intracranial pressure (ICP) that mainly affects young obese women. IIH is a diagnosis of exclusion. Patients present with headaches, visual loss, diplopia, and pulsatile tinnitus.

While the term “idiopathic” is used to describe IIH, research is pointing to the condition having a neurovascular origin.

The cerebrospinal fluid (CSF) found around the brain and spinal cord is absorbed from the brain and spinal subarachnoid spaces into the systemic circulation by arachnoid granulations located within the walls of dural venous sinuses. Dural venous sinuses are intracranial venous channels located between the two layers of the dura mater (endosteal layer and meningeal layer). Dural venous sinuses are like veins but unlike other veins in the body, they run alone and not parallel to arteries.

Blockage or stenoses of the dural venous sinuses can reduce CSF re-absorption, and lead to intracranial CSF buildup which raises ICP. Dural VSS can be intrinsic or extrinsic stenosis. Intrinsic stenosis refers to defects such as enlarged arachnoid granulations that narrow the sinus. Extrinsic stenosis involves external compression of the sinus by adjacent brain tissue. Transverse venous sinuses are susceptible to extrinsic stenosis because of their potential to collapse in the setting of increased ICP due to any cause. An increased volume of CSF causes the venous sinuses to be compressed against the skull (an extrinsic transverse venous sinus stenosis) exacerbating CSF buildup and rise in ICP. Studies have shown that most patients with IIH have an extrinsic stenosis.

For more information see:
Dural venous sinuses.
https://radiopaedia.org/articles/dural-venous-sinuses#:~:text=Dural%20venous%20sinuses%20are%20venous,and%20not%20parallel%20to%20arteries.
Advances in the Understanding of the Complex Role of Venous Sinus Stenosis in Idiopathic Intracranial Hypertension (31/3/2022).
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9541264/

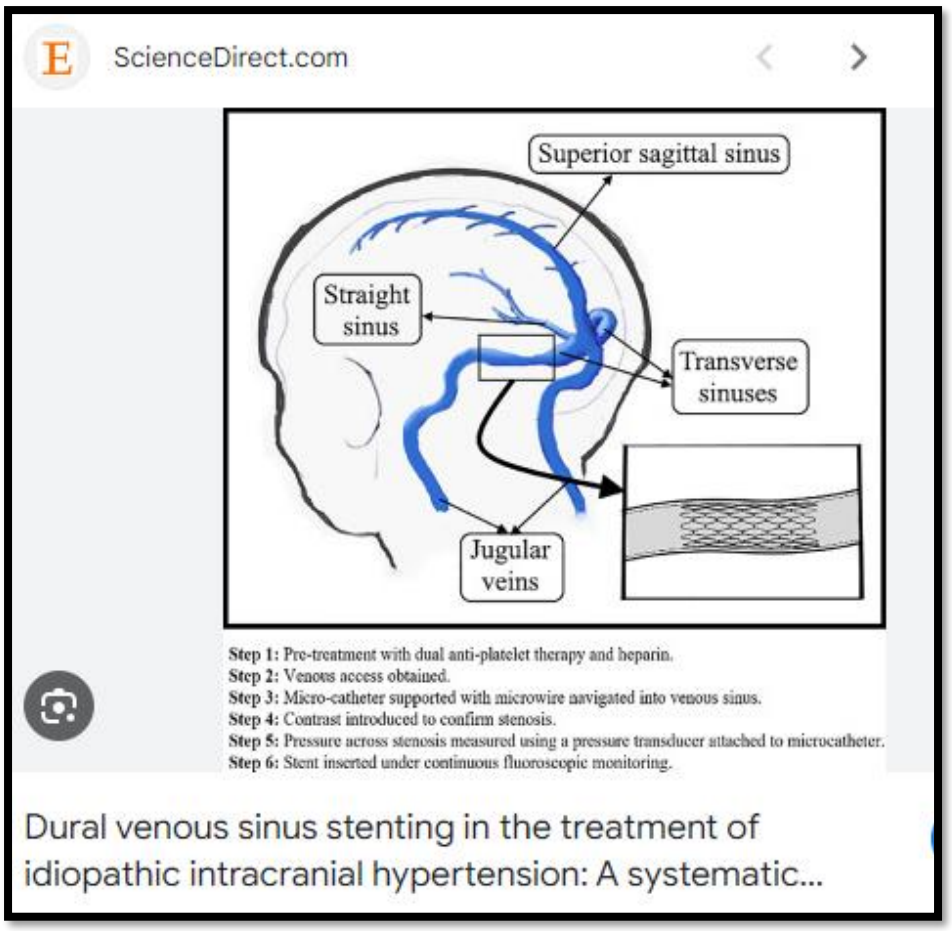


Image from:
Dural venous sinus stenting in the treatment of idiopathic intracranial hypertension: A systematic review and critique of literature.
https://www.sciencedirect.com/science/article/abs/pii/S003962572100120X

Clinical documentation abstraction

Example:

Principal diagnosis: IIH
Comments: presents for intracranial venous stent insertion.

Clinical synopsis:

- Presenting history.

Previous stenting of right transverse venous sinus. Cerebral digital subtraction angiography (DSA) and manometry show recurrent IIH secondary to a new stenosis in the medial part of the right transverse venous sinus.

- Operation.

Transverse dural sinus stenting to treat intracranial hypertension.
The stent was deployed across the dural VSS and augmented with balloon angioplasty (right transvers sinus to superior sagittal sinus). Pre- and post- stenting venography and manometry were performed. Sinus pressure and pressure gradient was reduced afterward.

Classification

For IIH assign **G93.2 *Benign intracranial hypertension***

Following the Index pathway for the IIH synonym, benign intracranial hypertension

Hypertension, hypertensive
- benign, intracranial G93.2

There is no Index entry for VSS. Therefore, for a best fit diagnosis code assign **I87.1 *Compression of vein***

Following the Index pathway
Stenosis (cicatricial) — see also Stricture.
Stricture
- vein I87.1 Compression of vein

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 12th August 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024010
QUERY TITLE	**Resection of cystic plate during cholecystectomy**
QUERY SPECIALTY	DIGS – Diseases of the digestive system
DATE QUERY RECEIVED	08/03/2024
DATE QUERY RESPONDED TO	28/06/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify resection of cystic plate?

Laparoscopic cholecystectomy operation report states ‘diathermy to take cystic plate from liver.’ Cystic plate resection was performed due to suspicion of gallbladder cancer, with the cystic plate being sent to pathology. A clinician query response confirmed that resection of cystic plate is not a routine part of laparoscopic cholecystectomy and ought to be coded as an additional procedure.

We considered the code 90331-00 [1004] *Other procedures on abdomen, peritoneum or omentum*.

RESPONSE

Clinical information

The cystic plate is exposed as a whitish/greyish fibrous sheet once the gallbladder is dissected off the liver. The cystic plate is a part of the sheath/plate system of the liver and is continuous with the liver capsule (Safe laparoscopic cholecystectomy: Adoption of universal culture of safety in cholecystectomy - PMC (nih.gov)).

Classification

There is no specific ACHI Index pathway for resection of cystic plate. As the cystic plate is part of the liver, it should be classified as a liver procedure. Diathermy was performed to yield the cystic plate specimen, rather than as a destruction procedure, therefore the lead term ‘destruction’ is not appropriate. Instead, use the logic in National Coding Advice Q3460 *Diathermy for control of haemorrhage due to*

minor liver laceration (effective 1 Jan 2023 to current) to assign the best fit code 90319-03 [956] *Other endoscopic procedures on liver* via Index pathway:

Procedure
…
- digestive system
- - liver
- - - endoscopic 90319-03 [956]

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 15th July 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024008
QUERY TITLE	**Ministroke**
QUERY SPECIALTY	NERV – Diseases of the nervous system
DATE QUERY RECEIVED	05/03/2024
DATE QUERY RESPONDED TO	26/06/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify a ministroke?

We've considered the following options:

1. Ministroke is synonymous with transient ischaemic attack, therefore assign G45.9 *Transient cerebral ischaemic attack, unspecified*.

2. For ministroke, follow the lead term 'Stroke' in the ICD-10-AM Index to assign I64 *Stroke, not specified as haemorrhage or infarction*.

RESPONSE

Clinical information

The Australian Stroke Clinical Registry considers the term 'ministroke' to be synonymous with Transient Ischaemic Attack (TIA). A TIA or ministroke is a temporary (transient) lack of blood flow to part of the brain, spinal cord, or the retina. It may cause temporary stroke-like symptoms. **A TIA/ministroke doesn't damage brain cells or cause permanent disability like a stroke. This is how it differs from a stroke.** A TIA/ministroke is a medical emergency. It's a chance to get treatment that can prevent a future stroke.

For more information, please see the Australian Stroke Clinical Registry: https://auscr.com.au/about/frequently-asked-questions/

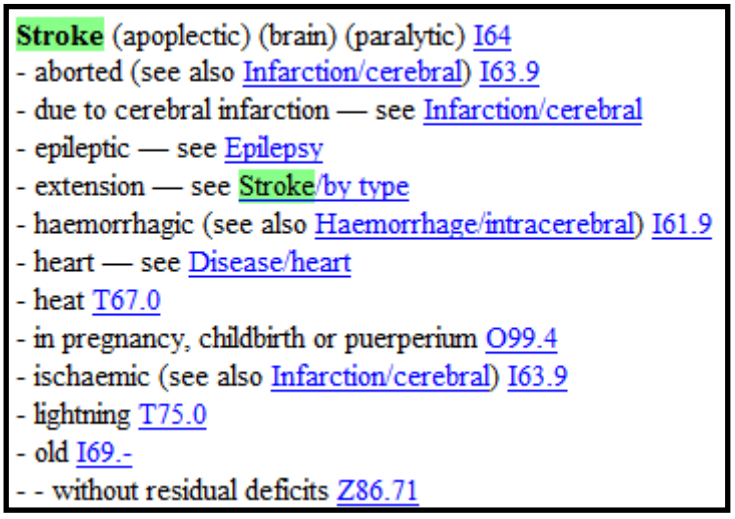
Classification
The term 'ministroke' is not recognised in ICD-10-AM, however its synonym 'transient ischaemic attack' is. Therefore, for ministroke assign G45.9 *Transient cerebral ischaemic attack, unspecified* following Index pathway:

Attack
-transient ischaemic (TIA) G45.9

For ministroke it's not appropriate to follow the ICD-10-AM Index at the lead term Stroke because:

- stroke without further specificity is classified to I64 *Stroke, not specified as haemorrhage or infarction*. As per the clinical information above, a ministroke is a TIA, not a stroke.

- The subterms at Stroke (see below) represent types of cerebrovascular stroke (cerebrovascular accident) (i.e., aborted, due to cerebral infarction, extension, haemorrhagic, ischemic, old), and types of non-cerebrovascular stroke (i.e., epileptic, heart, heat, lightening). Ministroke is not a type of cerebrovascular stroke, nor non-cerebrovascular stroke.


Stroke (apoplectic) (brain) (paralytic) I64
- aborted (see also Infarction/cerebral) I63.9
- due to cerebral infarction — see Infarction/cerebral
- epileptic — see Epilepsy
- extension — see Stroke/by type
- haemorrhagic (see also Haemorrhage/intracerebral) I61.9
- heart — see Disease/heart
- heat T67.0
- in pregnancy, childbirth or puerperium O99.4
- ischaemic (see also Infarction/cerebral) I63.9
- lightning T75.0
- old I69.-
- - without residual deficits Z86.71

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. A query was submitted on 9th July 2024 to the Independent Health and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024007
QUERY TITLE	**Liver transplant complication**
QUERY SPECIALTY	INPO - Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	05/03/2024
DATE QUERY RESPONDED TO	25/06/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code hepatic vein anastomotic stricture following liver transplant, requiring venoplasty/angioplasty?

These are the codes we have considered:

> T82.84 *Stenosis following insertion of cardiac and vascular prosthetic devices, implants and grafts*
> I87.1 *Compression of vein*
>
> or
>
> T86.89 *Other complications of transplanted organs and tissues, NEC*
> I87.1 *Compression of vein*

RESPONSE

Clinical information

Stenosis of anastomosed vessels (hepatic arteries, portal vein, hepatic vein and inferior vena cava) are known complications of liver transplant. Treatment involves balloon angioplasty/venoplasty, and stenting may be required.

Classification

In accordance with ACS 1904 *Procedural complications*, OVERVIEW, second dot point, stenosis/stricture of an anastomosed vessel is an example of an inherent relationship where the stenosis is deemed a procedural complication for classification purposes, even in the absence of a documented relationship such as ‘due to’.

A recent IHACPA jurisdictional response to an interstate query for perinephric haematoma following kidney transplant highlights the uncertainty between classifying a transplant complication to a code from T81-T85, versus a code from T86 *Failure and rejection and other complications of transplanted organs and tissues.*

IHACPA's September 2023 jurisdictional response stated:

> The Tenth Edition review of ACS 1904 was developed with the ITG with expanded classification guidelines to reflect updated clinical information and to support the major expansion of ICD-10-AM codes enhancing the classification of procedural complications. However, it is evident from jurisdictional feedback and coding queries that there is continuing uncertainty regarding some aspects of code assignment for procedural complications.
>
> In response to your query submission IHACPA analysed code assignment in the data. This analysis demonstrated issues of inconsistency in classifying haematoma as a complication from transplanted organs.
>
> IHACPA agrees with CCAQ interpretation to assign T81.0 *Haemorrhage and haematoma complicating a procedure NEC* with external cause code Y83.02 *Kidney transplant* to provide specificity of the kidney transplant.
> However, given current coding practice appears to be inconsistent and IHACPA is currently progressing an addenda proposal to review the classification of procedural complications, including complications (other than failure and rejection) from transplanted organs for implementation in Thirteenth Edition, national classification advice will not be introduced for the remainder of Twelfth Edition. Rather, it will be held over for implementation in Thirteenth edition to ensure consistency from 1 July 2025.
>
> You may wish to issue local advice in the interim or once the direction of the Thirteenth edition development task becomes apparent.

Thirteenth Edition addenda proposals for ACS 1904 *Complications of surgical and medical care* have clarified the following:

- 'grafts' in block T82 *Complications of cardiac and vascular prosthetic devices, implants and grafts* includes: tissue graft and transplanted organ/tissue/cells.

- only transplant failure or transplant rejection will be classifiable to T86.
  T86 has been renamed in Thirteenth Edition from:

  - *Failure and rejection **and other complications** of transplanted organs and tissues*
    to
    Failure and rejection of transplanted organs and tissues.

For hepatic vein anastomotic stricture following liver transplant, assign T82.84 *Stenosis following insertion of cardiac and vascular prosthetic devices, implants and grafts* via Index pathway:

> **Complication(s)** (from) (of)
> - vascular
> - - device, implant or graft
> …
> - - - stricture (stenosis) T82.84

and external cause code Y83.06 *Liver transplant* via External Causes of Injury Index pathway:

> **Complication(s)** (delayed)(medical or surgical procedure)(of or following)
> - transplant, transplantation (partial or whole organ, any)
> - - liver Y83.06

plus the appropriate place of occurrence and activity codes.

In accordance with ACS 1904, I87.1 *Compression of vein* is not assigned as an additional code because the condition ‘stenosis’ has already been classified in T82.84 *Stenosis following insertion of cardiac and vascular prosthetic devices, implants and grafts.*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024006
QUERY TITLE	**PELVIS syndrome**
QUERY SPECIALTY	CONG - Congenital malformations, deformations and chromosomal abnormalities
DATE QUERY RECEIVED	19/02/2024
DATE QUERY RESPONDED TO	02/07/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify PELVIS syndrome?

RESPONSE

Clinical information

Infantile haemangiomas are the most common benign blood vessel tumours of childhood, and they affect up to 10% of infants. They arise in the first few months of life.

Infantile haemangiomas may be segmental. Segmental haemangiomas involve a large anatomic region, are plaque-like and measure more than 5 cm in diameter.

Segmental infantile perineal hemangiomas may be associated with anorectal, neurologic, renal, urinary tract, and genital defects.

The acronym PELVIS syndrome represents the characteristic findings of this syndrome:

- perineal hemangioma
- external genitalia malformations
- lipomyelomeningocele
- vesicorenal abnormalities
- imperforate anus
- skin tag.

Synonyms for PELVIS syndrome are:

- Sacral syndrome
- LUMBAR syndrome: **L**ower body hemangioma, **u**rogenital anomalies, **m**yelopathy, **b**ony deformities, **a**norectal and arterial malformations, and **r**enal anomalies syndrome.

For more information on haemangiomas and PELVIS syndrome see:

- Infantile haemangiomas: Identifying high-risk lesions in primary care
  - https://www1.racgp.org.au/ajgp/2021/december/infantile-haemangiomas
- Clinical Features of Segmental Infantile Hemangioma: A Prospective Study
  - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7850443/
- PELVIS syndrome
  - https://jamanetwork.com/journals/jamadermatology/fullarticle/406327
- PELVIS and LUMBAR syndromes
  - https://dermnetnz.org/topics/pelvis-and-lumbar-syndromes

Classification

Classify PELVIS syndrome to ICD-10-AM code, Q87.89 *Other specified congenital malformation syndromes, not elsewhere classified*. This aligns with other classifications:

- Orphanet nomenclature of rare diseases classifies PELVIS syndrome to ICD-10 code Q87.8 *Other specified congenital malformation syndromes, not elsewhere*.
  - For Orphanet see: https://www.orpha.net/en/disease/detail/83628?name=pelvis%20syndrome&mode=name
- ICD-11 classifies PELVIS syndrome to LD2F.1Y *Other specified syndromes with multiple structural anomalies, not of environmental origin*.
  - For ICD-11 see: https://icd.who.int/browse/2024-01/mms/en#1106405864%2Fother

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 9th July 2024.

WACCA have asked IHACPA to confirm if it is correct to assign a single nonspecific code for a syndrome (e.g., Q87.89 *Other specified congenital malformation syndromes, not elsewhere classified* for PELVIS syndrome) when the syndrome is not specifically indexed but the code aligns with ICD-11, rather than following ACS 0005 *Syndromes* to assign multiple codes for manifestations of the syndrome, in combination with 'flag code' U91 *Syndrome, not elsewhere classified.*

WACCA have also asked if this instruction in ACS 0005 *Syndromes*:

*'Where there is **no single** ICD-10-AM code to classify all the elements of a syndrome …*'

requires that a syndrome be specifically indexed to a single code, or can this pathway:

Syndrome NEC
- congenital (malformation)
-- affecting multiple systems NEC Q87.89

be followed to assign a **single code**?

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024005
QUERY TITLE	**Postoperative blood loss anaemia during admission & chronic anaemia NOS before admission**
QUERY SPECIALTY	BLIM - Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
DATE QUERY RECEIVED	22/01/2024
DATE QUERY RESPONDED TO	02/08/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What anaemia code/s do you assign for the following scenario?

Scenario
Admitted for above knee amputation (AKA). Chronic anaemia (not otherwise specified) treated with packed cell transfusion prior to AKA. Following AKA, drop in haemoglobin treated with further packed cell transfusion.

RESPONSE

Both ‘chronic anaemia’ and ‘anaemia -postoperative’ are nonspecific terms classified to D64.9 *Anaemia, unspecified.* Where anaemia is documented as postoperative, WACCA encourage clinical clarification to confirm anaemia is due to (acute) blood loss.

Classification

Where both chronic anaemia (not otherwise specified) and acute blood loss anaemia are documented and meet criteria in ACS 0001 *Principal diagnosis* and/or ACS 0002 *Additional diagnoses* assign a code for each type of anaemia, as these are separate clinical concepts, each warranting assignment of their own code.

For ‘chronic anaemia NOS’ assign D64.9 *Anaemia, unspecified,* using the default in the Index.

For ‘acute blood loss anaemia’ assign D62 *Acute posthaemorrhagic anaemia* by following the Index pathway:

Anaemia
- due to
- - haemorrhage (chronic) D50.0
- - - acute D62
- - loss of blood (chronic) D50.0
- - - acute D62

Other comments

This advice is consistent with that given in Q2023076_BLIM_*Acute on chronic anaemia*. During preparation for this response an anomaly was noted in IHACPA Coding Rule Q3569 *Iron deficiency anaemia with chronic normocytic anaemia* which will be queried. The original query resulting in publication of Q3569, queried code whether two ICD-10-AM codes were required to classify documentation of “anaemia – chronic normocytic, iron deficient”, a single type of anaemia. WACCA will ask IHACPA to confirm Q3569 applies to a single type of anaemia only. Until clarification is obtained, WACCA advise caution applying classification advice in Q3569 for multiple types of anaemia.

WACCA encourage submission of any further scenarios regarding anaemia through the coding query process.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website, proposed as a WA Coding Rule via the Western Australian Clinical Coding Technical Advisory Group process, and submitted as a query to the Independent Hospital and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024004
QUERY TITLE	**Same-day chemotherapy cancelled or abandoned after premedication**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	22/01/2024
DATE QUERY RESPONDED TO	25/06/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Do the following examples qualify for admission, and if so, how are they coded?

Example 1

- Patient admitted for same-day intravenous (IV) chemotherapy for a neoplasm.
- IV premedication given.
- Patient has adverse reaction to premedication.
- IV chemotherapy infusion is cancelled (the intervention is not performed).
- Patient admitted overnight for management of the adverse reaction.

Example 2

- Patient admitted for same-day IV chemotherapy for a neoplasm.
- IV cannula inserted.
- Oral premedication given.
- Patient has adverse reaction to premedication.
- IV chemotherapy infusion is cancelled (the intervention is not performed).
- Patient is admitted overnight for management of the adverse reaction.

Example 3

- Patient admitted for same-day IV chemotherapy for a neoplasm.
- IV cannula inserted.
- Oral premedication given.
- Intervention cancelled due to an administrative problem.
- IV chemotherapy infusion is cancelled (the intervention is not performed).
- Patient discharged the same day.

RESPONSE

Examples 1 and 2 – Qualification for admission

Despite IV chemotherapy being cancelled in Examples 1 and 2, the admissions are still reported because they continue for management of the adverse reactions – see Admitted Patient Activity Data Business Rules, Section 11 *Cancelled or abandoned booked procedures.*

Examples 1 and 2 – Code assignment

In Examples 1 and 2, the intervention (e.g., IV chemotherapy) is not initiated but the admission continues for care of another condition (e.g., adverse reaction), therefore ACS 0011 *Intervention cancelled or not performed*, Point 2 is applicable:

2. If a patient is admitted to a facility for an intervention (e.g., IV chemotherapy) *that was not undertaken (or initiated) due to another condition or complication* (e.g., adverse reaction)*, and the patient requires ongoing inpatient care for that other condition* (e.g., adverse reaction) *assign:*

- *a code for the condition responsible for the cancellation of the intervention, as principal diagnosis*
- *a code for the condition that required the cancelled intervention, or appropriate Z code for the reason for admission, as an additional diagnosis*
- *Z53.0 as an additional diagnosis.*

Therefore, assign:

	COF	
PDx	(2)	Adverse reaction
ADx	(2)	External cause, place of occurrence, activity codes for the adverse reaction
	(2)	Neoplasm codes (site and morphology)
	(1)	Z53.0 *Procedure not carried out because of contraindication*

Do not assign:

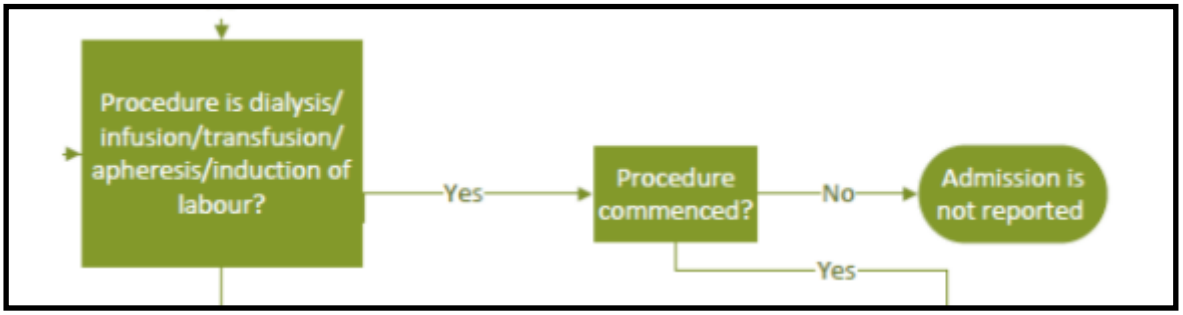
- Z51.1 *Pharmacotherapy session for neoplasm* in an overnight/multi-day episode of care (see ACS 0206 *Pharmacotherapy for neoplasms*).
- a chemotherapy ACHI code because the intervention was not performed.

Condition Onset Flag (COF) 2 is assigned for the adverse reaction because it's the principal diagnosis (as per ACS 0048 *Condition onset flag*).

Example 3 – Qualification for admission

Despite IV chemotherapy being cancelled in Example 3, the admission is still reported because the patient received pre-medication – see Admitted Patient Activity Data Business Rules, Section 11 *Cancelled or abandoned booked procedures.*

Note: The *Appendix B – Flowchart – Cancelled or abandoned booked procedures*, within the Admitted Patient Activity Data Business Rules (July 2023) requires updating. The middle box in the diagram below will be amended to the effect of 'Procedure commenced and/or pre-medication given?'



Example 3 – Code assignment

In Example 3, the intervention (e.g., IV chemotherapy) is not initiated and the patient is discharged, therefore ACS 0011 *Intervention not performed or cancelled*, Point 1 is applicable. ACS 0011, Point 1 does not include a specific instruction or example, for the scenario in Example 3, however Point 1/Point C is the best fit:

1. If a patient was admitted to a facility for an intervention (e.g., IV chemotherapy) *that was not undertaken (or initiated) and the patient was discharged, classify as follows:*

…

C. Where a Z code would normally be assigned as principal diagnosis to identify the reason for admission, and due to another condition or complication the intervention was cancelled, assign:

- *an appropriate Z code for the reason for admission as principal diagnosis*
- *Z53.0 as an additional diagnosis*
- *a code for the condition responsible for the cancellation of the intervention, as an additional diagnosis.*

Therefore, assign:

	COF	
PDx	(2)	Z51.1 *Pharmacotherapy session for neoplasm*
ADx	(2)	Neoplasm codes (site and morphology)
ADx	(1)	Z53.8 *Procedure not carried out for other reasons*

Do not assign:

- a chemotherapy ACHI code because the intervention was not performed.

Neoplasm codes are assigned as additional diagnoses because the admission was for treatment of a neoplasm (see ACS 0206 *Pharmacotherapy for neoplasms* and ACS 0236 *Neoplasm coding and sequencing*).

As there's no condition responsible for the cancellation of IV chemotherapy, the instruction at the third dot point in Point 1/Point C is not applicable for Example 3.

For further information see:

- ACS 0011 *Intervention cancelled or not performed*
- ACS 0206 *Pharmacotherapy for neoplasms*
- WACCA Clinical Coding Guidelines: ACS *0011 Intervention not performed or cancelled and ACS 0019 Intervention abandoned, interrupted or not completed*
- Admitted Patient Activity Data Business Rules (July 2023)

Further actions

The *Appendix B – Flowchart – Cancelled or abandoned booked procedures*, within the Admitted Patient Activity Data Business Rules (July 2023) will be updated for 1 July 2025.

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024003
QUERY TITLE	**Femoral osteochondroplasty**
QUERY SPECIALTY	MSCT – Diseases of the musculoskeletal system and connective tissue
DATE QUERY RECEIVED	11/01/2024
DATE QUERY RESPONDED TO	08/04/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Which ACHI code(s) are assigned for femoral osteochondroplasty (resection of cam lesion/deformity) or acetabular osteochondroplasty (resection of pincer deformity) performed for hip dysplasia with cam or pincer deformity?

Example operation report

Diagnosis: Right hip acetabular retroversion/dysplasia + cam deformity
Procedure: Right periacetabular osteotomy + femoral head/neck osteochondroplasty

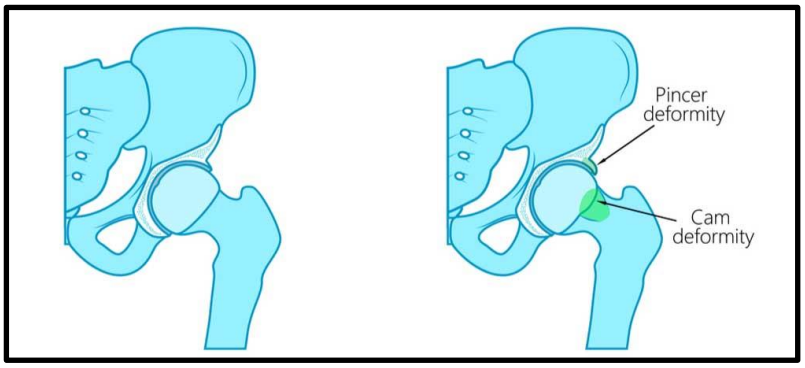
Spinal + GA, Supine on Jackson table
EUA at commencement. Flexion: 90 0/20/40 45/30/50 90/-10/60
Bikini incision over ASIS, mobile window created
Modified Smith Peterson approach; ASIS osteotomy; distally TFL/Sartorius, proximally over iliac crest
Iliacus stripped from inner table of iliac wing and interval extended distally between rectus and psoas
Iliopectineal fascia stripped off pelvic brim and sub periosteal dissection extended distally between rectus and psoas
Periosteum over superior pubic ramus divided and peeled anteriorly and posteriorly to expose superior pubic ramus
Superior ramus osteotomy performed with fluoroscopic guidance
Interval between rectus and psoas further developed and blunt dissection to ischium anterior to femoral neck
Periosteum freed from ischium and ischial osteotomy performed under fluoroscopic guidance
Baseline xrays taken. Iliac cut made with precision saw
Extended into retroacetabular cut with Ganz osteotome under fluoroscopic guidance in Faux Profile position
Final posterolateral cortex underwent controlled fracture
Acetabular fragment correction was performed (anteversion, posterior and lateral coverage) and the fragment was temporarily fixed with k-wires and position confirmed with fluoroscopy
Definitive small fragment screws inserted across the osteotomy and final II images taken
EUA following correction: Flexion 100, 0/30/40 45/40/50 90/10/55

Interval extended between medius and rectus, capsule identified and opened in Z capsulotomy
Large cam deformity resected under II guidance with burr; bear area visible on lateral head/neck junction
EUA following correction: 90/30/55
Wound thoroughly irrigated EBL 1200mL
200mm On Q wound catheter inserted through the tensor and on to the inner table of the pelvis
ASIS repaired with 1 vicryl transosseous suture; Closure with 1/Vicryl with 3/0 Stratafix in the skin
60ml 0.2% Naropin was infiltrated into the surrounding tissues
Prineo and Dermabond applied with opsite visible dressing

RESPONSE

Clinical information
Hip dysplasia is where the hip fails to develop normally; and may be congenital or acquired. Due to the structural abnormalities that occur with dysplasia, friction occurs in the hip joint and can lead to a cam deformity/lesion and/or pincer deformity/lesion which are associated with impingement known as femoroacetabular impingement (FAI). There is often associated damage to articular cartilage or the labrum. The labrum is a fibro-cartilaginous structure attached to the edge of the acetabulum.

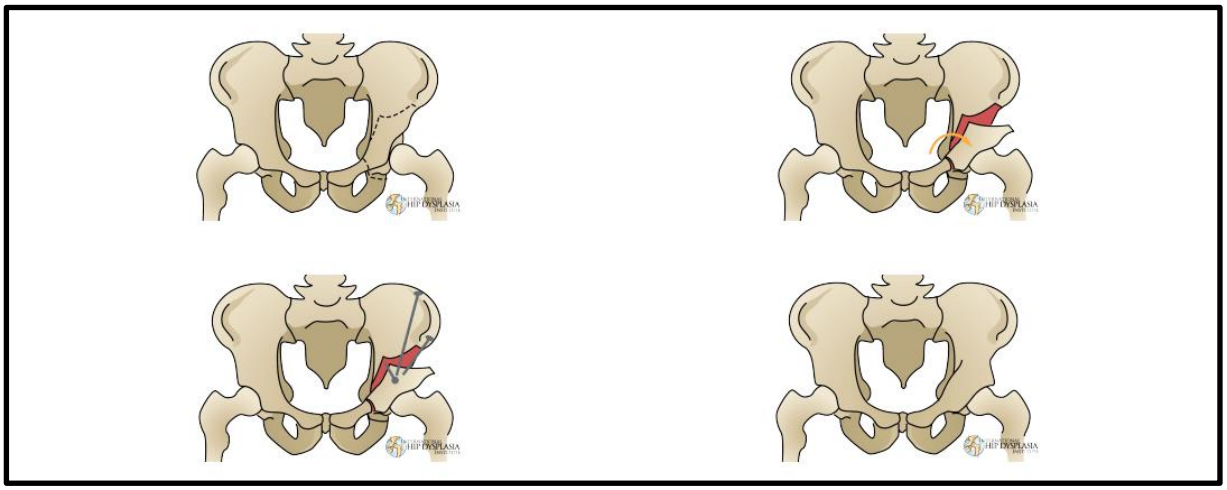
Diagram 1: Normal hip joint versus joint with cam deformity and pincer deformity



Cam Deformity Femoral Head | Cam Lesion | Hip Impingement (FAI) | Manhattan, Brooklyn, New York City, NY (manhattansportsdoc.com)

Surgery for hip dysplasia
Surgical management of hip dysplasia includes periacetabular osteotomy (also known as Ganz osteotomy) which involves cutting the pelvis bone (e.g., pubis, ischium, ilium); shifting it into a better position; and screw fixation for the bone to subsequently heal in the new position.
Note: Trochanteric osteotomy is not a type of periacetabular osteotomy. Trochanteric osteotomy is usually performed to gain surgical access for some hip procedures such as hip osteochondroplasty, and is an inherent component of hip osteochondroplasty.

Diagram 2: Periacetabular osteotomy



Hip Preservation Surgery - International Hip Dysplasia Institute

Surgery for cam and/or pincer deformity (impingement)
Surgery for cam and/or pincer deformity can be performed via arthroscopy or open approach and involves:

1. Acetabular osteochondroplasty/acetabuloplasty/osteoplasty/pincer resection – these terms may be used interchangeably for resection of pincer deformity and reshaping of the acetabulum. The acetabulum bone is covered in cartilage, hence the term 'osteochondroplasty' is often used. To expose the pincer deformity, the labrum is undermined or detached.

   In open acetabular osteochondroplasty, surgical dislocation of hip or trochanteric flip osteotomy may be performed to gain surgical access and are considered inherent in the osteochondroplasty.

2. Femoral osteochondroplasty/osteoplasty/cam resection – these terms may be used interchangeably for resection of cam deformity and reshaping of the femoral head. The femoral bone is covered in cartilage, hence the term 'osteochondroplasty' is often used.

   In open femoral osteochondroplasty, surgical dislocation of hip or trochanteric flip osteotomy may be performed to gain surgical access and are considered inherent in the osteochondroplasty.

'Plasty' is broadly translated to mean 'repair'. The term 'osteochondroplasty' describes the re-shaping/repair of bone and cartilage (including resection of the cam/pincer deformity/ies). Patients may undergo surgery for both hip dysplasia and cam/pincer deformity in the same surgical episode, as is the case in this query's example operation report.

The following procedures may also be performed with osteochondroplasty, however WACCA require examples of operation reports (in particular open surgery for pincer deformity) involving such procedures, before advice can be provided about if/how they should be coded.

- Labral tear repair or excision
- Repair (e.g., microfracture) of an associated articular lesion

Classification
The term ‘osteochondroplasty’ is not recognised in ACHI.

The lead terms ‘osteoplasty’ and ‘chondroplasty’ do not have ‘hip’ Indexed as a sub-term.

Applying the logic that ACHI classifies osteoplasty and chondroplasty of knee as ‘Repair’, follow Index pathway: Repair/hip NEC to assign 90552-00 *Other repair of hip* for hip osteochondroplasty i.e., cam and/or pincer resection with re-shaping of bone and cartilage. This decision aligns with Victoria ICD Coding Committee query 3838 *Osteochondroplasty of hip.*

Note: Periacetabular osteotomy is a separate procedure performed for hip dysplasia and is classified separately to 50394-00 1478] *Multiple peri-acetabular osteotomies.*

For this query’s example operation report, assign the following ACHI codes:
50394-00 [1478] *Multiple peri-acetabular osteotomies*
90552-00 [1491] *Other repair of hip*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a public submission to the Independent Hospital and Aged Care Pricing Authority (IHACPA). If possible, please provide pincer deformity operation report examples as these will be included with the other operation reports for the public submission.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2024002
QUERY TITLE	**Endoscopic administration of agent into lesion of stomach or duodenum**
QUERY SPECIALTY	DIGS – Diseases of the digestive system
DATE QUERY RECEIVED	09/01/2024
DATE QUERY RESPONDED TO	02/07/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Is 30478-07 [870] *Endoscopic administration of agent into lesion of stomach or duodenum* always assigned with 90296-00 [887] *Endoscopic control of upper gastrointestinal bleeding* when there is administration of any agent (e.g., injection of adrenaline) into a bleeding gastrointestinal lesion?

RESPONSE

90296-00 [887] *Endoscopic control of upper gastrointestinal bleeding* is assigned for methods such as clipping and suturing. The highlighted *Excludes* note (below) was added in 12th Edition to the ACHI Tabular List at 90296-00:

90296-00 Endoscopic control of upper gastrointestinal bleeding

Includes:
clipping

Note:
Performed for:

- bleeding peptic ulcer (duodenal) (gastric)
- Mallory-Weiss laceration

Excludes:
by administration of agent into lesion (30478-07 **[870]**)

This *Excludes* note instructs coders that control of gastrointestinal bleeding by the administration of an agent is classified elsewhere in ACHI, i.e., to 30478-07 [870] *Endoscopic administration of agent into lesion of stomach or duodenum.* This *Excludes* note prompts coders that they are in the wrong place in the ACHI Tabular List to classify, for e.g., sclerotherapy.

This *Excludes* note does not instruct that 30478-07 is always assigned with 90296-00 when there is administration of any agent into a bleeding gastrointestinal lesion.

For injection of adrenaline, for example:

- Follow National Coding Advice *Q3240 Control of bleeding during ERCP* (effective 1 Oct 2018 to current) to **assign** 30478-07 when adrenaline is the agent administered to control bleeding.

- Follow ACS 0016 *General procedure guidelines, Procedural components* and **do not assign** 30478-07 when adrenaline is injected as a component of a more significant intervention to control bleeding e.g., when injected sclerosant is localised by adrenaline, or when adrenaline is administered for temporary haemostasis before suturing etc.

Further actions
WA Coding Rule 0716/05 *Injection of adrenaline into bleeding gastric ulcer* will be updated to clarify National Coding Advice Q3240 *Control of bleeding during ERCP* (effective 1 Oct until current) and application of the 12th Edition ACHI Tabular List *Excludes* note at 90296-00. The updated WA Coding Rule will be discussed by the WA Clinical Coding Technical Advisory Group prior to publication.

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023083
QUERY TITLE	**Piriformis syndrome**
QUERY SPECIALTY	NERV – Diseases of the nervous system
DATE QUERY RECEIVED	19/12/2023
DATE QUERY RESPONDED TO	24/01/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

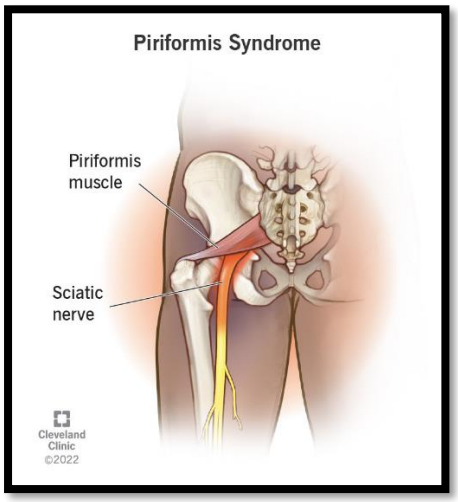
How do you classify Piriformis syndrome (PS)?

RESPONSE

Clinical information

PS is a neuromuscular disorder due to compression (entrapment) of the sciatic nerve at the level of the pelvic ischial tuberosities (sit bones). The nerve compression is caused by damage to the piriformis muscle. The signs and symptoms of PS are that of sciatic neuropathy, with pain, tingling and numbness in the buttock and along the distribution of the sciatic nerve into the legs.

For further information see: https://www.ncbi.nlm.nih.gov/books/NBK448172/



https://my.clevelandclinic.org/health/diseases/23495-piriformis-syndrome

Classification
For Piriformis syndrome assign G57.0 *Lesion of sciatic nerve*
following Index pathway: **Compression**, nerve, sciatic G57.0.

Other comments

- Classifying PS to G57.0 *Lesion of sciatic nerve* aligns with:
  - the International Classification of Diseases 11th Revision (ICD-11), which assigns 8C11.00 *Sciatic nerve piriformis syndrome*. See: ICD-11: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1379565645
  - the United States' ICD-10-CM, which assigns G57.0- *Lesion of sciatic nerve.* See: ICD-10-CM: https://www.icd10data.com/ICD10CM/Codes/G00-G99/G50-G59/G57-/G57.00

- The Victorian ICD Coding Committee (VICC) has retired advice for PS - Q2729 *Piriformis syndrome* advice (retired 30/6/2017). VICC advised PS was to be assigned M62.85 *Other specified disorders of* ***muscle****, pelvic region and thigh*, following Index pathway: **Disorder**, muscle, specified M62.8-. WACCA doesn't agree with this advice because PS is a **nerve** disorder.

- The NSW Clinical Coding Leadership Group (CCLG) has submitted a public submission to IHACPA for PS - P479 *Index for Piriformis syndrome* (4/7/2020). CCLG suggested several classification options for PS:

  > *' … M62.85, G57.0 (Piriformis syndrome without documentation of sciatica) and U91; M62.85, M54.3 (Piriformis syndrome with documentation of sciatica) and U91; M62.85, M51.1, G55.1 (Piriformis syndrome with sciatic nerve compression also due to disc disorder. Apply ACS 0001 for PDx sequencing …'*

  WACCA doesn't agree with these options because:
  - a single ICD-10-AM code classifies all elements of PS, so ACS 0005 *Syndromes* does not apply and U91 *Syndrome, not elsewhere classified* should not be assigned
  - They don't align with ICD-11 and ICD-10-CM which classify PS to a single code.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023082
QUERY TITLE	**Documentation of deconditioning by physiotherapists**
QUERY SPECIALTY	MSCT – Diseases of the musculoskeletal system and connective tissue
DATE QUERY RECEIVED	15/12/2023
DATE QUERY RESPONDED TO	29/02/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can you code ‘deconditioning’ documented by physiotherapists, as an additional diagnosis?

RESPONSE

Clinical information

Deconditioning is a reversible physiological change (cognitive and physical) caused by a period of inactivity. It reduces the ability to do the activities of daily living. It is often associated with hospitalisation in the elderly. The most predictable effects of deconditioning are seen in the musculoskeletal system and include reduced muscle mass (sarcopenia), decreased muscle strength, muscle shortening, and changes in joint structure. The decrease in muscle mass and strength is linked to falls, functional decline, increased frailty, and immobility.

Deconditioning is caused by inactivity, due to:

- Illnesses such as cancer and stroke
- Injuries, especially fractures
- Age
- Obesity
- Depression
- Cognitive impairment
- Hospitalisation.

Deconditioning is treated with a physiotherapist supervised exercise program that: builds muscle mass, improves heart and lung function, increases joint flexibility, and improves balance.

For further information see:

- Deconditioning
  - https://elsevier.health/en-US/preview/deconditioning
- Hospital-associated deconditioning: Not only physical, but also cognitive
  - https://onlinelibrary.wiley.com/doi/full/10.1002/gps.5687

Classification

ACS 0010 *Clinical documentation and general abstraction guidelines* instructs that documentation by clinicians other than doctors may be used to inform code assignment where the documentation is appropriate to the clinician's scope of practice. Management of deconditioning is within a physiotherapist's scope of practice.

To code deconditioning documented by a physiotherapist, it needs to have had, at least one of the ACS 0002 *Additional Diagnosis* criteria performed for it (and be evidenced within the documentation):

- Commencement, alteration, or adjustment of therapeutic treatment
  - E.g., commencement of an exercise program for deconditioning, by the physiotherapist, within the admission.

- Diagnostic interventions
  - E.g., muscle assessment to investigate deconditioning, by the physiotherapist, within the admission.

- Increased clinical care
  - E.g., **consultation**/review for deconditioning **and** documentation of a **care plan** for deconditioning such as education and an exercise program.
  - Note, ACS 0002 Example12 illustrates increased clinical care by a physiotherapist.

Where there's documentation of an underlying cause for deconditioning, apply the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* or ACS 0002 *Additional diagnoses/Problems and underlying conditions*.

The code for deconditioning is M62.50 *Muscle wasting and atrophy, not elsewhere classified, multiple sites*, following Index pathway:

Deconditioning M62.50

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023081
QUERY TITLE	**Principal diagnosis selection: Gastroenteritis versus syncope**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	13/12/2023
DATE QUERY RESPONDED TO	19/02/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Scenario

Discharge summary
1 – 5 January 2024
Principal diagnosis: **Syncope**
Discharge plan: MRI, TTE, Holter monitor.

Medical officer notes
1 Jan
2x LOC of unknown duration. Headache the night before. Urinary incontinence noted. Diarrhoea in preceding weeks. Plan: **syncope** for work up.

2 Jan
Syncope - unknown cause. Plan: await CT angiogram, consider LP to **rule out subarachnoid haemorrhage.**

3 Jan
Impression: **syncope** and urinary incontinence **?cause**.
Possibilities: seizure/hypovolaemia/cardiac. Sentinel bleed less likely with normal imaging. **?Hypovolaemia contributing** – diarrhoea and abdominal pain in preceding weeks. Treated as diverticulitis by GP with symptoms improving.
Plan: Holter monitor and echocardiogram to **exclude arrhythmia/valve disease**.

4 Jan
Headache on standing this morning.
Plan: chase CT angiogram for **?stenosis neck/vertebral arteries**.

4 Jan
Headache this morning associated with nausea – largely resolved with Metoclopramide. CT abdomen ordered by GP reportedly showing ?diverticulosis.
Plan: discussion with external neurologist. Advice**: most likely related to gastrointestinal upset**.
Plan: inpatient Holter, TTE and MRI to **rule out ?stroke**. Chase CT abdomen from GP.

5 Jan
Discharge today. Awaiting MRI brain **?stroke.** Machine unavailable, to be performed as outpatient along with TTE and Holter monitor. For consideration of further discussion with neurologist.

RESPONSE

Classification

1. Syncope is the PD, with the rationale being:

- Syncope is documented as the PD on the discharge summary. As per ACS 0010 *Clinical documentation and general abstraction guidelines*, identification and documentation of the PD is the responsibility of the treating clinician.

- Syncope can be verified against the ACS 0001 *Principal diagnosis* definition: *the diagnosis established **after study** to be **chiefly** **responsible for occasioning an episode.***

    - For instance: admitted for investigation into syncope. Multiple investigations are performed and multiple differential diagnoses are documented (high-lighted green in the scenario). Plans made for further investigation into syncope post-discharge. At discharge (after study), syncope is not attributed to any of the differential diagnoses or a (suspected) final/principal diagnosis. Therefore, after study, syncope is chiefly responsible for occasioning the admission, and is the PD.

- For this scenario, the symptom ‘syncope’ meets the criteria for coding because:

- a related definitive diagnosis has not been established as per ACS 0001 *Principal diagnosis/Codes for symptoms, signs and ill-defined conditions.*

- it was an episode for a which a more precise diagnosis was not available - see the *Note* at the beginning of Chapter 18 *Symptoms, signs and abnormal clinical findings, not elsewhere classified, Point e*.

2. Gastrointestinal (GI) upset is not the PD, with the rationale being:

- GI upset is not documented as the PD on the discharge summary. As per ACS 0010, identification and documentation of the PD is the responsibility of the treating clinician.

- GI upset can't be verified against the ACS 0001 *Principal diagnosis* definition: *the diagnosis established* ***after study*** *to be* ***chiefly*** ***responsible for occasioning an episode****.*

  - For instance: admitted for investigation into syncope. Multiple investigations are performed and multiple differential diagnoses, including *GI upset* are documented (high-lighted green in the scenario). Plans made for further investigation into syncope post documentation of *GI upset* and post-discharge. At discharge (after study), syncope is not attributed to any of the differential diagnoses, or a (suspected) final/principal diagnosis such as 'GI upset,' 'likely GI upset,' or '? GI upset.' The clinician was not satisfied that *GI upset* was the (suspected) cause of syncope. Therefore, *GI upset* is not chiefly responsible for occasioning the admission, and is not the PD.

3. ACS 0012 *Suspected conditions* is not applicable to this scenario because:

- Documentation did not indicate uncertainty about the **final** diagnosis (PD) at discharge. The final diagnosis/PD was syncope, not 'likely GI upset' or '? GI upset' (for e.g.).

4. Gastrointestinal upset is non-specific terminology. It should be considered and clarified in the context of documented diarrhoea, vomiting, abdominal pain, and diverticular disease.

Other comments
This response is consistent with WA's IHACPA coding query IHACPA0418 *Changing the documented principal diagnosis*, submitted 23/09/2022.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023080
QUERY TITLE	**Adenoid hypertrophy grades**
QUERY SPECIALTY	RESP – Diseases of the respiratory system
DATE QUERY RECEIVED	08/12/2023
DATE QUERY RESPONDED TO	02/02/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify adenoid grades?

> **Example operation report**
> Findings: Grade 2-3 adenoids
> Procedure: Adenoidectomy

RESPONSE

Clinical information

Adenoids are lymphoid tissue normally found in the nasopharynx of young children. Adenoid enlargement is a cause of nasal obstruction (causing snoring/mouth breathing) in this age group. There's little agreement amongst surgeons on how to assess the size of adenoids preoperatively. Nasoendoscopy may be performed if adenoid hypertrophy is suspected. Adenoid hypertrophy can be graded in terms of the amount of choanae occupied by the adenoid (choanae are funnel-shaped openings, between the nasal cavity and the pharynx):

Grade	Description
Grade 1	Adenoids tissue filling one-third of the vertical portion of the choanae
Grade 2	Adenoids tissue filling from one-third to two-third of the choanae
Grade 3	From two-third to nearly complete obstruction of the choanae
Grade 4	Complete choanal obstruction

Table reference: https://www.semanticscholar.org/paper/Assessment-of-Adenoids-Hypertrophy-by-Plain-X-ray-Alwan-Al-Dahan/b7d43004cced23294071e44c51409fde2cf5f456

Adenoid grades at nasoendoscopy:

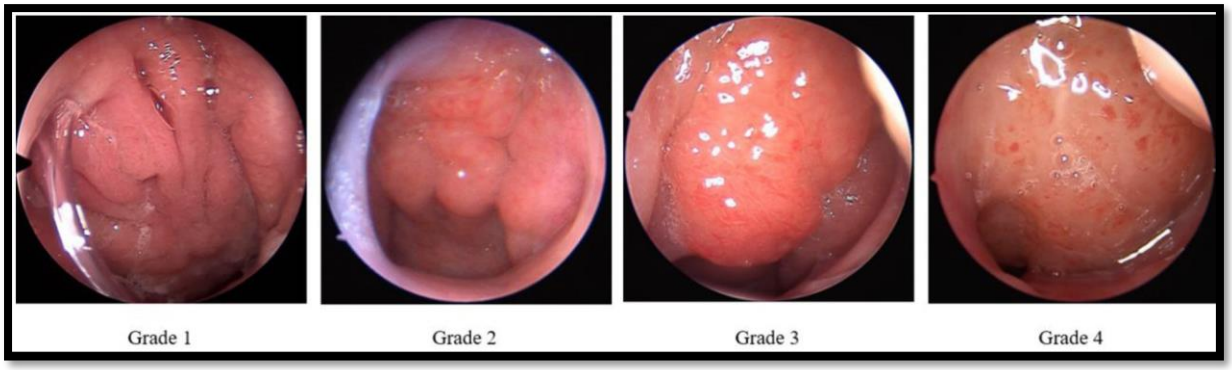


Table reference: https://www.frontiersin.org/articles/10.3389/fmed.2023.1142261/full

For further information on adenoid grading see:

- ***Grading adenoid utilizing flexible nasopharyngoscopy*** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6078522/#:~:text=Adenoids%20were%20categorized%20into%20the,Grade%20III%20%E2%80%93%20adenoid%20tissue%20obstructs

- ***Update of endoscopic classification system of adenoid hypertrophy based on clinical experience on 7621 children*** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9330757/

Classification

- Adenoid grades are not Indexed in ICD-10-AM.
- Note: from 12th Edition, tonsil grades have been Indexed in ICD-10-AM as non-essential modifiers at:

  Enlargement, enlarged – see also Hypertrophy
  - tonsils (greater than grade 3) J35.1

  Hypertrophy
  - tonsils (faucial) (greater than grade 3) (infective) (lingual) (lymphoid) J35.1

- Where documentation of adenoid grades, such as 'grade 2-3 adenoids' meets the criteria for coding (e.g., meets ACS 0002 'therapeutic treatment' because an adenoidectomy is performed), and there's no more specific-documentation available (such as 'adenoid hypertrophy') assign J35.9 *Chronic disease of tonsils and adenoids, unspecified* following Index pathway:

Disease, diseased
- adenoids (and tonsils) J35.9

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023079
QUERY TITLE	**Radiology report indication as principal diagnosis**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	01/12/2023
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can a radiology report indication be assigned as principal diagnosis?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023078
QUERY TITLE	**Schimmelpenning Feuerstein Mims (Linear Nevus Sebaceous) Syndrome**
QUERY SPECIALTY	CONG – Congenital malformations, deformations and chromosomal abnormalities
DATE QUERY RECEIVED	23/11/2023
DATE QUERY RESPONDED TO	17/01/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify Schimmelpenning Feuerstein Mims (SFM) syndrome?

RESPONSE

Clinical information

The Genetic and Rare Diseases Information Centre (GARD) lists the following synonyms for SFM syndrome:

- Linear nevus sebaceous syndrome
- Jadassohn nevus phakomatosis (JNP)
- Nevus sebaceous of Jadassohn
- Organoid nevus phakomatosis
- Solomon syndrome

GARD: https://rarediseases.info.nih.gov/diseases/10291/linear-nevus-sebaceous-syndrome

SFM syndrome is a phakomatosis. The phakomatoses (also known as neurocutaneous syndromes) are disorders characterised by abnormalities of structures from the embryonic ectoderm (i.e., the central nervous system, skin, and eyes). Other systems may also be involved.

For further information see: https://radiopaedia.org/articles/phakomatoses-1

Classification
'SFM syndrome' is not indexed in ICD-10-AM. To classify SFM syndrome assign Q85.89 *Other specified phakomatoses* following the Index pathway:

Phakomatosis (see also specific eponymous syndromes) Q85.9
- Bourneville's Q85.1
- specified NEC Q85.89

Other comments
Classifying SFM syndrome to ICD-10-AM code Q85.89 *Other specified phakomatoses* aligns with:

- ICD-11 classification of SFM syndrome to LD2D.Y *Other specified phakomatoses or hamartoneoplastic syndromes.*
- Orphanet's classification of SFM syndrome to ICD-10 code Q85.8.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023077
QUERY TITLE	**Reconstruction following mastectomy for breast cancer**
QUERY SPECIALTY	SKSC – Diseases of the skin and subcutaneous tissue
DATE QUERY RECEIVED	07/11/2023
DATE QUERY RESPONDED TO	29/02/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What is the principal diagnosis for this scenario:

> ***Scenario***
> Principal diagnosis: Breast cancer
> Admitted for breast reconstruction, postmastectomy for breast cancer.
> Currently undergoing chemotherapy for breast cancer but no chemotherapy administered in this admission.

Does the coding logic from WA Coding Rule 0511/3 *Post Mohs defect reconstruction* (effective 11 October 2017) apply to this scenario?

RESPONSE

Classification

ACS 0236 *Neoplasm coding and sequencing* lists the circumstances when a code for a primary neoplasm should be assigned.

None of these circumstances are applicable to this scenario, as the scenario is **not** for:

- initial diagnosis of the primary neoplasm
- surgery for removal of the primary neoplasm, wider excision, staged prophylactic
- removal of a related organ
- pharmacotherapy or radiotherapy, or
- medical care related to treatment of the primary neoplasm.

ACS 0236 *Neoplasm coding and sequencing,* directs the coder to ACS 1204 *Plastic surgery* and ACS 2114 *Prophylactic surgery* for guidelines on follow-up care.

ACS 1204 *Plastic surgery* instructs that when the reason for cosmetic or reconstructive plastic surgery is documented, code this condition, current disease, or injury as the principal diagnosis.

Although 'Breast cancer' is documented as the principal diagnosis, it cannot be assigned as such because it's not the specific reason for admission/breast reconstruction (it doesn't meet the ACS 0001 principal diagnosis definition). Breast reconstruction is performed to rebuild the shape of the removed breast(s), not to treat breast cancer.

For the scenario provided, in the absence of a documented condition or deformity, assign as principal diagnosis, Z42.1 *Follow-up care involving plastic surgery of breast*, by following Alphabetic Index pathway:

Surgery (admission for)
- reconstructive, following healed injury or operation (no underlying cause) Z42.9
- - breast Z42.1

Other comments

- This response is consistent with Victorian ICD-10-AM Coding Committee (VICC) Query 2919 *Admission for osseointegrated implant,* published September 2014.
- Western Australian Coding Rule (WACR) 1017/02 *Post Mohs defect reconstruction,* effective 11 October 2017 (superseding WACR 0511/3 *Post Mohs defect reconstruction*, effective 18 May 2011), is specific to post Mohs reconstruction and should not be applied to other scenarios.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023076
QUERY TITLE	**Acute on chronic anaemia**
QUERY SPECIALTY	BLIM – Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
DATE QUERY RECEIVED	24/10/2023
DATE QUERY RESPONDED TO	18/07/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can D62 *Acute post haemorrhagic anaemia* and D64.9 *Anaemia, unspecified* be assigned for 'Acute on chronic anaemia' in the following scenario, or do we apply the logic in National Coding Advice (NCA) Q3569 *Iron deficiency anaemia with chronic normocytic anaemia* (effective 1 Apr 2023 to current) to assign D62 only?

Scenario
Discharge summary: Acute on chronic anaemia

At admission for joint replacement surgery, patient has pre-existing chronic anaemia, not further specified (haemoglobin 97). This anaemia does not affect patient care, i.e., it does not require repeated tests/investigations, treatment before surgery, surgery delay/change/cancellation etc.

After joint replacement surgery, patient develops postoperative haematoma, resulting in acute anaemia (haemoglobin drops to 65) - treated with packed cell transfusion.

RESPONSE

Classification

Caution!
Coders should exercise caution before assigning multiple different anaemia codes for an admission – for some documentation it will be appropriate, for other documentation it will not.

Acute anaemia
For this scenario, the acute anaemia resulting from the postoperative haematoma meets additional diagnosis criteria for coding (i.e., it's treated with packed cells), so **assign** D62 *Acute post haemorrhagic anaemia* following Alphabetic Index pathway:

Anaemia
- due to
- - haemorrhage (chronic) D50.0
- - - acute D62

Chronic anaemia
For this scenario, **do not assign** D64.9 *Anaemia, unspecified* for the pre-existing chronic anaemia, not further specified (following Alphabetic Index pathway: '**Anaemia** D64.9') because:

1. ACS 0001 *Principal diagnosis*/*Acute on chronic conditions* is not applicable to the classification of anaemia: neither 'acute' nor 'chronic' are subterms at lead term **Anaemia**.

   ACS 0001 *Principal diagnosis*/*Acute on chronic conditions:*

   where *a condition is described as both acute (subacute) and chronic and separate subterms exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.*

2. The pre-existing chronic anaemia does not meet ACS 0002 *Additional diagnosis* criteria for coding.

NCA Q3569 Iron deficiency anaemia with chronic normocytic anaemia
Do not apply the logic in NCA Q3569 to the classification of 'Acute on chronic anaemia' in this scenario. In this scenario, there are two clinical concepts (i.e., multiple types of anaemia) to be considered for code assignment: 1) acute anaemia resulting from postoperative haematoma, and 2) chronic anaemia, not further specified. NCA Q3569 *actually* provides classification instruction for one clinical concept (i.e., a single type of anaemia): "anaemia – chronic

normocytic, iron deficient" (or chronic normocytic iron deficiency anaemia). See 'Other comments' below.

Other comments

During preparation of this response, an anomaly was noted in NCA Q3569 which will be queried with IHACPA. The original query resulting in publication of NCA Q3569 asked whether two ICD-10-AM codes were required to classify documentation of "anaemia – chronic normocytic, iron deficient" - a single type of anaemia (i.e., a single clinical concept). WACCA will ask IHACPA to confirm or otherwise, whether NCA Q3569 only applies to a single type of anaemia.

WACCA encourage health services to submit further anaemia queries/scenarios via the WA Coding Query Process.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website, proposed as a WA Coding Rule via the Western Australian Clinical Coding Technical Advisory Group process and submitted as a query to the Independent Hospital and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023075
QUERY TITLE	**Arthroscopic reconstruction of knee with meniscectomy, indexing anomaly**
QUERY SPECIALTY	MSCT - Diseases of the musculoskeletal system and connective tissue
DATE QUERY RECEIVED	24/10/2023
DATE QUERY RESPONDED TO	09/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Is 'meniscectomy' equivalent to 'repair of meniscus' in the following ACHI codes?

49542-00 Arthroscopic reconstruction of knee with repair of meniscus
Includes:
debridement
repair or reconstruction of ligament:
- collateral
- cruciate

49542-01 Reconstruction of knee with repair of meniscus
Includes:
debridement
repair or reconstruction of ligament:
- collateral
- cruciate

RESPONSE

Classification

In Twelfth Edition (implemented 1 July 2022) the following occurred:

- Q3325 *Arthroscopic ACL reconstruction with meniscectomy* was retired
- ACHI Alphabetic Index pathways were created (blue font):

Meniscectomy
- knee (open) (total) 49503-00 **[1505]**
- - with reconstruction (collateral) (cruciate) 49542-01 **[1522]**
- - - arthroscopic (closed) (partial) 49542-00 **[1522]**
- - arthroscopic (closed) (partial) (total) 49560-03 **[1503]**

→ the equivalent Index pathways were erroneously omitted at lead term "Reconstruction". This omission will be referred to IHACPA.

- An *Excludes* note was added in the ACHI Tabular List at:

  49503-00 Meniscectomy of knee
  Excludes: that with reconstruction (49542-01 **[1522]**)

  → an equivalent Excludes note was erroneously omitted at code 49560-03 *Arthroscopic meniscectomy of knee*, to redirect to 49542-00. This omission will be referred to IHACPA.

As per the ACHI Alphabetic Index, 'meniscectomy' is equivalent to 'repair of meniscus' for the ACHI codes 49542-00 *Arthroscopic reconstruction of knee with repair of meniscus* and 49542-01 *Reconstruction of knee with repair of meniscus.* The lead term 'Meniscectomy' should be followed to reach the correct code.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA). The issue will also be reported to 3M in case they are able to update their pathway while awaiting the ACHI omissions to be rectified.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023085
QUERY TITLE	**Mitomycin intravascular chemoembolization (MICE) for lipid keratopathy**
QUERY SPECIALTY	EYEA – Diseases of the eye and adnexa
DATE QUERY RECEIVED	17/10/2023
DATE QUERY RESPONDED TO	01/02/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What is the code for Mitomycin Intravascular Chemoembolisation (MICE)?
(it's used to treat corneal neovascularisation in lipid keratopathy).

> **Example operation report**
> Diagnosis: Right corneal scar with dense lipid keratopathy.
> Operation: Right mitomycin intravascular chemoembolisation.
> Procedure performed: 5X MICE injections.

RESPONSE

Clinical information

Corneal neovascularisation and lipid keratopathy

- In lipid keratopathy, there's abnormal growth of blood vessels into the cornea (called neovascularisation) (note - a healthy cornea does not have blood vessels, a healthy cornea is avascular).
- Lipids (fats) leak from these blood vessels and deposit in the cornea, causing corneal clouding and reduced vision.

Mitomycin Intravascular Chemoembolisation (MICE)

- Treatment of lipid keratopathy aims to destroy the abnormal blood vessels and prevent further blood vessel growth.

- Mitomycin C is a type of pharmacotherapy that destroys (is cytotoxic to) the cells lining blood vessels.

- In MICE, Mitomycin C is injected into the abnormal corneal blood vessels. This embolises (blocks) the vessels and stops fat depositing in the cornea.

- These websites have further information on corneal neovascularisation, lipid keratopathy and Mitomycin Intravascular Chemoembolisation (MICE):

    - https://eyewiki.aao.org/Mitomycin_Intravascular_Chemoembolization_(MICE)
    - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7708541/

Classification
MICE is not Indexed in ACHI. For MICE, assign 90067-00 [176] *Other procedures on cornea*, following Index pathway:

Procedure
-cornea NEC 90067-00 [176]

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. As MICE is a new intervention, this query was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023074
QUERY TITLE	**Primary Ciliary Dyskinesia (Immotile-cilia Syndrome**
QUERY SPECIALTY	CONG - Congenital malformations, deformations and chromosomal abnormalities
DATE QUERY RECEIVED	16/10/2023
DATE QUERY RESPONDED TO	14/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What code is assigned for Primary Ciliary Dyskinesia (PCD) without situs inversus?

RESPONSE

Clinical information

PCD:

- is a rare, genetically heterogeneous, autosomal recessive primary respiratory disorder characterized by chronic upper and lower respiratory tract disease.
- presents early in life and typically progresses to bronchiectasis.
- affects the movement of cilia (tiny hair-like structures on body cells).
    - Cilia are present on many types of cells, particularly those in the respiratory tract.

People with PCD:

- cannot clear the mucous/fluid in their lungs and airways, leading to frequent respiratory infections, continuous nasal congestion, and coughing.
- may have abnormal placement of organs in the body, known as situs abnormalities (organ laterality defects). E.g., their heart may be on the right side of their chest instead of the left. Situs abnormalities may include situs inversus totalis or situs ambiguous/heterotaxy.

PCD synonyms are:

- Immotile cilia syndrome (ICS)
- Polynesian bronchiectasis

PCD sub-types are:
- Kartagener's syndrome also known as Siewert syndrome
- Dextrocardia-bronchiectasis-sinusitis triad/syndrome

Note: ciliary dyskinesia has an acquired/secondary form that results from respiratory tract injury associated especially with respiratory infections such as bronchiolitis or chronic obstructive pulmonary disease. These are unrelated to the rare primary forms.

For more information, see the Orphanet nomenclature of rare diseases:
Orphanet: Primary ciliary dyskinesia

And the National Organisation for Rare Disorders (NORD):
https://rarediseases.info.nih.gov/diseases/4484/index

Classification

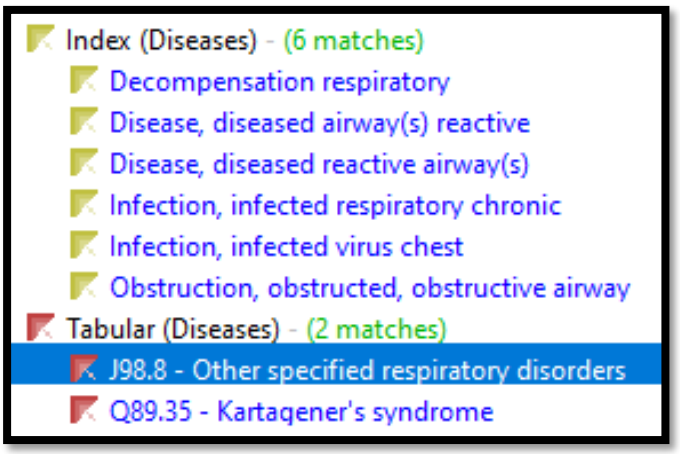
1. ICD-10-AM

Index pathways:
- There is no index pathway for PCD or (other) immotile cilia syndrome.
- There is an Index pathway for: Kartagener's syndrome or triad → Q89.35.

Tabular List:
Q89.35 *Kartagener's syndrome*
Kartagener's triad
Excludes: other immotile cilia syndrome (J98.8)

The Tabular Excludes note instructs the coder to assign J98.8 for 'other immotile cilia syndrome'.

The Index entries for J98.8 *Other specified respiratory disorders* are:



Note, there is no Index pathway to J98.8 with the terms “other immotile cilia syndrome”.

2. ICD-11

In ICD-11:

Ciliary dyskinesia is classified to:
CB40.0 Ciliary dyskinesia
Ancestors
Ch 12 Diseases of the respiratory system
-CB40 Certain diseases of the respiratory system
--**CB40.0 Ciliary dyskinesia**
Coded Elsewhere
- **Primary ciliary dyskinesia** (LA75.Y)
- Syndromic ciliary dyskinesia (LA75.Y)

PCD is classified to:
LA75.Y Other specified structural developmental anomalies of lungs
Ancestors
Ch 20 Developmental anomalies
-Structural developmental anomalies primarily affecting one body system
--Structural developmental anomalies of the respiratory system
---LA75 Structural developmental anomalies of lungs
----**LA75.Y Other specified structural developmental anomalies of lungs**

For ICD-11 see: https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f955573234

3. ICD-10-CM

In ICD-10-CM, PCD is classified to:

Q34.8 Other specified congenital malformations of respiratory system
Includes
- Atresia of nasopharynx, congenital
- Congenital atresia of nasopharynx
- Immotile cilia syndrome

In ICD-10-CM, PCD/ICS are Inclusion terms only. There are no Index pathways to Q34.8 including the terms primary ciliary dyskinesia and immotile cilia syndrome.

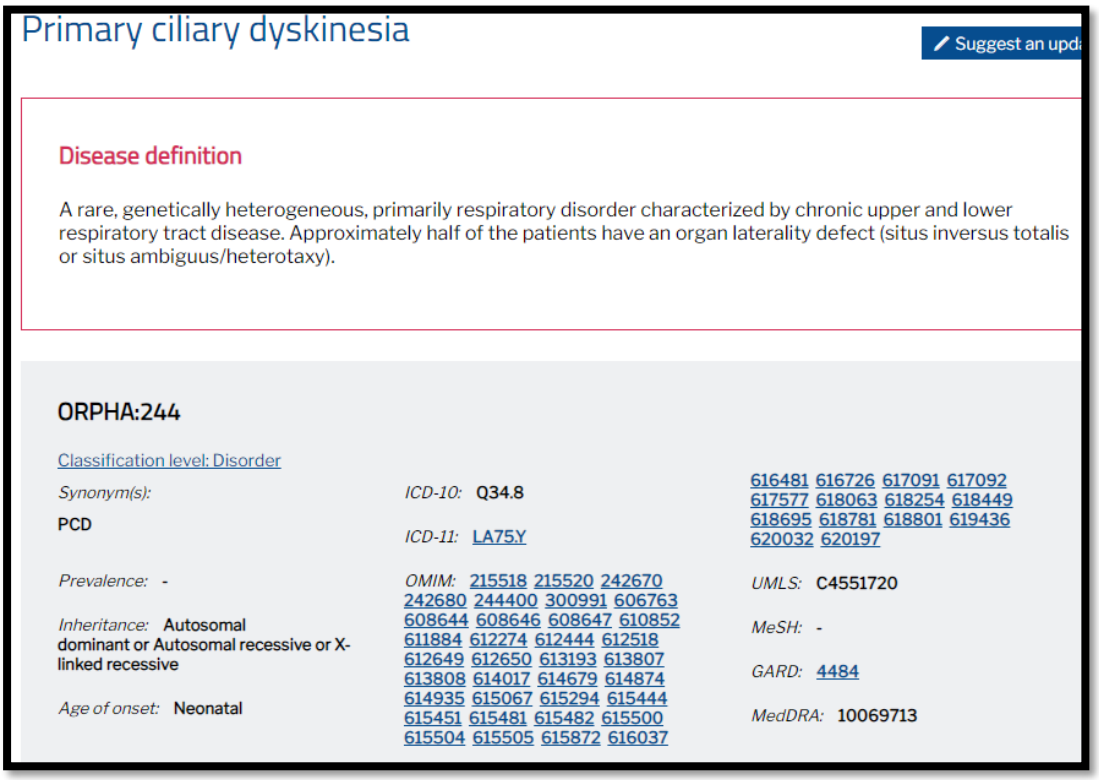
In ICD-10-CM Kartagener Syndrome is classified to Q89.3 *Situs inversus* following Index pathways:

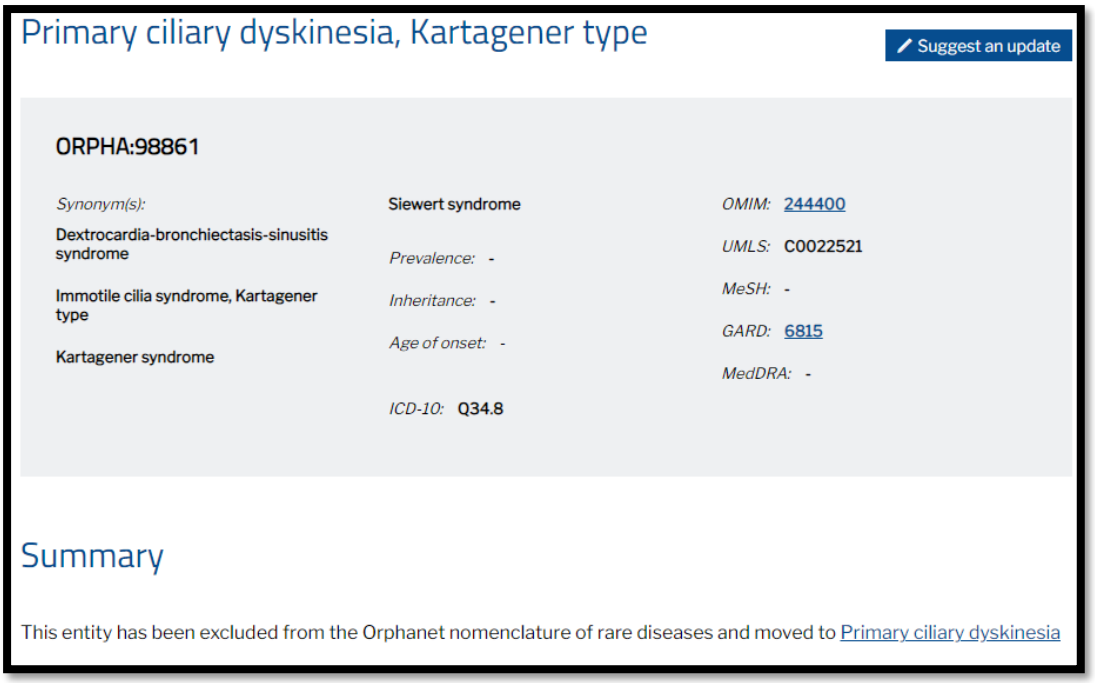
Syndrome - see also Disease
-Kartagener's Q89.3
-sinusitis-bronchiectasis-situs inversus Q89.3

For ICD-10-CM see: https://www.icd10data.com/ICD10CM/Codes/Q00-Q99/Q30-Q34/Q34-/Q34.8

4. Orphanet

Orphanet classifies PCD to ICD-10 code **Q34.8 Other specified congenital malformations of respiratory system**:





https://www.orpha.net/consor/cgi-bin/Disease_Search_Simple.php?lng=EN&diseaseGroup=ciliary+

WACCA recommendation

Kartagener's syndrome (Q89.35) is classified in ICD-10-AM to a specific Australian code in category Q89.3 *Situs inversus*. ICD-10-AM Q89.35 *Kartagener's syndrome* excludes other immotile cilia syndromes (i.e., without situs inversus) and redirects the coder to assign J98.8 for other immotile cilia syndromes. The Excludes note redirects the coder from an incorrect code to a correct code. WACCA believe the redirect at Q89.35 is not specific enough and the Excludes note ought to redirect to both a congenital chapter code for a **primary condition** that is not Kartagener's syndrome and to a respiratory chapter code for a **secondary**/acquired **condition**.

Therefore, for primary ciliary dyskinesia or immotility such as PCD/ICS assign Q34.8 *Other specified congenital malformations of respiratory system* following Index pathway:

Anomaly, respiratory system, specified NEC Q34.8

For secondary ciliary dyskinesia assign J98.8 *Other specified respiratory disorders* following the Excludes note at Q89.95 *Kartagener's syndrome*. Note: WACCA infer from the Excludes note, that J98.8 classifies secondary ciliary dyskinesia. However, due to an absence of Index pathways this will be queried with IHACPA.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023072
QUERY TITLE	**Condition Onset Flag (COF) for diabetes mellitus with hypoglycaemia during admission**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	04/10/2023
DATE QUERY RESPONDED TO	20/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

For the following scenario, what Condition Onset Flag (COF) is assigned to E10.64 *Type 1 diabetes mellitus with hypoglycaemia* considering hypoglycaemia was not present on admission?

Discharge summary:
Principal diagnosis: Newly diagnosed Type 1 diabetes mellitus

Integrated progress notes:
Blood glucose levels (BGLs) remained high during the admission (i.e. BGLs 20+). However, on the evening prior to discharge, 'hypoglycaemia (BGL 3.7) due to not having food following insulin administration' is documented. Hypoglycaemia treated with administration of Dextrose solution and patient given toast and milk.

Code assignment:
Principal diagnosis: E10.64 *Type 1 diabetes mellitus with hypoglycaemia*

RESPONSE

Classification
As per ACS 0015 *Combination codes*, E10.64 *Type 1 diabetes mellitus with hypoglycaemia* is a combination code. It classifies a diagnosis (T1DM) and an associated complication (hypoglycaemia).

As per ACS 0048 *Condition onset flag,* assign COF:

- '1' for conditions arising during the admission, that are not present or suspected on admission.
- '2' for conditions existing or suspected on admission.

For the scenario cited, COF '2' applies to the T1DM because it existed on admission, however COF '1' applies to the hypoglycaemia as it arose during the admission.

As per ACS 0048 *Condition onset flag*, GUIDE FOR USE, Point 7:

> 'Where multiple conditions/sites are classifiable to a single ICD-10-AM code that meets the criteria for different condition onset flag values, assign COF 1. The exception to this is when the condition is sequenced as the **principal diagnosis** and **must be assigned COF 2**.'

Therefore, as E10.64 is the principal diagnosis code for this scenario, assign a COF of '2' to accompany E10.64.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023071
QUERY TITLE	**Assigning 96273-00 [1866] Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV2]**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	03/10/2023
DATE QUERY RESPONDED TO	27/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

With regards to IHACPA Coding Rule TN1601 Twelfth Edition FAQ: *Testing for severe acute respiratory syndrome coronavirus 2* (1 Oct – current), which documentation can be abstracted from to assign 96273-00 [1866] *Testing for severe acute respiratory syndrome coronavirus 2 [SARS-CoV2]*?

Can 96273-00 be assigned:

1. for documentation of ‘COVID +ve’ or ‘COVID -ve’ in the episode?
2. from nursing documentation in the episode?
3. when there’s documentation in the episode, that a Biofire test has been performed during the episode?

RESPONSE

1.
Can 96273-00 be assigned for documentation of 'COVID +ve' or 'COVID -ve' in the episode?

First, consider these classification instructions:

a.
ACS 0002 *Additional diagnoses/Additional diagnosis reporting referred to in other standards* lists COVID-19 as a mandatory condition for code assignment and directs coders to ACS 0113 C*oronavirus disease 2019 (COVID-19)*.

b.
ACS 0113 C*oronavirus disease 2019 (COVID-19)* instructs:

> ***Assign 96273-00*** *[1866]* ***where laboratory testing*** *(eg polymerase chain reaction (PCR)* ***has been performed during an episode*** *of care* ***to identify a SARS-CoV-2 infection****.*

c.
IHACPA document *How to classify COVID-19, Guidance for data analysts using ICD-10-AM Eleventh Edition*, indicates **96273-00**:

> *… is* ***assigned to identify laboratory testing activity for COVID-19*** *…*

d.
IHACPA Coding Rule TN1601 *Twelfth Edition FAQ: Testing for severe acute respiratory syndrome coronavirus 2* (1 Oct – current) instructs:

> *…* ***do not assign 96273-00*** *…* ***based on*** *the presence of* ***a test result alone****:* ***testing for COVID-19 must be specified*** *in the … documentation* ***within the current episode*** *…*

e.
TN1601 is consistent with ACS 0010 *Clinical documentation and general abstraction guidelines*, which indicates:

- Test results are a source of information outside of the body of the current episode.
- Information from test results should be qualified with clinical documentation in the body of the current episode.
- Do not use test results to determine code assignment where there is no clinical documentation in the body of the current episode to indicate the significance of the test result.

Bringing these classification instructions together, the take-away points are:

- **Assign 96273-00** to identify COVID-19 laboratory testing in an episode. To assign 96273-00, COVID-19 laboratory testing must be:
    - performed in the episode, **and**
    - evidenced by documentation in the body of the current episode.
        - Documentation of 'COVID +ve' or 'COVID -ve' in the body of the current episode (e.g., in the integrated progress notes) constitutes sufficient evidence.

- **Do not assign 96273-00** by abstracting from COVID-19 laboratory test results alone, i.e., by accessing COVID-19 laboratory test results from the Microbiology Section of the health care record, alone.

2.
Can 96273-00 be assigned from nursing documentation?

ACS 0002 *Additional diagnoses*/*Additional diagnosis reporting referred to in other standards* lists COVID-19 as a mandatory condition for code assignment and directs coders to ACS 0113 C*oronavirus disease 2019 (COVID-19)*.

Conditions and procedures listed in ACS 0113 C*oronavirus disease 2019 (COVID-19)* are mandatory for code assignment.

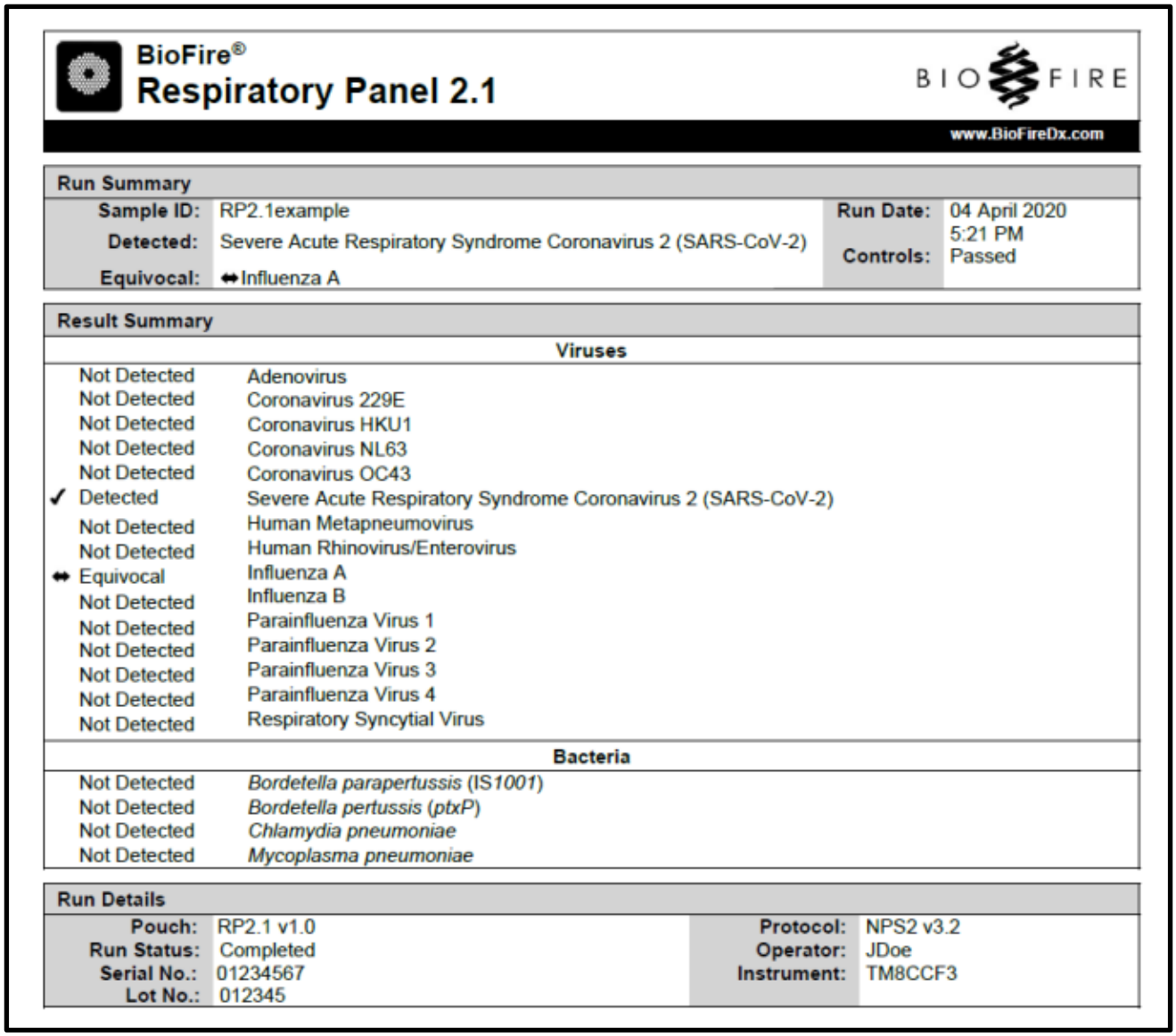
The WACCA *Guide to Major Eleventh Edition Changes: ACS 0010 Clinical documentation and general abstraction guidelines (August 2019)*/*Documentation of mandatory conditions*, indicates:

> *… the ACCD advised that **conditions listed as mandatory** for coding … can be **documented by any clinician** (i.e. medical officer, nurse, allied health).*

Therefore, 96273-00 can be assigned from nursing documentation.

3.
Can 96273-00 be assigned when there's documentation in the episode, that a Biofire test has been performed during the episode?

Clinical information
The BioFire FilmArray System performs Polymerase Chain Reaction (PCR) testing. The System simultaneously tests for multiple pathogens known to cause similar signs/symptoms. For instance, the System can test for multiple pathogens (e.g. COVID-19/SARS-CoV-2, Influenza, Respiratory Syncytial Virus etc.) that are known to cause respiratory infections. See the diagram below, for an example of the results generated from a BioFire System test on respiratory pathogens.



BioFire® Respiratory Panel 2.1

BIOFIRE

www.BioFireDx.com

Run Summary

Sample ID:	RP2.1example	**Run Date:**	04 April 2020 5:21 PM
Detected:	Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)	**Controls:**	Passed
Equivocal:	⬌Influenza A		

Result Summary

Viruses	
Not Detected	Adenovirus
Not Detected	Coronavirus 229E
Not Detected	Coronavirus HKU1
Not Detected	Coronavirus NL63
Not Detected	Coronavirus OC43
✓ Detected	Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)
Not Detected	Human Metapneumovirus
Not Detected	Human Rhinovirus/Enterovirus
⬌ Equivocal	Influenza A
Not Detected	Influenza B
Not Detected	Parainfluenza Virus 1
Not Detected	Parainfluenza Virus 2
Not Detected	Parainfluenza Virus 3
Not Detected	Parainfluenza Virus 4
Not Detected	Respiratory Syncytial Virus
Bacteria	
Not Detected	*Bordetella parapertussis* (IS*1001*)
Not Detected	*Bordetella pertussis* (*ptxP*)
Not Detected	*Chlamydia pneumoniae*
Not Detected	*Mycoplasma pneumoniae*

Run Details

Pouch:	RP2.1 v1.0	**Protocol:**	NPS2 v3.2
Run Status:	Completed	**Operator:**	JDoe
Serial No.:	01234567	**Instrument:**	TM8CCF3
Lot No.:	012345		

For more information on the BioFire FilmArray System, see:

What is PCR Testing? | BioFire Diagnostics (biofiredx.com)

BioFire® Respiratory Panel 2.1 (RP2.1) - Instructions for Use (fda.gov)

om_biomerieux_blood-culture_rp-instruction-booklet-full-details-and-quickstart.pdf (mediray.co.nz)

Classification
ACS 0113 C*oronavirus disease 2019 (COVID-19)* instructs:

> ***Assign 96273-00 [1866] where laboratory testing*** *(eg polymerase chain reaction (PCR)* ***has been performed during an episode*** *of care* ***to identify a SARS-CoV-2 infection****.*
>
> and
>
> IHACPA document *How to classify COVID-19, Guidance for data analysts using ICD-10-AM Eleventh Edition*, indicates 96273-00:
>
> *… is assigned to* ***identify laboratory testing activity for COVID-19*** *…*
>
> and
>
> IHACPA Coding Rule TN1601 *Twelfth Edition FAQ: Testing severe acute respiratory syndrome coronavirus 2* (1 Oct – current) instructs:
>
> *…* ***do not assign 96273-00*** *…* ***based on*** *the presence of* ***a test result alone****:* ***testing for COVID-19 must be specified*** *in the … documentation* ***within the current episode*** *…*

Therefore 96273-00 can be assigned when a BioFire test, tests for COVID-19 and it's evidenced by documentation in the body of the current episode.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023070
QUERY TITLE	**Postoperative pain**
QUERY SPECIALTY	INPO - Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	02/10/2023
DATE QUERY RESPONDED TO	14/12/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

When is pain management following a procedure considered 'significantly beyond routine' (as per ACS 1904 *Procedural complications*) to justify pain being coded as a procedural complication?

Example documentation of pain management following total hip arthroplasty:

> **01/01 21:10**
> **Nursing progress notes**
> RTW 1805. Obs stable. NVOBs intact. Tolerating diet and fluids. 1915 pt stated pain increase to 10/10. Was using Fentanyl PCA (20mcg). Stated not working. Orthopaedic consultant reviewed on ward. Anaesthetist called, to continue PCA Fentanyl 1 hour and push every dose allowed and to call back and report. All other oral analgesia given, as allowed with PCA. Pt reports at 2010 pain in 12/10, visibly shaking in bed. Anaesthetist called, PCA changed to Morphine 1mg and to give a stat 4mg dose on commencement. IDC draining minimal amounts. Rechecked 30 minutes post commencement of PCA Morphine, pain now 6/10. Ice has been applied x2 since pt RTW. Pt Unable to tolerate abduction pillow due to pain and was pulling off Hudson mask so changed to nasal prongs. Please note BP elevated, Dr X aware and not concerned, no modifications currently in place. Skin integrity intact. All care given.
>
> *Note: the ward review by Orthopaedic consultant does not have a corresponding progress note entry by the Orthopaedic consultant.*

02/01 08:00
Orthopaedic Intern review
D1 post L total hip replacement
Pt feels well, was unable to sleep last night secondary to pain, given analgesia. Nil SOB, dizziness, chest pain, numbness of limb, fever. Generally well.
O/E: Obs stable. Afebrile.
Post op wound dressing noted minimal oozing of blood (dried). Pedal pulses present. Sensation intact.
Plan: cont current management as per post op orders. XR and bloods today.

Anaesthetic Record
Notes:
1) O2 6L/min 24 hours
2) Fentanyl PCA
3) 2 further doses tranexamic acid
4) Xarelto starting tomorrow
5) IV Antibiotics for 48 hours
6) FBC U&E in am

Patient Controlled Intravenous Analgesia (PCIA) Prescription Chart
The form contains separate charts under headings: Fentanyl Prescription, Hydromorphone Prescription, Morphine Prescription.

RESPONSE

Clinical background
It's routine for nursing staff to monitor pain scores postoperatively and liaise with clinicians to optimise analgesia. Liaison may be via telephone or in-person. It may also be routine for surgical patients in some hospitals to have their postoperative analgesia regimen established and optimised by an Acute Pain Service (APS) team.

When a clinician authorises change of medication via telephone, the nurse can administer the medication and the clinician is required to sign the medication chart when they next have access to the medical record. The clinician usually does not generate a formal progress note entry for this type of routine clinical care.

However, if a significant issue has been conveyed to the clinician during a telephone discussion; or if the clinician makes a significant decision during a telephone discussion, they ought to generate a formal progress note entry when they next have access to the medical record.

Telephone communication is a tool used between staff as part of routine clinical care and is not automatically to be considered a 'consultation' for classification purposes.

However, a 'consultation' **may** occur via telephone (e.g. Example 14 in ACS 0002 *Additional diagnoses*, where a radiation oncology opinion was sought). Such

consultations usually involve seeking assessment, review and opinion from a clinician external to the treating team(s).

Classification
12th Edition
ACS 0010 *Clinical documentation and general abstraction guidelines* instructs:

> Accurate clinical documentation is the responsibility of the treating clinician.

ACS 1904 *Procedural complications* instructs:

> Some conditions, especially medical conditions commonly seen intraoperatively and in the postoperative period, are not solely related to the procedure performed, but are related to the complex interaction between the disease process and the procedure (that is, the cause of the condition is multifactorial). **These conditions are not classified as procedural complications unless the causal relationship is clearly documented**…
>
> …
>
> …[natural or expected events] are only assigned as procedural complications when there is documentation of care or management that is **significantly beyond routine care**. Care that is in excess of routine in the postoperative period (i.e. meeting the criteria in ACS 0002) may include:
>
> - Consultation/treatment by a clinician resulting in a change of management.

Classification Step 1
Rule out alternative causes(s) or contributing factor(s) for postoperative pain

Pain is a natural/expected event following surgery. However, uncontrolled postoperative pain may be multi-factorial e.g., if pain or injury was present prior to surgery, it may be a contributing factor to uncontrolled postoperative pain. The episode's documentation should be assessed to identify any documented alternative cause(s) or contributing factor(s) for postoperative pain.

If there is no evidence of an alternative cause(s) or contributing factor(s) for postoperative pain, then a documented causal relationship such as "pain **due to** arthroplasty surgery" is **not** required, in accordance with ACS 1904/Overview/dot point 2:

- Certain conditions where the relationship is inherent in the diagnosis (e.g. infection or bleeding of a surgical wound, stoma or anastomosis, wound dehiscence, transfusion related lung injury).

Classification Step 2
Determine if postoperative pain received 'significantly beyond routine' care

The next step is to determine whether the clinical care for natural/expected postoperative pain is considered 'significantly beyond routine'. Examples of 'significantly beyond routine' care that warrant assignment of T81.83 *Pain following a procedure NEC* include:

- A clinician performing a clinical consultation for postoperative pain, usually evidenced by a concurrent or retrospective formal entry in the Integrated Progress Notes (or another part of the medical record) explaining the 'consultation' and care plan.
  The care plan may be to:
  - Request input from the Acute Pain Service team
  - Delay discharge date
  - Delay planned date of disconnection of PCIA catheter
- Acute Pain Service, after having undertaken planned/routine establishment and optimisation of analgesia, documenting postoperative pain requiring delay in planned disconnection date of PCIA catheter.
- Admission to hospital specifically for postoperative pain i.e., pain is the principal diagnosis. For example, admission for prosthesis replacement due to pain.

13th Edition
ACS 1904 is currently being revised for Thirteenth Edition. IHACPA have provided the following advice during the Thirteenth Edition development process, noting that ACS 1904 revision is yet to be finalised:

- *Routine postoperative care is defined as: the management of a patient after surgery…The goal of postoperative care is to prevent complications such as infection, ensure adequate pain management, promote healing of the surgical incision, and return the patient to a state of health….Particularly in the early postoperative period, there may be rapid changes in physiology and pathology. Recognition and management of these changes by trained and skilled staff is required until a patient's physiological variables are stable, allowing discharge to the ward or discharge from the facility. For example, routine postoperative care may include: prescribing and administering analgesic medication (e.g. for operative site pain).*
- *It is not the role of the ACS to provide extensive lists or local clinical practice context for all users, guidance must be provided within the health service providing the care.*
- *Do not assign a code for a condition that results in routine intraoperative/postoperative care alone (i.e. where the condition itself does not require additional or escalated care from the treating team). Some conditions that develop postoperatively (e.g. pain,*

swelling, wound ooze, erythema) are natural or expected consequences or events following a procedure and are managed by routine intraoperative/postoperative care.

Abstraction and coding of query example
The nurse's Integrated Progress Notes entry states that the patient was reviewed on the ward by the Orthopaedic consultant, however there is no documentation by the clinician of this review i.e. for classification purposes, it does not equate to a 'consultation' that was potentially 'significantly beyond routine'.

Two telephone calls subsequently occurred from the nurse to the Anaesthetist. WACCA interpret these telephone discussions most likely constitute routine postoperative care for the following reasons:

- There is no corresponding formal retrospective documentation by the Anaesthetist when they next have access to the medical record.
- The ward round documentation the following morning did not indicate that care significantly beyond routine had occurred.

A local discussion with nursing and clinical teams would be beneficial to determine the significance of phone calls such as those that occurred in this query example, and about general postoperative communication and prescribing processes at your hospital.

A key question to ask: if the Anaesthetist had been present on the ward, would their ordered change from Fentanyl to Morphine have resulted in:

- A) the clinician documenting a formal entry in the medical record evidencing a 'consultation';
  or
- B) the clinician updating the Prescription Chart?

A) **potentially** equates to *Increased clinical care* (dependent on the content of the documentation generated by the Anaesthetist). Therefore, assignment of T81.83 *Pain following a procedure, not elsewhere classified* may be appropriate, depending on the Anaesthetist's documentation.

B) equates to routine care, therefore assignment of a code for the pain occurring in the postoperative period, is not appropriate. The method of discussion between clinical teams (phone or in person) is irrelevant.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023069
QUERY TITLE	**Wiedemann-Steiner Syndrome**
QUERY SPECIALTY	CONG – Congenital malformations, deformations and chromosomal abnormalities
DATE QUERY RECEIVED	27/09/2023
DATE QUERY RESPONDED TO	13/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify Wiedemann-Steiner Syndrome (WSS)?

RESPONSE

Clinical background

The Orphanet rare diseases nomenclature definition for Wiedemann-Steiner Syndrome is:

> *A rare, genetic multiple congenital anomalies/dysmorphic syndrome characterized by short stature, hypertrichosis (most commonly of the back or elbow regions), facial dysmorphism, behavioural problems, developmental delay and, most commonly, mild to moderate intellectual disability.*

A synonym for WSS is:
Hypertrichosis-short stature-facial dysmorphism-developmental delay syndrome.
See also the National Organisation for Rare Disorders:
https://rarediseases.org/rare-diseases/wiedemann-steiner-syndrome/

Classification
Orphanet classifies WSS to ICD-10 code Q87.1 *Congenital malformation syndromes predominantly associated with short stature*.

ICD-10-AM has category Q87.1 *Congenital malformation syndromes predominantly associated with short stature* but does not have a unique (specific) fifth digit code for WSS syndrome.

Therefore, for WSS assign as a best fit, Q87.19 *Other specified congenital malformation syndromes predominantly associated with short stature* by:

1. Following Index pathway:

   Short, shortening, shortness
   -stature NEC E34.3 → E34.3 *Short stature, not elsewhere classified*

2. Then following the Tabular List Excludes note at E34.3:

   Excludes short stature: in congenital malformation syndromes (Q87.1-)

3. Then following the Tabular List to category:

   Q87.1 *Congenital malformation syndromes predominantly associated with short stature*

4. Then selecting:

   Q87.19 *Other specified congenital malformation syndromes predominantly associated with short stature*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. It was submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) on 29 February 2024.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0159
QUERY TITLE	**Clarification of TN1601 Twelfth Edition FAQ: Personal history of coronavirus disease 2019, and use of nursing documentation for current and past COVID-19**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	22/09/2023
IHACPA QUERY ID NUMBER	Q3901
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

WACCA request IHACPA's assistance to clarify TN1601 *Twelfth Edition FAQ: Personal history of coronavirus disease 2019* regarding the use of hospital pre-admission forms and COVID/Infectious screening forms for abstraction and code assignment of current or past COVID infection (see attached examples of forms).

TN1601 reinforces concepts of ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* in relation to components of health risk screening (assessment) tools not being considered diagnoses for classification purposes.

However, TN1601 then goes on to state that personal history of COVID-19, confirmed by documentation from a treating clinician within the episode of care, such as part of patient history, is assigned U07.3 *Personal history of coronavirus disease 2019 [COVID-19]*.

Hospital pre-admission forms and COVID/Infectious screening forms are usually completed by nurses and form part of documentation within the episode of care.

WACCA do not interpret these forms to be “health risk tools” such as Malnutrition Universal Screening Tool (MUST), Alcohol Withdrawal Scale (AWS) or Fagerstrom Nicotine Dependence Scale which contain values or scores precluded from being used in isolation to inform code assignment.

Like tobacco use status, documentation of a personal history of COVID-19 is most commonly found on pre-admission forms. This information is generally not transcribed into the progress notes unless it is deemed relevant by a clinician to the condition being treated; or medical progress notes may not be generated for same-day intervention episodes where the clinician only generates an operation report.

For example, a patient admitted for a same-day surgical procedure is likely to only have their personal history of COVID status documented in a pre-admission screening form or a COVID/Infectious screening form. If such forms are unable to be used for abstraction, a large volume of admitted episodes will not capture history of COVID.

Could IHACPA please clarify whether ACS 0010 *Clinical documentation and general abstraction guidelines/Test results and medication charts* is applicable to pre-admission forms and COVID/Infectious screening forms?

Should documentation completed by a nurse and contained within a pre-admission form or COVID/Infectious screening form, indicating current or past COVID-19, be coded?

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023068
QUERY TITLE	**Wrong intraocular lens inserted requiring return to theatre for lens exchange**
QUERY SPECIALTY	INPO – Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	07/02/2023
DATE QUERY RESPONDED TO	15/09/2023
IHACPA QUERY ID NUMBER	Q3856
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

We have received a query relating to insertion of an incorrect device (intraocular lens) requiring return to theatre for replacement of the lens with the correct one. The response provided by us was to assign procedure codes for the replacement of the device, but that no diagnosis code(s) should be assigned because as there was “no injury or harm caused” the criteria for an unintentional event in ACS 1904 *Procedural complications* were not met.

We wish to confirm if this advice is correct, as performance of an incorrect procedure requiring an otherwise unnecessary return to theatre could be considered harm.

Question
Could you please advise if the following scenario meets the criteria of the Procedural complication/unintentional event?

Patient admitted for cataract surgery and had phacoemulsification of crystalline lens with insertion of intraocular lens performed. It was discovered en route to recovery (i.e., still in surgical suite) that the incorrect (power) lens had been implanted. Patient was taken back to theatre for intraocular lens exchange.

There was no documented injury or harm to patient. Patient discharged same day as planned.

As per ACS 1904 *Procedural complications/Unintentional event(s)* an unintentional event (previously termed misadventure) is defined as injury or harm caused during medical or surgical care. If it is advised this needs to be captured as a complication or misadventure, can we also be advised of the correct code selection.

Response
As was stated in the query, ACS 1904 *Procedural complications* defines an unintentional event as "injury or harm caused during medical or surgical care". We advise that the scenario provided does not meet the criteria in ACS 1904 *Procedural complications* to code as an unintentional event as there was no injury or harm caused.

A code can be assigned for the procedure requiring the return to theatre; however, a diagnosis code cannot be assigned for insertion of the wrong lens.

IHACPA RESPONSE

Thank you for your query submission. Please find the response to your query below.

Re: Q3856

ACS 1904 *Procedural complications/Unintentional event(s)* states:

> *An unintentional event (previously termed misadventure) is defined as injury or harm caused during medical or surgical care.*

To classify an unintentional event, the injury or harm must be a condition classifiable in accordance with ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

The primary reporting mechanism for clinical incidents or events is not through the national morbidity data collection. Clinical incidents should be identified and managed by health service organisations via an organisation-wide incident management and investigation system (Australian Commission on Safety and Quality in Health Care 2023).

IHACPA agrees with CCAQ's interpretation that the scenario provided does not meet the criteria in ACS 1904 *Procedural complications* to code as an unintentional event as there was no injury or harm caused. IHACPA also agrees that an ACHI code for the procedure requiring return to theatre should be assigned but no diagnosis code for insertion of the wrong lens.

As noted, IHACPA is currently progressing an update to the Australian Coding Standards and the classification of procedural complications, including conditions that result from unintentional events, for implementation in Thirteenth Edition.

As this advice follows published guidelines, it will not be published.

References:

Australian Commission on Safety and Quality in Health Care 2023, The National Safety and Quality Health Service (NSQHS) Standards: Clinical Governance Standard: Patient safety and quality systems, viewed 7 September 2023, https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-111.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023067
QUERY TITLE	**Perinephric haematoma due to a kidney transplant procedure**
QUERY SPECIALTY	INPO – Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	09/06/2022
DATE QUERY RESPONDED TO	15/09/2023
IHACPA QUERY ID NUMBER	Q3798
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

Can you please confirm the correct procedural complication code to assign for a perinephric haematoma due to a kidney transplant?

Should T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* be assigned, following the ICD-10-AM index **Complication(s)**/postprocedural/haemorrhage or haematoma NEC?

Or is a transplant considered synonymous with a graft, making T83.81 *Haemorrhage and haematoma following insertion of genitourinary prosthetic devices, implants and grafts* more appropriate, via the index **Complication**/genitourinary NEC/device, implant or graft/ haemorrhage (bleeding) or **Haemorrhage, haemorrhagic**/due to or associated with/device, implant or graft NEC/urinary?

Question
Can you confirm the correct complication and external cause codes to assign for a perinephric haematoma due to a kidney transplant procedure?

Pt admitted for a kidney transplant for end stage renal failure due to polycystic kidney disease. Postoperatively there was a haemoglobin drop and an ultrasound showed a 10cm haematoma around the left kidney transplant. Pt was taken back to theatre where they found bleeding from the arterial anastomosis. The haematoma was evacuated, and the anastomosis was oversewn.

Response

For the scenario provided (perinephric haematoma due to a kidney transplant procedure) we advise to assign the following complication and external cause codes:

T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified*

Y83.02 *Kidney transplant as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure*

Y92.24 *Health service area, this facility*

Note: We also considered T83.81 *Haemorrhage and haematoma following insertion of genitourinary prosthetic devices, implants and grafts* and T86.89 *Other complications of transplanted organs and tissues, not elsewhere classified* as alternative codes to assign. However were more in favour of T81.0 as it sufficiently described the complication, and the addition of external cause code Y83.02 *Kidney transplant as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure* provided specificity of the cause.

IHACPA RESPONSE

Thank you for your query submission. Please find the response to your query below.

Re: Q3798

The Tenth Edition review of ACS 1904 *Procedural complications* was developed in consultation with the International Classification of Diseases (ICD) Technical Group (ITG) with expanded classification guidelines to reflect updated clinical information and to support the major expansion of ICD-10-AM codes enhancing the classification of procedural complications.

However, it is evident from jurisdictional feedback and coding queries that there is continuing uncertainty regarding some aspects of code assignment for procedural complications.

In response to your query submission IHACPA analysed code assignment in the data. This analysis demonstrated issues of inconsistency in classifying haematoma as a complication from transplanted organs.

IHACPA agrees with CCAQ interpretation to assign T81.0 *Haemorrhage and haematoma complicating a procedure, not elsewhere classified* with external cause code Y83.02 *Kidney transplant as the cause of abnormal reaction, or of later complication, without mention of unintentional events at the time of the procedure* to provide specificity of the kidney transplant.

However, given current coding practice appears to be inconsistent and IHACPA is currently progressing an addenda proposal to review the classification of procedural complications, including complications (other than failure and rejection) from transplanted organs for implementation in Thirteenth Edition, national classification advice will not be introduced for the remainder of Twelfth Edition. Rather, it will be held over for implementation in Thirteenth Edition to ensure consistency from 1 July 2025.

You may wish to issue local advice in the interim or once the direction of the Thirteenth Edition development task becomes apparent.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023066
QUERY TITLE	**Performance of inappropriate operation**
QUERY SPECIALTY	INPO – Injury, poisoning and certain other consequences of external causes
DATE QUERY RECEIVED	07/05/2021
DATE QUERY RESPONDED TO	15/09/2023
IHACPA QUERY ID NUMBER	Q3710
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

The query sought advice on what codes should be assigned for performance of inappropriate operation in the following scenario.

Elective L3/4 Discectomy & Laminectomy for L3/4 disc herniation. Post-operatively, patient had weakness in right leg. An urgent MRI was ordered showing an epidural haematoma, but in addition it was identified that the operation was “performed at the wrong level”. Clinician notes “level check done intraoperatively & it was deemed correct level. On reviewing the saved shots, I can see it is the level above. This is the issue with monitors in OT not being as clear as seeing it on PACs subsequently”.

XXXX members agreed & as per VIC advice 3212 – cannot code the inappropriate operation so therefore to send the query to ACE for advice on how to code an inappropriate operation where there is no harm to the patient, no complication of the surgery but the patient does require further surgery in the future on the correct level.

IHACPA RESPONSE

Thank you for your query submission. Please find the response to your query below.

Re: Q3710

ACS 1904 *Procedural complications/Unintentional event(s)* states:

> *An unintentional event (previously termed misadventure) is defined as injury or harm caused during medical or surgical care.*

To classify an unintentional event, the injury or harm must be a condition classifiable in accordance with ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

The primary reporting mechanism for clinical incidents or events is not through the national morbidity data collection. Clinical incidents should be identified and managed by health service organisations via an organisation-wide incident management and investigation system (Australian Commission on Safety and Quality in Health Care 2023).

IHACPA agrees with CCAQ's interpretation that the scenario provided does not meet the criteria in ACS 1904 *Procedural complications* to code as an unintentional event as there was no injury or harm caused.

As you would be aware, IHACPA is currently progressing an update to the Australian Coding Standards and the classification of procedural complications, including conditions that result from unintentional events, for implementation in Thirteenth Edition.

As this advice follows published guidelines, it will not be published.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023065
QUERY TITLE	**Is 'clinically dry' synonymous with dehydration?**
QUERY SPECIALTY	ENMD – Endocrine, nutritional and metabolic diseases
DATE QUERY RECEIVED	19/09/2023
DATE QUERY RESPONDED TO	27/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Is 'clinically dry' or 'dry' synonymous with dehydration?

Example
Integrated progress notes
Probable clostridium difficile
Diarrhoea, clinically dry, ?secretory diarrhoea, ?clostridium difficile
Plan:
-One litre intravenous hydration then encourage per oral fluids
-Diet as tolerated – bland
-Chase stool. If clostridium difficile negative cease Vancomycin
-Known aortic stenosis, keep towards euvolaemia

RESPONSE

This query was discussed by the WA Clinical Coding Technical Advisory Group (TAG).

The query and response has been published as WA Coding Rule 0424/01 *Is 'clinically dry' synonymous with dehydration* (effective 1 Apr – current). See the WA Clinical Coding Authority website for this Rule.

The Rule will be submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023064
QUERY TITLE	**Condition Onset Flags (COF) for conditions occurring in ED – Aspiration pneumonia due to difficult intubation**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	19/09/2023
DATE QUERY RESPONDED TO	25/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

For this scenario, do you assign Condition Onset Flag (COF) 1 or 2, for aspiration pneumonia due to difficult intubation?

Scenario:
Discharge summary
Complications: Aspiration pneumonia due to difficult intubation.

14/10 1700 Patient presents to Emergency Department (ED).
14/10 1750 Patient intubated in ED, prior to admission.
14/10 1830 Admission time.
14/10 1840 X-ray chest for Endotracheal tube (ETT) position/?Aspiration returns: satisfactory ETT position and small volume bilateral lower lobe atelectasis.
14/10 2200 Medical Officer: ‘Tazocin for aspiration.’
15/10 1035 Medical Officer: ‘Aspiration pneumonia.’

RESPONSE

Classification

As per ACS 1924 *Difficult intubation*, documentation of 'difficult intubation' accompanied by Grade 2 or higher Cormack-Lehane or Mallampati score, is assigned:

T88.42	*Difficult intubation*
Y84.8	*Other medical procedures as the cause of abnormal reaction …*
Y92.24	*Place of occurrence, health service area, this facility*
U73.8	*Other specified activity*
	(as per WA Coding Rule 0919/01 *Activity (J50-U73) codes*)

Aspiration pneumonia is assigned J69.0 *Pneumonitis due to food and vomit* following Index pathway: **Pneumonia**, -aspiration.

As per ACS 0048 *Condition onset flag*, assign COF:

- '1' for conditions arising during the admission that are not present or suspected on admission.
- '2' for conditions present or suspected on admission.
- '2' for conditions, when it's difficult to tell if they were present or suspected on admission or arose during the admission.

For the scenario cited:

- COF '2' applies to the difficult intubation because it existed on admission - it occurred prior to admission. Therefore, assign COF '2' to T88.42, Y84.8, Y92.24 and U73.8.
- COF '2' applies to the aspiration pneumonia because it's difficult to tell if it was present on admission or arose during the admission. Whilst aspiration during (difficult) intubation occurred prior to admission, it's unclear if the aspiration pneumonia was present on admission or arose during the admission. Therefore, assign COF '2' to J69.0.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023063
QUERY TITLE	**Principal diagnoses for patients with COVID-19**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	07/09/2023
DATE QUERY RESPONDED TO	20/12/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What do you sequence as the principal diagnosis when patients are admitted with:

- a significant/severe symptom of COVID-19?
- a manifestation of COVID-19?
- an existing condition exacerbated by COVID-19?

It's challenging for coders to determine when they're faced with:

- clinicians regularly documenting 'COVID-19' (or similar) as the principal diagnosis
- 12th Edition permitting assignment of U07.1- / U07.2 *Coronavirus disease 2019 [COVID-19]* as principal diagnosis
- a variety of national and state coding instructions for COVID-19

Here's some examples for context:

Example 1
Significant/severe symptom of COVID-19 (wheeze)

DISCHARGE SUMMARY
Principal diagnosis: Viral induced wheeze. Principal diagnosis comments: COVID-19 positive
Presenting history:
GP transfer for observation/treatment of wheeze with increased work of breathing
Pyrexia, coryzal symptoms, cough, mild increased work of breathing with accessory muscle use
COVID-19 positive RAT in ED
Family history of asthma
Management: admitted for observation, Salbutamol, asthma action plan

Example 2
Manifestation of COVID-19 (croup)

DISCHARGE SUMMARY
Principal diagnosis: Acute COVID-19
Comorbidities: Croup
Presenting history: 1 year old with COVID +ve Croup, 3 days of cough, coryza, increased work of breathing, biphasic stridor, oxygen saturations 85%
Treatment:

ICU for observation
Dexamethasone and nebulised Adrenaline
Oxygen (via mask and nasal prongs) to maintain saturations above 92%

INTEGRATED PROGRESS NOTES
COVID positive croup
COVID positive RAT in ED
Biofire positive for COVID

Example 3
Existing condition exacerbated by COVID-19 (asthma)

DISCHARGE SUMMARY
Principal diagnosis: COVID-19
Presenting history:

COVID-19 - viral exacerbation of asthma
No oxygen requirement
Treatment: Salbutamol, Atrovent, Dexamethasone, asthma action plan and education

EMERGENCY DEPARTMENT DOCUMENTATION
Past medical history: asthma triggered by viral infections, on monthly Symbicort
Rapid antigen test at home positive for COVID-19
GP prescribed Salbutamol five days ago, 2 puffs every 2 hours therefore presented to ED
Impression: Mild-moderate asthma exacerbation secondary to COVID infection
Plan: admit for acute asthma protocol, Dexamethasone stat, (weaning) stretching Salbutamol, asthma action plan and education

Example 4
Manifestation of COVID-19 (delirium) and
Existing condition exacerbated by COVID-19 (heart failure)

DISCHARGE SUMMARY
Principal diagnosis: COVID-19
Complications: Delirium, Heart Failure
Management:

1. COVID-19: Treated with Paxlovid. No oxygen requirement
2. Delirium secondary to COVID-19 infection. Medications rationalised. Well orientated by discharge
3. Exacerbation of heart failure secondary to COVID-19 infection

RESPONSE

Please find a summary of the applicable classification instructions:

1. For COVID-19 presentations, the principal diagnosis is determined according to ACS 0001 *Principal diagnosis:*

ACS 0113 *Coronavirus disease* 2019 ▪ Symptoms of COVID-19 are only assigned in accordance with ACS 0001 and ACS 0002.
TN1601 *Twelfth Edition FAQ: Symptomatic versus asymptomatic coronavirus disease 2019* ▪ The principal diagnosis should be determined according to ACS 0001 *Principal diagnosis*. ▪ Assign a diagnosis code for a manifestation of COVID-19 from chapters other than Chapter 18 when it meets the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnosis*. (IHACPA Coding Rule, 1 Oct 2022 – current)
Q3844 *Manifestations of COVID-19* ▪ A COVID-19 code may be assigned as principal diagnosis, but sequencing should be based on the circumstances of admission. (IHACPA coding query response, WACCA query ID number J2023039, 1 Jul 2023)

2. ACS 0001 *Principal diagnosis* states:

   ▪ the principal diagnosis is the diagnosis established after study to be chiefly responsible for occasioning the admission
   ▪ the circumstances of admission govern principal diagnosis selection

3. ACS 0010 *Clinical documentation and general abstraction guidelines* supports application of ACS 0001 by specifying:

   ▪ the clinician must document the principal diagnosis on the discharge summary
   ▪ the coder must verify diagnoses documented on the discharge summary with documentation in the body of the episode, before assigning codes for diagnoses
   ▪ clinicians may be queried, where documentation, for coding purposes, is conflicting

To follow the above classification instructions (listed at points 1-3), the principal diagnosis documented by the clinician must be coded and sequenced as the principal diagnosis. See also WACCA's coding query submission to IHACPA: IHACPA0148 *Changing the principal diagnosis* (see published WACCA coding queries).

But, if the principal diagnosis nominated by the clinician, conflicts with documentation in the body of the episode (because it doesn't meet the ACS 0001 principal diagnosis definition), then the clinician should be queried prior to code assignment and sequencing.

So, if:

- the principal diagnosis documented by the clinician is 'COVID-19' (or similar)

  and

- it conflicts with documentation in the body of the admission which demonstrates:

  - a significant/severe symptom of COVID-19 **or**
  - manifestation of COVID-19 **or**
  - existing condition exacerbated by COVID-19

  was responsible for occasioning the admission,

the clinician should be queried prior to code assignment and sequencing.

Clinicians may be unaware of the effect of principal diagnosis documentation on coding/grouping of COVID-19 admissions, so health services are encouraged to engage in clinical documentation improvement activities for these admissions.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

This query and response will be discussed by the Western Australian Clinical Coding Technical Advisory Group in March 2024 because WACCA recognises there are currently, differing practices for principal diagnosis selection for COVID-19 admissions.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023062
QUERY TITLE	**Pascal technique for autologous augmentation of buttocks and body lift**
QUERY SPECIALTY	SKSC – Diseases of the skin and subcutaneous tissue
DATE QUERY RECEIVED	06/09/2023
DATE QUERY RESPONDED TO	27/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What ACHI code/s do you assign for autologous augmentation of buttocks by Pascal technique?

Example operation report 1
Procedure title: Circumferential body lift
Procedure:
Prone:
Liposuction to lateral thighs and flanks.
Pascal technique for auto-augmentation of buttocks.
Supine:
Liposuction to anterior thighs, mons pubis and entire abdomen.
High superior tension abdominoplasty with rectus plication.
Scar from midline excised and reclosed.

The surgeon for this operation was asked to describe the procedural components of 'Pascal technique for auto-augmentation of buttocks,' to which they replied: 'it's 'part of a standard body lift.'

Example operation report 2
Procedure title: Posterior body lift for localised adiposity
Procedure:
Prone:
Posterior body lift.
Liposuction to lower back.
Auto-augmentation Pascal to buttocks.

Supine:
Excise 2x dog ears.
Liposuction to mons pubis.

RESPONSE

Clinical information
See these websites for information on auto-augmentation/lift of buttocks.

1.
Dr Jean-Francois Pascal's website:
https://www.docteur-pascal.com/en/body-contouring-procedures/body-lifts/the-lower-body-lift/buttock-lift

> Excerpt from this website:
> *"…Ageing of the buttocks occurs normally with age and depends on the specific genetics of the individual. Weight variations can accelerate this natural phenomenon...*
>
> *As with the breasts, buttocks that sag become flatter. Dimples and ripples of skin appear at the bottom of the buttock…*
>
> ***Buttock surgery allows excess skin to be removed from the buttocks while lifting them. It is nearly always accompanied by remodelling of the region, particularly refinement of the waist or correction of the thighs by liposuction**…*
>
> *Buttock lifts can be combined with many other procedures.* ***If I perform abdominal surgery at the same time, with a circular scar which incorporates the scar associated with buttock surgery, this operation is called the BODY LIFT (or bodylift).*** *We can also simultaneously perform a thigh lift, an infragluteal lift, lipomodelling, etc…"*

2.
This website contains images of autologous gluteal (buttock) augmentation with dermal-fat rotation flaps:

https://plasticsurgerykey.com/autologous-gluteal-augmentation-with-mid-pedicle-superior-pole-perforator-flaps/

Classification
The Pascal technique for auto-augmentation of buttocks has been confirmed by a surgeon to be part of a body lift. Body lift is a term recognised by the 12th ACHI Index:

Body lift — **see** Lipectomy/by site

Lipectomy
- abdominal (apron) (circumferential) (wedge) 30165-00 **[1666]**
- - radical 30177-00 **[1666]**
- - suction 45584-00 **[1666]**
- arm (circumferential) (wedge)
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**
- buttock (circumferential) (wedge)
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**
- specified site (circumferential) (wedge) NEC
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**
- subumbilical — see Lipectomy/abdominal
- thigh (circumferential) (wedge)
- - 1 excision 30168-00 **[1666]**
- - 2 excisions 30171-00 **[1666]**
- - suction 45584-00 **[1666]**

For operation reports 1 and 2, assign ACHI codes for:

- Liposuction in accordance with ACS 0020 *Bilateral/multiple procedures*/Point 4: Assign codes more than once to classify different anatomical sites.
- Abdominoplasty
- Scar excision(s)
- Buttock lift
    - For Pascal technique (for auto-augmentation of buttocks) assign a code following ACHI Index pathway:

        Body lift — see **Lipectomy/by site**

        Lipectomy

        - buttock (circumferential) (wedge)
        - - 1 excision 30168-00 [1666]
        - - 2 excisions 30171-00 [1666]
        - - suction 45584-00 [1666]

For operation reports 1 and 2, the number of excisions is not documented, therefore clinician clarification is required, and if unavailable then default to coding 1 excision

(as per A*CS 0038 Procedures distinguished on the basis of size, time, number of lesions or sites)*.

Further actions

We suspect a buttock lift by Pascal technique for auto-augmentation may be more extensive than a lipectomy (e.g., it may entail dermal-fat flaps). A code for lipectomy may not capture this detail adequately, hence, we will forward a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023061
QUERY TITLE	**Same-day intravenous Bevacizumab for Hereditary Haemorrhagic Telangiectasia**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
DATE QUERY RECEIVED	05/09/2023
DATE QUERY RESPONDED TO	02/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Which ACHI code is assigned for intravenous Bevacizumab (an antineoplastic agent) administered in a same-day episode for Hereditary Haemorrhagic Telangiectasia?

RESPONSE

Classification

The two-digit extension *-00 antineoplastic agent* in Block 1920 is only assigned in the treatment or prophylaxis of a **neoplasm** as per the Instructional note in the ACHI Tabular List:

> *Note:* This extension is assigned for any agent classified to block [1920] that is administered for a neoplasm, for purposes of treatment or prophylaxis.

i.e., the two-digit extension *-00 antineoplastic agent* is selected based on the **condition** being treated, not the type of **agent** administered. See ACS 0206 *Pharmacotherapy for neoplasms.*

Assign 96199-19 *Intravenous administration of pharmacological agent, other and unspecified pharmacological agent* for intravenous Bevacizumab for hereditary haemorrhagic telangiectasia.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023060
QUERY TITLE	**Documentation for Supplementary (U) codes for chronic conditions**
QUERY SPECIALTY	ASCD – General standards for diseases
DATE QUERY RECEIVED	03/07/2023
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Which documentation can coders abstract from, to assign supplementary (U) codes for chronic conditions?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023059
QUERY TITLE	**Cerebral infarction with haemorrhagic transformation**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
DATE QUERY RECEIVED	04/09/2023
DATE QUERY RESPONDED TO	02/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Q3233 *Cerebral infarction with haemorrhagic transformation* was retired 30 June 2019 (when 11th Edition was implemented).

Is the logic contained in Q3233, to code both infarction and haemorrhage, still current?

RESPONSE

Classification

WACCA interpret that Q3233 was retired because it is based on existing classification guidelines (*Conventions used in the ICD-10-AM Tabular List of Diseases/Multiple condition coding*) and the rule was deemed unnecessary.

3M Codefinder still contains the following pathway:

-- INFAR

-- Infarct, infarction (of)

-- Cerebral

-- Unspecified

-- No manifestation or not listed

-- Haemorrhagic transformation (with cerebral infarction)

-- Unspecified

-- No manifestation or not listed

-- No conditions, or already coded

-- No procedure performed or already coded

→ assigns a separate code for infarction (I63) and haemorrhage (I61).

The logic in the rule is still current, despite it being retired. Therefore, in the absence of a precoordinated code for cerebral infarction with haemorrhagic transformation, assign codes from categories I63 *Cerebral infarction* and I61 *Intracerebral haemorrhage* as per *Conventions used in the ICD-10-AM Tabular List of Diseases/Multiple condition coding.*

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023058
QUERY TITLE	**Viral-induced wheeze with multiple viruses including COVID**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	23/08/2023
DATE QUERY RESPONDED TO	27/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code viral induced wheeze due to multiple viruses, including laboratory confirmed COVID-19, respiratory syncytial virus (RSV), rhinovirus and enterovirus?

RESPONSE

As per IHACPA Coding Rule Q3235 *Viral induced wheeze* (1 Jan 2017 - current), viral induced wheeze is assigned R06.2 *Wheezing* and a code(s) for the virus.

For viral induced wheeze due to laboratory confirmed COVID-19, RSV, rhinovirus and enterovirus assign:

R06.2 *Wheezing*

Plus
U07.12 *Coronavirus disease 2019 [COVID-19], virus identified, symptomatic*

Plus
B97.4 *Respiratory syncytial virus as the cause of diseases classified to other chapters*

Plus
B97.81 *Rhinovirus as the cause of diseases classified to other chapters*

Plus
B97.1 *Enterovirus as the cause of diseases classified to other chapters*

Note, IHACPA coding query response Q3802 *Viral-induced wheeze due to COVID-19* (WACCA query ID number J2023040, 01/07/2023) is consistent with IHACPA Coding Rule Q3235 as it also instructs:

1. Assign a code for COVID-19 (***virus***)
2. Assign code for symptoms (***wheeze***) in line with ACS 0113 *Coronavirus disease 2019 (COVID-19)*, ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnosis*.

IHACPA coding query response Q3802 does not however, provide sequencing instruction and **cautions coders against indiscriminate coding of COVID-19 symptoms** (e.g., fever, cough, lethargy) as additional diagnoses by referring to IHACPA Coding Rule TN1601 *Twelfth Edition FAQ: Symptomatic versus asymptomatic coronavirus disease 2019* (1 Oct 2023 – current).

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023057
QUERY TITLE	**Cerebral hypoperfusion**
QUERY SPECIALTY	NERV – Diseases of the nervous system
DATE QUERY RECEIVED	14/08/2023
DATE QUERY RESPONDED TO	15/11/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you code cerebral hypoperfusion?

RESPONSE

Clinical information

Cerebral hypoperfusion:

- Is reduced blood flow to the brain.
- May be acute or chronic, focal, or global.
- Can vary from very mild to severe, leading to stroke.
- May result in transient or permanent effects.
- May be a feature of other conditions such as vascular dementia or orthostatic hypotension.

Classification

Before assigning any code, ensure cerebral hypoperfusion meets ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* criteria for coding.

Cerebral hypoperfusion is not Indexed in ICD-10-AM, however, synonyms cerebral ischaemia and cerebrovascular insufficiency are:

Ischaemia, ischaemic I99
- cerebral (chronic) (generalised) I67.8
- - arteriosclerotic I67.2
- - in pregnancy, childbirth or puerperium O99.4
- - intermittent G45.9
- - newborn P91.0
- - old I69.-
- - - without residual deficits Z86.71

- - recurrent focal G45.8
- - transient G45.9
- - - history Z86.61

Insufficiency, insufficient
- cerebrovascular (acute) I67.8
- - with transient focal neurological signs and symptoms G45.8

Where cerebral hypoperfusion is documented, seek further specificity before classifying it. You may need to liaise with your clinicians and/or clinical documentation improvement specialists to gain further specificity. Here's an example of a clinical documentation query letter (based on the context example) that may guide you:

Dear Treating Clinician

The term "cerebral hypoperfusion" is not specifically recognised in the ICD-10-AM classification, so we require your assistance to classify this concept.

Noting this patient had documented transient neurological symptoms (dizziness, slurred speech, facial droop, left sided weakness, headache), are you able to indicate (via ticking) if this patient's presentation of cerebral hypoperfusion is synonymous with one of these ICD-10-AM concepts?

☐ Ischaemia, cerebral, transient
☐ Ischaemia, cerebral, recurrent focal
☐ Ischaemia, cerebral, intermittent
☐ Insufficiency/insufficient, cerebrovascular, with transient focal neurological symptoms
☐ Unable to determine

If multiple concepts apply, please tick which **most** describes the patient's presentation of cerebral hypoperfusion.

Where further specificity cannot be obtained, assign I67.8 *Other specified cerebrovascular diseases.*

Further actions
During preparation for this response, it was noted that there's overlap in the Alphabetic Index for the terms 'transient', 'recurrent focal', and 'with transient focal neurological signs and symptoms' under lead terms 'Ischaemia' and 'Insufficiency,' so clarification from IHACPA will be sought.

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged

Care Pricing Authority (IHACPA). A public submission will also be made to IHACPA, for consideration of including cerebral hypoperfusion as a concept in the Alphabetic Index.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023056
QUERY TITLE	**Excision of osteophytes**
QUERY SPECIALTY	MSCT - Diseases of the musculoskeletal system and connective tissue
DATE QUERY RECEIVED	14/08/2023
ATE QUERY RESPONDED TO	23/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Should a diagnosis and procedure code be assigned for osteophyte and its excision, when performed as part of orthopaedic interventions such as joint arthroplasty or spinal fusion?

If osteophyte excision is considered inherent in an orthopaedic ACHI code, should a diagnosis code still be assigned to show that osteophyte has met ACS 0002 *Additional diagnoses*?

Operation report one
Pre-operative diagnosis: knee OA
Operation: A medial parapatellar approach was used. The knee joint was exposed. The patella fat pad was removed. Osteophytes were removed. Tibial and femoral surfaces were cut using a gap balancing method. The tibial and femoral components were trialled. Following trialling the following components were inserted:
Tibia size – 5 cemented GMK Sphere
Femur size – 6 cemented
Polyethylene liner – 10mm
The patella was denervated, and patella tracking was good. A full range of movement was achieved. The wound was closed in layers. Local anaesthetic infiltration was employed. Skin was closed with Monocryl.

Operation report 2
Diagnosis: C4/5 stenosis
Procedure: R neck skin crease incision and platysma undermined. Routine approach medial to carotid sheath to prevertebral region. C4/5 level confirmed with fluoro. Complete C4/5 discectomy down to PLL *(posterior longitudinal ligament)* and

disc space distracted. Anterior osteophyte rongeured off. Uncovertebral joint and ?posterolat [illegible] osteophyte drilled off; PLL opened and complete thecal sac and bilateral C5 decompression. End plates prepared with curettes/drill. Interbody fusion with size 6 JASPIS ST packed with BOOST. C4/5 anterior fixation with OZARK plate x 4 screws. Kenacort 10 over C5 nerve and oesophagus. Closure 2.0 PDO/3.0 Monocryl.
MBS item numbers
51011
51021
51041
18216

Operation report 3
Diagnosis: Severe right C6/7 foraminal stenosis with a superimposed foraminal disc prolapse
Procedure: right C6/7 posterior cervical foraminotomy, microdiscectomy
Operation: A midline incision was made and right C6/7 exposure obtained. A generous laminotomy was performed with resection of the medial part of the facet joint complex. The C7 nerve was identified and decompressed in its course. I explored underneath the C7 nerve within the axilla. There was a disc osteophytic complex. I cut into this and obtained several small pieces of soft disc fragments but this was quite a hard lump for most part of it. Nonetheless, the C7 nerve was maximally decompressed posteriorly. Haemostasis was achieved. The wound was then closed in the routine fashion in layers.

Accompanying letters for Operation report 3
Letter 1
Thank you very much for asking me to review for an opinion. I reviewed via Telehealth today. X has now presented with a 4-month history of right sided arm pain which radiates from chest/periscapular region and down the arm along his triceps. The pain has been very severe. Recently, had a CT guided cortisone injection which led to some improvement for about a week. X continues to experience persistent and significant right sided arm pain. The MRI scan of cervical spine shows that he very severe right sided C6/7 foraminal stenosis which is multifactorial, possibly with a superimposed foraminal disc prolapse.

I went through all the imaging findings in detail with and I explained the pros and cons of options of conservative management, pain management with cortisone injections etc. and surgery. X is at a point where feels that symptoms are significant enough to consider surgery. The surgery I would consider would be a right sided C6/7 posterior cervical foraminotomy +/- microdiscectomy. However, I would like to see in person and examine before discussing surgery in greater detail.

Letter 2
X has experienced ongoing right sided arm pain for nearly 5 months now. On examination, has 4/5 weakness of right finger extension and of right triceps. X has a depressed right elbow reflex.

The MRI scan of cervical spine shows severe right C6/7 foraminal stenosis with a superimposed foraminal disc prolapse.

It is reasonable to consider surgery because of the ongoing pain and weakness. X has a short neck and bulky shoulders. A posterior approach is preferable. The surgery option involves a right sided C6/7 posterior cervical foraminotomy +/- microdiscectomy with an estimated 80% chance of improving the pain and 70% chance of improving the weakness. I have explained the goals of surgery and outlined the risks of infection, bleeding, dural tear with CSF leak, nerve root/ neurological injury as well as a chance of recurrence. X has given informed consent to proceed with surgery.

RESPONSE

Clinical information
Osteophytes are cartilage-capped bony proliferations (also known as bone spurs) that most commonly develop at the margins of a synovial joint as a response to the body attempting to repair articular cartilage damage, as seen commonly in degenerative joint disease. Osteophytes have the potential to cause symptoms, particularly spinal osteophytes which can contribute to nerve root compression, foraminal stenosis or canal stenosis.

A surgeon's decision-making regarding osteophyte excision during arthroplasty or spinal surgery is dependent on multiple factors including osteophyte location, size, and impact on soft tissue balancing in arthroplasty.

Osteophyte excision **during arthroplasty** is usually performed to ensure good balance and surgical result, and prevent impingement.

Osteophyte excision **during spinal surgery** may be performed for decompression e.g. decompression of canal stenosis (operation report 2); decompression of foraminal stenosis/spinal nerve roots (operation report 3).

Classification
ACS 0016 *General procedure guidelines* instructs:

> Do not code procedures which are individual components of another procedure. These components would usually be considered a routine or inherent part of the more significant procedure being performed.

Clinical advice (VICC coding query 3851 *Removal of osteophytes*) indicates osteophyte excision is inherent in arthroplasty and spinal surgery.

Therefore, in accordance with the clinical advice and ACS 0016 *General procedure guidelines*, osteophyte excision is considered inherent in arthroplasty or spinal surgery ACHI codes and does not require assignment of its own ACHI code.

An ICD-10-AM diagnosis code should be assigned where there is documentary evidence of osteophyte and its excision, in accordance with ACS 0002 *Additional diagnoses.*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a Public Submission to the Independent Health and Aged Care Pricing Authority (IHACPA) for consideration of appropriateness of creation of Includes notes in the ACHI Tabular List.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023052
QUERY TITLE	**vNOTES Vaginal Natural Orifice Transluminal Endoscopic Surgery**
QUERY SPECIALTY	GEUR – Diseases of the genitourinary system
DATE QUERY RECEIVED	03/08/2023
DATE QUERY RESPONDED TO	24/08/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What ACHI codes should be assigned for vNOTES (Vaginal Natural Orifice Transluminal Endoscopic Surgery) hysterectomy?

RESPONSE

Clinical information

Natural orifice transluminal endoscopic surgery (NOTES) is a surgical technique whereby an endoscope is passed through a natural orifice (mouth, urethra, anus, vagina, etc.) and then through an **internal incision** made inside the orifice, avoiding any **external** incisions or scars.

vNOTES (vaginal natural orifice transluminal endoscopic surgery) is an advanced minimally invasive gynaecologic surgery where the surgeon inserts a vNOTES device into the pelvic cavity through a vaginal incision. The vNOTES device inflates the patient's abdomen with carbon dioxide, giving the surgeon access to the uterus, fallopian tubes, ovaries, and the remainder of the pelvic cavity. The space provided by the device allows the surgeon to both see and operate on the organs inside.

The vNOTES device contains numerous special openings through which the surgeon can insert the long, thin, surgical tools necessary for a hysterectomy procedure. Also, the surgeon employs the use of a specialised, high-definition camera, which can be inserted through the same access points; the camera allows extensive visualisation into the area and allows the utmost precision. Once removal of the uterus is completed, the vNOTES device is removed, and the excess carbon dioxide can escape. It allows complex surgery to be performed without visible external incisions with faster recovery and return to normal activities.

vNOTES: The Newest Non-Invasive Hysterectomy Procedure - AZGyn

vNOTES differs to 'laparoscopic assisted vaginal hysterectomy' whereby endoscopic visualisation is obtained via percutaneous abdominal ports.

Classification
In Twelfth Edition, the following definitions were added to ACS 0023 *Minimally invasive interventions,* and a new code created: 96234-01 [1923] *Percutaneous endoscopic-assisted intervention NEC.*

> **ACS 0023 *Minimally invasive interventions***
>
> Endoscopic approach to an operative site may be:
>
> • **Percutaneous** – access through one or more minor incisions in the skin or subcutaneous layers or **mucous membrane**, allowing passage of endoscopic instruments to visualise an operative site and guide the procedure. This may include thoracoscopy, laparoscopy, arthroscopy, percutaneous nephroscopy or percutaneous endoscopic spinal surgery
>
> • **Transorifice** – access via a natural or artificial opening to reach an operative site. This may include gastroscopy or colonoscopy performed via a natural opening, or cystoscopy performed via a cystostomy (an artificial opening).

Natural orifice endoscopic surgery involves **internal** incision of **mucous membrane** (lining of body orifices or organs), NOT **external percutaneous** incision. The transorifice definition in ACS 0023 fails to clarify that transorifice involves internal mucous membrane incision.

This issue will be referred to IHACPA, seeking confirmation that 96234-01 *Percutaneous endoscopic-assisted intervention NEC* is the correct code assignment for transorifice endoscopic approach as per ACS 0023 transorifice Example 4, and the Tabular List Note at 96234-01.

> ***Note:***
> Percutaneous endoscopic approach involves access through one or more minor incisions in the skin and subcutaneous layers or mucous membrane, allowing passage of endoscopic instruments to visualise the operative site and guide the procedure.

EXAMPLE 4:
Hemithyroidectomy via transoral endoscopic vestibular approach (TOEVA).
Procedure sequenced first: 30306-01 **[114]** *Total thyroid lobectomy, unilateral*
Associated procedure: 96234-01 **[1923]** Percutaneous endoscopic-assisted intervention, not elsewhere classified

In Tenth Edition, the following ACHI codes were created to classify Robotic Assisted Technology.

- 96233-00 **[1923]** *Robotic-assisted intervention*
- 96234-00 **[1923]** *Technology-assisted intervention, not elsewhere classified*

96234-00 was created for classification of robotic technology that could not be classified to 96233-00. The ITG feedback process questioned what type of intervention would be classified to 96234-00, however clarification was not forthcoming. While awaiting IHACPA clarification, do not assign 96234-00 *Technology-assisted intervention, not elsewhere classified* for natural orifice transluminal endoscopic surgery (NOTES). Apply instead:

- the logic in ACS 0023 Example 4; and
- the 96234-01 Tabular List Note which includes “incision of mucous membrane”.

To summarise, assign 96234-01 *Percutaneous endoscopic-assisted intervention NEC* for **endoscopic minimally invasive surgery**, including:

- Percutaneous endoscopic approach (e.g., endoscopic minimally invasive spinal surgery MISS – as per Example 3)
- Transorifice/mucous membrane endoscopic approach (e.g., vNOTES – as per Example 4).

For vNOTES, assign:
35657-00 *Vaginal hysterectomy*
Any other excision procedure performed e.g., 35717-04 *Salpingo-oopherectomy*
96234-01 *Percutaneous endoscopic-assisted intervention NEC*

This response differs to another jurisdiction’s decision to assign 35750-00 [1269*] Laparoscopic assisted vaginal hysterectomy* for vNOTES. The other jurisdiction has already submitted a query to IHACPA asking how to classify vNOTES, but we will also submit a query covering: 96234-01 versus 96234-00 for vNOTES; conflicting jurisdictional responses; and to advise that 96234-01 is missing an ACHI Alphabetic Index entry.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and proposed as a WA Coding Rule via the Western Australian Clinical Coding Technical Advisory Group process. In addition, a query will be submitted to the Independent Health and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

NOTE

A query on vNOTES was submitted to IHACPA by a state other than Western Australia. IHACPA responded by publishing Coding Rule/NCA Q3702 *Vaginal natural orifice transluminal endoscopic surgery (vNOTES) hysterectomy* (effective 1 Oct 2023).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023051
QUERY TITLE	**Uveitis-glaucoma-hyphema (UGH) syndrome due to iris prosthesis requiring removal**
QUERY SPECIALTY	EYEA – Diseases of the eye and adnexa
DATE QUERY RECEIVED	02/08/2023
DATE QUERY RESPONDED TO	16/08/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Which diagnosis and procedure codes are assigned for uveitis-glaucoma-hyphema (UGH) syndrome caused by iris prosthesis implanted in the sulcus, admitted for removal of prosthesis? The iris prosthesis was originally implanted for dilated pupil due to a complicated cataract operation.

Operation report

Diagnosis: LE iris prosthesis/UGH
Operation: LE iris prosthesis removal
Findings:
2x para
1x temporal clear [illegible] 2.4mm
Poorly dilated iris - phenylephrine
- 4x iris hooks
Prosthesis lifted into AC (found implanted upside down)
Prosthesis cut and removed.
Ant capsular phimosis, small CCC, plate haptic IOL
Provisc removed.
I/C Ceph
Post op instructions: Start drops when home: Chlorsig QID, [illegible], Continue Lumigan BD Xalatan nocte.

Correspondence prior to admission

Letter 1
As you know patient had a complicated cataract operation on left side with

zonular dehiscence but fortunately we were able to salvage the bag and the lens is currently central. Subsequent to the surgery patient developed a mildly dilated pupil for which I implanted an iris prosthetic. However I agree with your assessment that the prosthetic is causing UGH syndrome and that the endothelium is decompensating. I have advised that the prosthetic be removed as it is only implanted in the sulcus with no suturing. I would also appreciate if you would take over corneal care as an endothelial graft may be required in the future. I have advised that once the eye is stable the iris can be sutured at a later stage.

Letter 2
LE complicated phaco/iol May 2021
RE phaco/IOL Sept 2021
LE iris prosthesis Sept 2022
LE corneal decompensation
LE increased IOP ?UGH syndrome

I received correspondence from Dr xx who has requested me to take over care. Main issues are that patient has a sulcus iris prosthesis causing UGH syndrome with pigment on the endothelium and increased IOP (controlled with Combigan and Xalatan). Patient also has corneal endothelial decompensation with reduced vision.

We will need to remove the iris prosthesis and do an endothelial keratoplasty, which would be better in a staged procedure. Firstly I will remove the iris prosthesis. Pupil appears fixed and moderately dilated, so this may require iris hooks to enlarge to remove the iris prosthesis. Once the eye has settled down from this, secondly I will arrange a DSAEK to treat the corneal oedema.

Dr xx indicated that there was zonular dehiscence intra-operatively, so I'm uncertain as to how stable the bag-lens complex is. I have discussed with patient that if it appears unstable when I remove the iris prosthesis then it may require to be scleral fixed prior to an endothelial keratoplasty.

RESPONSE

Clinical information
Uveitis-glaucoma-hyphaema (UGH) syndrome, also known as Ellingson syndrome, is characterised by intraocular inflammation, increased intraocular pressure and hyphaema. It is caused by mechanical irritation of the iris, ciliary body or iridocorneal angle by foreign material, typically a malpositioned intraocular lens implant. It can also be caused by an iris prosthesis.

Clinical documentation abstraction
The manifestations of UGH syndrome documented for this patient include:

- Corneal oedema and decompensation
- Increased intraocular pressure

- Pigment on corneal endothelium

There is also documentation that the prosthesis was “found implanted upside down”. The referral letter infers that the patient’s natural iris was not originally excised at time of iris prosthesis insertion, as the documentation states: “once the eye is stable the iris can be sutured at a later stage”.

The letters indicate the iris prosthesis was implanted in the “sulcus”. This is presumed to be the ciliary sulcus in the posterior chamber. The procedure documented is corneal incision (“temporal clear [illegible]”) with prosthesis lifted into anterior chamber; and subsequently cut into pieces and removed.

Diagnosis classification
Uveitis-glaucoma-hyphaema (UGH) syndrome/Ellingson syndrome is not Indexed in ICD-10-AM. This syndrome is always due to an intraocular implant (usually an intraocular lens) causing mechanical irritation/chafing of the iris. In this case it was caused by an iris prosthesis (“iris prosthesis causing UGH syndrome”).

Assign T85.88 *Other complications of internal prosthetic device, implant and graft NEC* via Index pathway:

Complication(s) (from) (of)
- eye (see also Complication(s)/by site and type) H57.9
- - device, implant or graft T85.9
- - - embolism T85.84
- - - haemorrhage (bleeding) T85.83
- - - infection or inflammation T85.76
- - - mechanical T85.3
- - - - intraocular lens T85.2
- - - occlusion T85.84
- - - pain T85.85
- - - specified NEC T85.88
- - - stricture (stenosis) T85.86
- - - thrombosis T85.84

As per ACS 1904 *Procedural complications*, add codes for the condition(s) to provide specificity for T85.88:

H40.0 *Glaucoma suspect* (Index: pressure, intraocular, increased)
H18.2 *Other corneal oedema* (Index: oedema, corneal)

There is no ICD-10-AM code available to add specificity of “pigment on the corneal epithelium”.

As per ACS 0005 *Syndromes*, assign also U91 *Syndrome NEC.*

The syndrome is often caused by a malpositioned implant. As there is documentation of malposition (prosthesis “found implanted upside down”), assign also T85.3 *Mechanical complication of other ocular prosthetic devices, implants and grafts*
via Index pathway:

Malposition
--device, implant or graft
….
---ocular (canal graft)(orbital implant) NEC T85.3
--- intraocular lens T85.2

UGH syndrome is characterised by uveitis and hyphaema, however these manifestations are not documented for this patient. A clinician query would be ideal to clarify whether uveitis and/or hyphaema are present and add the appropriate codes if necessary.

Uveitis
T85.76 *Infection and inflammatory reaction due to ocular prosthetic implants, devices and grafts*
H20.9 *Iridocyclitis unspecified*

Hyphaema
H59.85 *Postprocedural hyphaema*

Procedure classification
Removal of iris prosthesis is not Indexed in ACHI. The iris prosthesis in this patient was implanted in the sulcus, presumably the ciliary sulcus in the posterior chamber. Clinician clarification to confirm this site is suggested.

Logic in retired IHACPA Coding Rule Q2657 *Removal of testicular implant* (effective 1 January 2012 – 30 June 2015) is that: when a code for removal of implant does not exist, incision of the site is coded. There is no ACHI code available for sulcus incision.

As a best fit, assign 90080-01 [214] *Other procedures on posterior chamber* via Index pathway:

Procedure
- posterior chamber NEC 90080-01 [214]

Final diagnosis and procedure code list
T85.88 *Other complications of internal prosthetic device, implant and graft NEC*
H40.0 *Glaucoma suspect*

H18.2 *Other corneal oedema*
+/- H59.85 Postprocedural hyphaema
+/- T85.76 *Infection and inflammatory reaction due to ocular prosthetic implants, devices and grafts*
+/- H20.9 *Iridocyclitis unspecified*
U91 *Syndrome NEC*
T85.3 *Mechanical complication of other ocular prosthetic devices, implants and grafts*
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.23 *Health service area, not specified as this facility*
U73.8 *Other specified activity*

90080-01 [214] *Other procedures on posterior chamber*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA). See next page for query submitted to IHACPA.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0165
QUERY TITLE	**Uveitis-glaucoma-hyphaema (UGH) syndrome requiring removal of iris prosthesis**
QUERY SPECIALTY	EYE – Diseases of the eye and adnexa
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	16/08/2023
IHACPA QUERY ID NUMBER	Q3896
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Which diagnosis and procedure codes are assigned for uveitis-glaucoma-hyphema (UGH) syndrome caused by iris prosthesis implanted in the sulcus, admitted for removal of prosthesis? The iris prosthesis was originally implanted for dilated pupil due to a complicated cataract operation.

The clinical documentation for this episode plus our suggested code assignment and rationale is outlined below, and we would appreciate confirmation of its accuracy or otherwise.

Clinical documentation

Operation report

Diagnosis: LE iris prosthesis/UGH
Operation: LE iris prosthesis removal
Findings:
2x para
1x temporal clear [illegible] 2.4mm
Poorly dilated iris - phenylephrine
- 4x iris hooks
Prosthesis lifted into AC (found implanted upside down)

Prosthesis cut and removed.

Ant capsular phimosis, small CCC, plate haptic IOL
Provisc removed.
I/C Ceph
Post op instructions: Start drops when home: Chlorsig QID, [illegible]
Continue Lumigan BD Xalatan nocte.

Correspondence prior to admission

Letter 1
As you know patient had a complicated cataract operation on left side with zonular dehiscence but fortunately we were able to salvage the bag and the lens is currently central. Subsequent to the surgery patient developed a mildly dilated pupil for which I implanted an iris prosthetic. However I agree with your assessment that the prosthetic is causing UGH syndrome and that the endothelium is decompensating. I have advised that the prosthetic be removed as it is only implanted in the sulcus with no suturing. I would also appreciate if you would take over corneal care as an endothelial graft may be required in the future. I have advised that once the eye is stable the iris can be sutured at a later stage.

Letter 2
LE complicated phaco/iol May 2021
RE phaco/IOL Sept 2021
LE iris prosthesis Sept 2022
LE corneal decompensation
LE increased IOP ?UGH syndrome

I received correspondence from Dr xx who has requested me to take over care. Main issues are that patient has a sulcus iris prosthesis causing UGH syndrome with pigment on the endothelium and increased IOP (controlled with Combigan and Xalatan). Patient also has corneal endothelial decompensation with reduced vision.

We will need to remove the iris prosthesis and do an endothelial keratoplasty, which would be better in a staged procedure. Firstly I will remove the iris prosthesis. Pupil appears fixed and moderately dilated, so this may require iris hooks to enlarge to remove the iris prosthesis. Once the eye has settled down from this, secondly I will arrange a DSAEK to treat the corneal oedema.

Dr xx indicated that there was zonular dehiscence intra-operatively, so I'm uncertain as to how stable the bag-lens complex is. I have discussed with patient that if it appears unstable when I remove the iris prosthesis then it may require to be scleral fixed prior to an endothelial keratoplasty.

Suggested code assignment issued by the WA Clinical Coding Authority

Uveitis-glaucoma-hyphaema (UGH) syndrome, also known as Ellingson syndrome, is characterised by intraocular inflammation, increased intraocular pressure and hyphaema. It is caused by mechanical irritation of the iris, ciliary body or iridocorneal angle by foreign material, typically a malpositioned intraocular lens implant. It can also be caused by an iris prosthesis.

Clinical documentation abstraction
The manifestations of UGH syndrome documented for this patient include:

- Corneal oedema and decompensation
- Increased intraocular pressure
- Pigment on corneal endothelium

There is also documentation that the prosthesis was “found implanted upside down”. The referral letter infers that the patient’s natural iris was not originally excised at time of iris prosthesis insertion, as the documentation states: “once the eye is stable the iris can be sutured at a later stage”.

The letters indicate the iris prosthesis was implanted in the “sulcus”. This is presumed to be the ciliary sulcus in the posterior chamber. The procedure documented is corneal incision (“temporal clear [illegible]”) with prosthesis lifted into anterior chamber; and subsequently cut into pieces and removed.

Diagnosis classification
Uveitis-glaucoma-hyphema (UGH) syndrome/Ellingson syndrome is not Indexed in ICD-10-AM. This syndrome is always due to an intraocular implant (usually an intraocular lens) causing mechanical irritation/chafing of the iris. In this case it was caused by an iris prosthesis (“iris prosthesis causing UGH syndrome”).

Assign T85.88 *Other complications of internal prosthetic device, implant and graft NEC* via Index pathway:

Complication(s) (from) (of)
- eye (see also Complication(s)/by site and type) H57.9
- - device, implant or graft T85.9
- - - embolism T85.84
- - - haemorrhage (bleeding) T85.83
- - - infection or inflammation T85.76
- - - mechanical T85.3
- - - - intraocular lens T85.2
- - - occlusion T85.84
- - - pain T85.85
- - - specified NEC T85.88
- - - stricture (stenosis) T85.86
- - - thrombosis T85.84

As per ACS 1904 *Procedural complications*, add codes for the condition(s) to provide specificity for T85.88:

H40.0 *Glaucoma suspect* (Index: pressure, intraocular, increased)
H18.2 *Other corneal oedema* (Index: oedema, corneal)
There is no ICD-10-AM code available to add specificity of “pigment on the corneal epithelium”.

As per ACS 0005 *Syndromes*, assign also U91 *Syndrome NEC.*

The syndrome is often caused by a malpositioned implant. As there is documentation of malposition (prosthesis “found implanted upside down”), assign also T85.3 *Mechanical complication of other ocular prosthetic devices, implants and grafts*
via Index pathway:

Malposition
--device, implant or graft
….
---ocular (canal graft)(orbital implant) NEC T85.3
--- intraocular lens T85.2

UGH syndrome is characterised by uveitis and hyphaema, however these manifestations are not documented for this patient. A clinician query would be ideal to clarify whether uveitis and/or hyphaema are present and add the appropriate codes if necessary.

Uveitis
T85.76 *Infection and inflammatory reaction due to ocular prosthetic implants, devices and grafts*
H20.9 *Iridocyclitis unspecified*

Hyphaema
H59.85 *Postprocedural hyphaema*

Procedure classification
Removal of iris prosthesis is not Indexed in ACHI. The iris prosthesis in this patient was implanted in the sulcus, presumably the ciliary sulcus in the posterior chamber. Clinician clarification to confirm this site is suggested.

Logic in retired IHACPA Coding Rule Q2657 *Removal of testicular implant* (effective 1 January 2012 – 30 June 2015) is that: when a code for removal of implant does not exist, incision of the site is coded. There is no ACHI code available for sulcus incision.

As a best fit, assign 90080-01 [214] *Other procedures on posterior chamber* via Index pathway:

Procedure
- posterior chamber NEC 90080-01 [214]

Final diagnosis and procedure code list
T85.88 *Other complications of internal prosthetic device, implant and graft NEC*
H40.0 *Glaucoma suspect*
H18.2 *Other corneal oedema*
+/- H59.85 Postprocedural hyphaema
+/- T85.76 *Infection and inflammatory reaction due to ocular prosthetic implants, devices and grafts*
+/- H20.9 *Iridocyclitis unspecified*
U91 *Syndrome NEC*
T85.3 *Mechanical complication of other ocular prosthetic devices, implants and grafts*
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.23 *Health service area, not specified as this facility*
U73.8 *Other specified activity* (WA mandated code with Y92.2-)
90080-01 [214] *Other procedures on posterior chamber*

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023050
QUERY TITLE	**Gastroscopy with adjustment of gastric pigtail stent**
QUERY SPECIALTY	DIGS – Diseases of the digestive system
DATE QUERY RECEIVED	01/08/2023
DATE QUERY RESPONDED TO	02/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify adjustment of gastric pigtail stent, in this scenario?

Gastroscopy report
Indication: Chronic gastric sleeve leak and fistula
Procedure: Gastroscope into fistula cavity. Internal pigtail stent within tract and not cavity – stent adjusted. Rest of cavity tract cleaned and debrided with scope.

RESPONSE

Clinical information

A staple-line (or anastomotic) leak is a complication of sleeve gastrectomy. The leak may progress to a fistula, connecting the remnant gastric cavity with an organised extra-gastric fluid collection.

There are several endoscopic techniques for managing the fistula and collection. One technique is called Endoscopic Internal Drainage (EID) which involves endoscopic placement of one or two double pigtail stents, through the fistula tract. One end of the pigtail stent is situated in the collection and the other end is situated in the gastric cavity.

The stent promotes drainage of the collection into the gastric cavity and closure of the fistula by secondary intention, through granulation tissue formation and fibrosis. As the collection drains and the fistula closes, they decrease/change in size/shape, and the stent migrates from the collection, through the fistula tract, towards the gastric cavity. Because of this, the stent may be regularly endoscopically adjusted or

exchanged for different sized stents until the collection and fistula have been adequately managed.

The queried scenario, is a case of endoscopic stent adjustment for ongoing management of a fistula and fluid collection (due to sleeve gastrectomy).

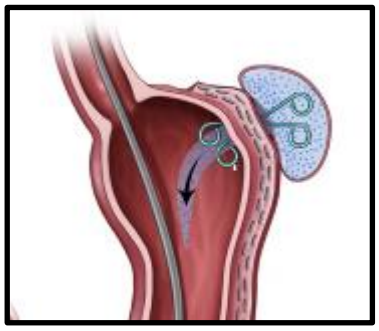


Image description: two pigtail stents inserted through fistula tract, with ends situated in collection and gastric cavity. Image source: Keep calm under pressure: a paradigm shift in managing postsurgical leaks (giejournal.org)

Note; stents can migrate in the opposite direction to that which is expected: through the fistula tract and out towards extra-gastric anatomy. This is a complication of the stent.

Classification
There is no specific ACHI code for adjustment of stent within gastric fistula.

For adjustment of stent within gastric fistula, assign 90305-00 [890] *Other procedures on stomach* following Index pathway:

Procedure
-stomach NEC 90305-00 [890]

Other comments
National Coding Advice (NCA) that refer to other anastomotic leak management procedures are:

- IHACPA Coding Rule Q3390 *Endoscopic vacuum-assisted closure (EVAC) of gastrointestinal defect* (effective 1 Apr 2019 until current).
- IHACPA Coding Rule Q3411 *Application, replacement and removal of endoluminal sponge for negative pressure wound treatment (NPWT)* (effective 1 Jan 2020 until current).

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023043
QUERY TITLE	**Haematological malignancy so described**
QUERY SPECIALTY	NEOP – Neoplasms
DATE QUERY RECEIVED	05/05/2023
DATE QUERY RESPONDED TO	26/07/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Which codes are assigned for “haematological malignancy” not otherwise specified?

RESPONSE

Clinical information

Haematological malignancy is an ambiguous diagnosis as it is an umbrella term that covers both myeloid (e.g., leukaemia) and lymphoid neoplasms (e.g., lymphoma and multiple myeloma). All these conditions are classified in the range C81-C96 *Malignant neoplasms of lymphoid, haematopoietic and related tissue.*

Classification

These Alphabetic Index entries from the Neoplasm Table support assignment of C96.9 for unspecified myeloid neoplasms:

	Primary	Secondary
- **bone**		
- - marrow NEC	C96.9	C79.5
- haematopoietic, haemopoietic		
tissue NEC	C96.9	-

However, this Index entry does not support C96.9 for unspecified lymphoid neoplasms, because C96.9 is listed in the “Secondary” column rather than “Primary” column:

- lymph, lymphatic		
- - channel NEC		
(see also Neoplasm/connective tissue)	C49.9	C79.88
…		
- - gland (secondary)	-	C77.9
…		
- - - primary NEC	-	C96.9

The Index seems to only allow classification of unspecified myeloid neoplasms, and not unspecified lymphoid neoplasms, which is inconsistent with the Tabular List code description for C96.9: *Malignant neoplasm of lymphoid, haematopoietic and related tissue, unspecified.*

C96.9 has been listed in the "Secondary" Index column since ICD-10-AM 1st edition, but may be an error because in ICD-10-CM (USA), lymph gland/primary NEC lists C96.9 in the "Primary" column (2023 ICD-10 Table of Neoplasms (icd10coded.com)). This likely error in the Alphabetic Index will be referred to IHACPA. In the interim, for haematologic malignancy NOS, assign:

C96.9	*Malignant neoplasm of lymphoid, haematopoietic and related tissue, unspecified*
M8000/3	*Neoplasm, malignant*

When the hospital confirms the documented diagnosis 'haematologic malignancy' via the edit process, the edit will be lifted.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website, and the query will also be referred to IHACPA See next page for query submitted to IHACPA.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0164
QUERY TITLE	**Haematological malignancy so described**
QUERY SPECIALTY	NEOP - Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	10/08/2023
IHACPA QUERY ID NUMBER	Q3895
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Which codes are assigned for “haematological malignancy” not otherwise specified?

Haematological malignancy is an ambiguous diagnosis as it is an umbrella term that covers both myeloid (e.g., leukaemia) and lymphoid neoplasms (e.g., lymphoma and multiple myeloma). All these conditions are classified in the range C81-C96 *Malignant neoplasms of lymphoid, haematopoietic and related tissue.*

These Alphabetic Index entries from the Neoplasm Table support assignment of C96.9 for unspecified myeloid neoplasms:

	Primary	Secondary
- **bone**		
- - marrow NEC	C96.9	C79.5
- haematopoietic, haemopoietic		
tissue NEC	C96.9	-

However, the following Index entry does not support C96.9 for unspecified lymphoid neoplasms, because C96.9 is listed in the “Secondary” column rather than “Primary” column:

- lymph, lymphatic
- - channel NEC
(see also Neoplasm/connective tissue) C49.9 C79.88
…
- - gland (secondary) - C77.9
…
- - - primary NEC - C96.9

The Index seems to only allow classification of unspecified myeloid neoplasms, and not unspecified lymphoid neoplasms, which is inconsistent with the code description for C96.9: *Malignant neoplasm of lymphoid, haematopoietic and related tissue, unspecified.*

C96.9 has been listed in the “Secondary” Index column since ICD-10-AM 1st edition, but may be an error because in ICD-10-CM (USA), lymph gland/primary NEC lists C96.9 in the “Primary” column (2023 ICD-10 Table of Neoplasms (icd10coded.com)https://icd10coded.com/cm/neoplasms/).

Thank you for advising code assignment for haematological malignancy NOS. In the interim, WACCA have advised to assign:

C96.9 *Malignant neoplasm of lymphoid, haematopoietic and related tissue, unspecified*
M8000/3 *Neoplasm, malignant*

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023049
QUERY TITLE	**Principal diagnosis in Rehabilitation episodes**
QUERY SPECIALTY	HSAC – Factors influencing health status and contact with health services
DATE QUERY RECEIVED	21/07/2023
DATE QUERY RESPONDED TO	Not yet responded to
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

Can WACCA publish a Coding Rule or Clinical Coding Guideline to assist with principal diagnosis selection for Rehabilitation Care Type episodes?

Principal diagnosis selection can be challenging due to:

- documentation of admissions for functional decline, deconditioning, reduced mobility, falls etc. which may be related to a single or multiple conditions (multi-factorial).
- documentation of ambiguous principal diagnosis statements.
- rehabilitation for a resolved medical condition.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023048
QUERY TITLE	**Aspiration pneumonia with identification of microorganisms**
QUERY SPECIALTY	RESP – Diseases of the respiratory system
DATE QUERY RECEIVED	20/07/2023
DATE QUERY RESPONDED TO	01/08/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How should aspiration pneumonia be classified when Pseudomonas is confirmed on MCS (Microscopy, Culture and Sensitivity) of the sputum?

J15.1 *Pneumonia due to Pseudomonas*
J69.0 *Aspiration pneumonia*
or
J69.0 *Aspiration pneumonia*
B96.5 *Pseudomonas*

RESPONSE

IHACPA Coding Rule Q3437 *Aspiration pneumonia or ventilation associated pneumonia (VAP) with a specified infectious agent* (published 20/3/2020, retired 01/07/2022) instructed:

> ‘Codes from category B95–B97 *Bacterial, viral and other infectious agents* are assigned as additional diagnosis codes to identify the infectious agent(s) in diseases classified elsewhere.
>
> The *Note* at B95–B97 states:
> *A code from these categories must be assigned if it provides more specificity about the infectious agent. Do not assign a code from these categories if the same agent has been identified in the infection code (eg streptococcal sepsis in A40.-).*

> Therefore, where there is documentation of either *aspiration* pneumonia or *ventilation associated* pneumonia and cytology confirms an organism as an infectious agent, assign J69.0 *Pneumonitis due to food or vomit* or J95.82
>
> *Ventilation associated pneumonia* with an additional code (B95–B97) to identify the infectious agent.'

Q3437 was presumably retired due to the Instructional note added in Twelfth Edition at J69.0 stating: *Use additional code (B95–B97) to identify infectious agent.*

For aspiration pneumonia with Pseudomonas confirmed on MCS of the sputum, assign:
J69.0 *Aspiration pneumonia*
B96.5 *Pseudomonas*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023046
QUERY TITLE	**Intraoperative 3D imaging systems**
QUERY SPECIALTY	ACSI – General standards for interventions
DATE QUERY RECEIVED	18/07/2023
DATE QUERY RESPONDED TO	01/09/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

3D intraoperative imaging can be performed during spinal and ear/nose/throat surgeries (for example) using systems such as O-arm and BrainLab Airo.

Query 1
Do you code 3D intraoperative imaging?

Query 2
Do the instructions in ACS 0629 *Stereotactic radiosurgery, radiotherapy and localization* or ACS 0023 *Minimally invasive interventions* apply to 3D intraoperative imaging?

RESPONSE

Device information
The BrainLab AIRO CT scanner system is a mobile imaging platform that can be used to obtain a high-resolution CT scan of a patient while in the operating room undergoing surgery. Benefits include verifying that any hardware placed is in the correct location, and if a tumour is resected, whether there is any residual left, prior to closure of the wound.
https://brownneurosurgery.com/portfolio/brainlab-airo-mobile-ct-scanner-with-navigation-system/

The O-Arm system is an intraoperative 2D/3D imaging system, designed for use in spine, cranial, orthopaedic, ENT and trauma--related surgeries. It provides real-time, intra-operative imaging of a patient's anatomy with high quality images.
O-arm - Surgical Imaging Systems | Medtronic

These imaging systems may be used with computer assisted navigation systems.

Query 1 response
3D intraoperative imaging is not coded as per Point 11. *Imaging services* in ACS 0042 *Procedures not normally coded.*

Where 3D intraoperative imaging systems such as 'BrainLab AIRO CT' and 'O-ARM navigation' are documented, follow the Alphabetic Index at:

Image guided intervention — code specific procedure(s) performed
or
Image intensifier intervention — code specific procedure(s) performed

and only code the procedure performed (e.g., the spinal or ENT surgery).

Query 2 response
ACS 0023 *Minimally invasive interventions* **only** recognises **minimally invasive interventions** as those performed **robotically** or **endoscopically**. There are, however, other minimally invasive interventions that are not recognised by ACS 0023, including those assisted by interventional radiology and transcatheter aortic valve implantation.

The use of 3D intraoperative imaging alone, also does not meet the ACS 0023 definition of minimally invasive intervention (i.e., it doesn't necessarily employ robotic and/or endoscopic techniques).

Note, endoscopic-assisted spinal surgery can be: 'full endoscopic,' 'microendoscopic,' or 'biportal endoscopic.' See: Minimally Invasive Spine Surgery: Techniques, Technologies, and Indications - PMC (nih.gov)

Liaise with the clinicians at your health service to find out whether these techniques are being used and how they are documenting them, so they can be coded.

Classification instruction in ACS 0629 *Stereotactic radiosurgery, radiotherapy and localization* (and ACS 0633 *Stereotactic neurosurgery*) is only for procedures documented as 'stereotactic.'

This query response is consistent with:

- IHACPA Coding Rule Q3130 *CT guided core biopsy of the lung*, effective 1 April 2017.
- Victorian ICD Coding Committee Coding Query 3522 *Computer Navigated Total Knee Replacement*, published June 2019.

Further actions
During preparation for responding to this query, we noticed Example 3 in ACS 0023 *Minimally invasive interventions* fails to specify that the MISS (Minimally Invasive Spinal Surgery) approach was endoscopic, and we will report this to IHACPA.

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023045
QUERY TITLE	**Contracted Care Flags, Hospital A, Diabetes**
QUERY SPECIALTY	ACSI – General standards for interventions
DATE QUERY RECEIVED	17/07/2023
DATE QUERY RESPONDED TO	11/08/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What Contracted Care Flags (CCFs) are reported by Hospital A with E11.22 *Type 2 diabetes mellitus with established diabetic nephropathy* and N18.5 *Chronic kidney disease, stage 5*, for a patient contracted for dialysis at Hospital B during their episode at Hospital A?

Scenario for context

- Admitted to Hospital A for COPD treatment. Comorbidities: type 2 diabetes, stage 5 chronic kidney disease on dialysis.
- Attends Hospital B for dialysis.
- Returns to Hospital A for continuing COPD treatment.

RESPONSE

As per the *Clinical Coding Guidelines: Contracted Care:*

The CCF values for diagnosis (ICD-10-AM codes) are:

- 'Null' (default value): indicates diagnosis (ICD-10-AM code) was **treated** at Hospital A only.
- 'B': indicates diagnosis (ICD-10-AM code) was **treated** at Hospital B only.
- 'AB': Indicates diagnosis (ICD-10-AM code) was **treated** at Hospital A and B.

E11.22 Type 2 diabetes mellitus with established diabetic nephropathy

In general, avoid indiscriminate flagging of “diabetes” and “diabetes with ...” E1x.xx codes in Hospital A episodes.

CCFs are only assigned to diagnosis codes when the '*diagnosis is* ***treated***.' Therefore, diabetes needs to meet ACS 0002 *Additional diagnoses* criteria on its own (not just mandatorily coded) at Hospital A and/or Hospital B before being assigned a CCF.

Where a code for diabetes (uncomplicated or with complications) is assigned as per ACS 0401 *Diabetes mellitus and intermediate hyperglycaemia* Rule 1 and Rule 4a only, and does not meet the criteria in ACS 0002, do not flag it with a CCF (i.e., 'flag' it with the 'Null' CCF value).

Where diabetes meets ACS 0002 criteria on its own, i.e., the diabetes '*is* ***treated***' at Hospital A only, Hospital B only or Hospital A and B, assign a CCF of 'Null,' 'B' or 'AB' respectively.

Depending on the clinical documentation at both hospitals for this scenario, E11.22 may be flagged with a 'Null,' 'B' or 'AB' CCF:

- CCF 'Null' if E11.22 is only coded mandatorily as per ACS 0401, Rule 1 and Rule 4a.
- CCF 'Null' if type 2 diabetes is treated/meets ACS 0002 criteria at Hospital A only.
- CCF 'B' if type 2 diabetes is treated/meets the ACS 0002 criteria at Hospital B only.
- CCF 'AB' if type 2 diabetes is treated/meets the ACS 0002 criteria at both Hospital A Hospital B.

For this scenario, only the 'diabetes' component of E11.22 is considered for CCF assignment because the chronic kidney disease is also classified to N18.5.

N18.5 Chronic kidney disease, stage 5

Depending on the clinical documentation at both hospitals for this scenario, N18.5 may be flagged with a 'B' if treated at Hospital B only (i.e., treated with dialysis), or with an AB if treated at both Hospital A and B.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

The *Clinical Coding Guidelines: Contracted Care* will be updated to include:

- the content of this query and response and
- further detail on assigning CCFs to combination codes such as “diabetes with …’ codes.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0155
QUERY TITLE	**Documentation of ESBL producing organism**
QUERY SPECIALTY	INFD - Certain infectious and parasitic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	13/07/2023
IHACPA QUERY ID NUMBER	Q3888
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Does “extended spectrum beta-lactamase producing” or “ESBL producing” need to be **specifically documented** (or so stated) with E. Coli and Klebsiella pneumoniae in order to assign U93 *Extended spectrum beta-lactamase [ESBL] producing organism*?

For instance, can U93 be assigned for all of the following statements?

1. ‘ESBL producing E. Coli’
2. ‘E. Coli’
3. ‘ESBL producing Klebsiella pneumoniae’
4. ‘Klebsiella pneumoniae’

Background

During the ITG process for ICD-10-AM 12th Edition (TN 1532, Version 5, page 126 of 132), IHPA was asked by NSW: “do coders assign a code for any ESBL producing organism such as E. coli **or** does there need to be documentation of ‘ESBL producing organism’”. IHPA responded “Yes; assign a code for any documented infection (e.g., E. Coli) due to an ESBL producing organism”.

NSW's question, IHPA's response and an unanswered WA question submitted via the 12th Edition FAQ process led to this interpretation by the WA Clinical Coding

Authority (WACCA): U93 *Extended spectrum beta-lactamase [ESBL] producing organism* is assigned when 'E.Coli' or 'Klebsiella pneumoniae' is documented regardless of whether "ESBL producing" is also specifically documented (or so stated), i.e. that U93 could be assigned for the following statements:

1. 'E. Coli'
2. 'Klebsiella pneumoniae'

Public submission request

To make 12th Edition ACS 0112 *Infection with drug resistant microorganisms* clearer, could IHACPA please consider changing the wording from:

'Extended spectrum beta-lactamases (ESBL) are enzymes produced by certain bacteria (e.g., Escherichia coli and Klebsiella pneumoniae)'

To:

'Extended spectrum beta-lactamases (ESBL) are enzymes produced by certain bacteria (e.g., some strains of Escherichia coli and Klebsiella pneumoniae)'

Background

Part of the wording for 12th Edition ACS 0112 has been taken from now retired Coding Rule Q3171 Extended spectrum beta-lactamase (ESBL) resistance:

12th Edition ACS 0112:
'Extended spectrum beta-lactamases (ESBL) are enzymes produced by certain bacteria (e.g., Escherichia coli and Klebsiella pneumoniae)'

Retired Coding Rule Q3171 *Extended spectrum beta-lactamase (ESBL) resistance* (1 Jan 2018 to 30 Jun 2022):
'Extended spectrum beta-lactamases (ESBL) are enzymes produced by certain bacteria (e.g., Escherichia coli and Klebsiella pneumoniae) that break down antibiotics and result in antibiotic resistance (Essex Health Protection Unit 2006; Rupp Fey 2003)'

If you refer to the reference from retired Coding Rule Q3171, you discover the following statement:

'Although the prevalence of ESBLs is not known, it is clearly increasing, and in many parts of the world 10–40% of strains of Escherichia coli and Klebsiella pneumoniae express ESBLs.'

The current wording in 12th Edition ACS 0112 *Infection with drug resistant microorganisms* requires amendment to clarify that not all strains of E coli and

Klebsiella pneumoniae express ESBLs, and that documentation of “ESBL producing” or equivalent is required in order for U93 to be assigned.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023044
QUERY TITLE	**Typhilitis and normal neutrophil count**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	17/07/2023
DATE QUERY RESPONDED TO	02/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify typhlitis in a patient with normal neutrophil count?

Scenario
Principal diagnosis: Typhlitis
History: abdominal pain localised around ACE button. History of anorectoplasty with subsequent appendicostomy.
Ultrasound abdomen: Appendicostomy in situ. Bowel wall thickening and hyperaemia involving the caecum adjacent to the appendicostomy site suggests typhlitis which may be reactive or inflammatory/infective.
Full Blood Picture: Neutrophils Absolute 6, reference range [1.50-8.50 10^x9/L]

RESPONSE

Clinical information

Typhlitis is a rare, inflammatory condition of the caecum affecting mainly neutropenic and immunocompromised patients, however, there have been cases of typhlitis diagnosed in immunocompetent patients without neutropenia.
Typhlitis | Radiology Reference Article | Radiopaedia.org
Unique case of non-neutropaenic typhlitis in an immunosuppressed liver transplant patient - PMC (nih.gov)

Neutropenia can be clinically suspected, however, it can only be diagnosed or confirmed by a blood test or bone marrow aspirate.
Neutropenia - Hematology and Oncology - MSD Manual Professional Edition (msdmanuals.com)
Neutropenia | healthdirect
Diagnosis & Testing (neutropenianet.org)

Clinical documentation abstraction

In the limited episode documentation provided, there is no mention of immunocompromise or neutropenia, and both white blood cell and neutrophil count are within normal limits. The CT abdomen report conclusion states:
"bowel wall thickening and hyperaemia involving the caecum adjacent to the appendicostomy site suggests typhlitis which may be reactive or inflammatory/infective".
The patient is treated with IV antibiotics.

Classification

Typhlitis without neutropenia or immunocompromise is exceedingly rare. A coding query should be sent to the treating clinician to clarify:

- Did patient have neutropenia?
- Should typhlitis/caecitis be classified as:
  - infectious
  - non-infectious
  - unspecified origin
- Patient had caecal hyperaemia and bowel wall thickening adjacent to the appendicostomy site. Was typhlitis due to previous surgery (appendicostomy)?

If clinician clarification is not possible:

- Involvement of the caecum is indicated on the CT scan report, consistent with documented principal diagnosis "Typhlitis". Caecitis is Indexed to K52.9 *Non-infective gastroenteritis and colitis, unspecified.* Follow the Excludes Note: *Excludes colitis of unspecified origin*, and assign A09.9 *Gastroenteritis and colitis of unspecified origin.*
- The documentation and pathology results do not indicate a state of neutropenia, thus, D70 *Agranulocytosis* should not be assigned.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website and submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA) to request an amendment to Q3593 *Neutropenic colitis (typhlitis)* to include the concept of typhlitis without neutropenia.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

Government of Western Australia
Department of Health

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023039
QUERY TITLE	**Manifestations of COVID-19**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	07/12/2022
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3844
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by the WA Clinical Coding Authority:

QUERY

Concept	ICD-10-AM Eleventh Edition	ICD-10-AM and ACHI Twelfth Edition
COVID-19 confirmed by laboratory testing	**CODE** • U07.1 Coronavirus *disease 2019 [COVID-19], virus identified* **CLASSIFICATION NOTES** **Assignment**: • This code is **not** assigned as principal diagnosis. **Related codes**: • For asymptomatic cases, B34.2 *Coronavirus infection, unspecified site* may be assigned as principal diagnosis. • For symptomatic cases, symptom(s) or condition(s) may be assigned as principal diagnosis. B97.2 *Coronavirus as the cause of diseases classified to other chapters and* U07.1 *COVID-19, virus identified* are assigned as additional diagnoses.	**CODES** Code U07.1 was expanded to identify symptomatic versus asymptomatic COVID-19. Code U07.1 is no longer a valid code. • U07.11 *Coronavirus disease 2019 [COVID-19], virus identified, asymptomatic* • U07.12 *Coronavirus disease 2019 [COVID-19], virus identified, symptomatic* **TWELFTH EDITION CHANGES** **Change to assignment**: • These codes **may** be assigned as principal diagnosis. **Change to related codes**: • Other coronavirus codes (B34.2 and B97.2) are no longer assigned for COVID-19. • Manifestations from chapters other than Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)* are assigned when they meet ACS 0002 *Additional diagnoses*. Symptoms are no longer coded.
COVID-19 clinically diagnosed, not confirmed by laboratory testing Includes clinical diagnosis supported by radiological imaging or rapid antigen tests	**CODE** • U07.2 *Coronavirus disease 2019 [COVID-19], virus not identified* **CLASSIFICATION NOTES** **Assignment**: • This code is **not** assigned as a principal diagnosis. **Related codes**: • For symptomatic cases, symptom(s) or condition(s) are assigned as principal diagnosis. B97.2 *Coronavirus as the cause of diseases classified to other chapters and* U07.1 *COVID-19, virus identified* are assigned as additional diagnoses.	**CODE** (No change) • U07.2 *Coronavirus disease 2019 [COVID-19], virus not identified* **TWELFTH EDITION CHANGES** **Change to assignment**: • This code **may** be assigned as principal diagnosis. **Change to related codes**: • Other coronavirus codes (B34.2 and B97.2) are no longer assigned for COVID-19. • Manifestations from chapters other than Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)* are assigned when they meet ACS 0002 *Additional diagnoses*. Symptoms are no longer coded.

IHACPA How to classify COVID-19 – Admitted patient care 46

- The use of the terminology “manifestations” in the IHACPA table above is ambiguous. Does manifestation refer to conditions causally linked with COVID e.g., pneumonia, delirium, embolism? Or is it referring to symptoms that

manifest during the acute phase of a COVID infection e.g., sore throat (J02.9), myalgia (M79), cough (R05)?

WACCA interpret the intent of the table is to reinforce that coding all symptoms that manifest during acute COVID infection is no longer required in 12th edition, unless the symptom/sign is significant in its own right i.e., meets 0001 or 0002. However, the instruction is ambiguous because it only refers to 0002 and the reference to Chapter 18 is problematic because some symptoms are assigned codes outside of Chapter 18 (e.g., sore throat: J02.9) but are unlikely to meet ACS 0001 or 0002; whereas some symptoms that may meet ACS 0001 or 0002 are in Chapter 18 (e.g., non-febrile seizure due to COVID in paediatric patients: R56.8).

- The table lacks a significant change in process between 11th and 12th Edition. In 11th Edition the following instruction existed in a Table on page 7 in "Supplementary guidance for classifying admitted care":

  "Principal diagnosis: Symptom(s) or condition(s) as per ACS 0001 *Principal diagnosis*
  Additional diagnoses: B97.2 *Coronavirus as the cause of diseases classified to other chapters* U07.1 *Emergency use of U07.1 [COVID-19, virus identified]"*

  https://www.ihacpa.gov.au/sites/default/files/2022-09/how_to_classify_covid-19_-_supplementary_guidance_and_faqs_for_classifying_admitted_care_in_eleventh_edition.docx

  This instruction indicated that for a manifestation/condition causally linked to COVID e.g., pneumonia, the manifestation/condition was sequenced as **principal diagnosis**, followed by B97.2.

In 12th Edition, U07.1 can now be assigned as principal diagnosis and B97.2 is gone. However, there is no guidance for coders about how this affects sequencing of principal diagnosis in 12th edition for admissions for manifestation/condition causally linked to COVID, but COVID (U07) is listed as principal diagnosis, as per below two discharge summary examples. Should U07 be sequenced as principal diagnosis in these instances, or should clinician clarification be sought to determine whether one of the manifestations/conditions causally linked to COVID better meets the definition of principal diagnosis?

Example discharge summary 1
Principal diagnosis: COVID-19
Comorbidities: Pneumonia, Acute renal failure
MANAGEMENT/PROGRESS:
1. AKI on CID in context of COVID positive
2. Superimposed bacterial pneumonia in context of COVID

Example discharge summary 2
Principal diagnosis: COVID-19
Comorbidities: Delirium secondary to covid infection, Heart failure
MANAGEMENT/PROGRESS:
1. COVID-19
2. Delirium secondary to covid infection
3. Exacerbation of heart failure secondary to covid infection

IHACPA RESPONSE

Query response

Dear WA Health

Thank you for your query submission. Please find the response to your query below.

Re: Q3844

Bullet point 1:

In the document *How to classify COVID-19 – Guidance for data analysts using ICD-10-AM Eleventh Edition: Appendix A: Comparison between Eleventh Edition and Twelfth Edition*, the use of 'manifestations' is intended to refer to conditions arising due to COVID-19, which are not symptoms (ie conditions not classified to Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified*).

The intent of the table is to reinforce that coding all symptoms that manifest during acute coronavirus disease 2019 (COVID-19) infection is no longer required in Twelfth Edition unless the symptom/sign is significant in its own right and qualifies for assignment in accordance with the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*. See also *Twelfth Edition FAQ: Symptomatic versus asymptomatic coronavirus disease 2019*.

Bullet point 2:

In Eleventh Edition, the principal diagnosis was assigned as the symptom/conditions in accordance with ACS 0001. This was necessary as B97.2 *Coronavirus as the cause of diseases classified to other chapters* is not permitted to be assigned as a principal diagnosis.

As noted, this is no longer the case for Twelfth Edition as the COVID-19 diagnosis may be assigned as principal diagnosis.

It is not appropriate to give a sequencing instruction as this should be determined based on the circumstances of the episode of care.

In **Discharge summary 1**, clinical documentation indicates COVID-19 as the principal diagnosis. Both pneumonia (described as bacterial, not viral) and the acute renal failure (AKI) on chronic kidney disease (CKD), are described as in context of COVID-19 positive. Therefore, follow the clinical documentation and assign pneumonia and AKI as additional diagnoses where they meet the criteria in ACS 0002.

In **Discharge summary 2**, clinical documentation indicates COVID-19 as the principal diagnosis. Both the delirium and the heart failure are documented as secondary to COVID infection. Therefore, follow the clinical documentation and assign these as additional diagnoses where they meet the criteria in ACS 0002.

Do not assign Z03.81 *Observation for suspected coronavirus disease 2019 [COVID-19], ruled out* for the initial suspected symptomatic COVID-19.

ACS 0113 *Coronavirus disease 2019 (COVID-19)* directs coders to assign Z03.81 in accordance with ACS 0012 *Suspected conditions/Observation for suspected diseases and conditions, ruled out (Z03.0–Z03.9)* which states:

...

An observation code is not assigned with additional related codes. If symptoms related to the suspected condition are noted, then the symptom codes are assigned, not Z03.-.

If symptoms are present, follow the guidelines in ACS 0113 which states:

> *Symptoms of COVID-19 are only assigned in accordance with ACS 0001* Principal diagnosis *and ACS 0002* Additional diagnoses.

IHACPA have amended the document *How to classify COVID-19 – Guidance for data analysts using ICD-10-AM Eleventh Edition: Appendix A: Comparison between Eleventh Edition and Twelfth Edition* for clarification.

As this response is based on existing classification guidelines, it will not be published.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023038
QUERY TITLE	**COVID-19 vaccination under anaesthesia**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	10/03/2022
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3781
ICD-10-AM/ACHI/ACS EDITION	12th

QUERY

Query details

COVID-19 vaccination administered under sedation or general anaesthesia during an admitted patient care episode.

Please give advice on the most appropriate diagnosis and intervention codes to assign in the case of a COVID-19 vaccination being given under sedation or general anaesthesia during an admitted episode of care.

In the interim we have advised coders to assign:

Z25.8 *Need for immunisation against other specified single viral diseases*

92157-00 *Vaccination against viral diseases, not elsewhere classified*

IHACPA RESPONSE

Re: Q3781

Assign the following codes where vaccination against COVID-19 is administered in an admitted episode of care, and meets the criteria for code assignment (eg cerebral anaesthesia is required):

- *Z25.2 Need for immunisation against coronavirus disease 2019 [COVID-19]* in obstetric episodes only, in accordance with ACS 1500 *Diagnosis sequencing in obstetric episodes of care*.
- a code from block **[1882]** (92157-03, 92157-04, 92157-05, 92157-06) in accordance with ACS 0113 *Coronavirus disease 2019 (COVID-19)*.

Follow the ICD-10-AM Alphabetic Index:

Vaccination

- prophylactic (against)

- - coronavirus disease 2019 (COVID-19) Z25.2

Follow the ACHI Alphabetic Index:

Vaccination (against) (prophylactic)

- coronavirus disease 2019 (COVID-19) 92157 **[1882]**

See also *Twelfth Edition FAQ: Vaccination against coronavirus disease 2019* and *Twelfth Edition FAQ: Z25.2 Need for immunisation against coronavirus disease 2019 [COVID-19] in an obstetric episode of care*.

As this response is based on existing classification guidelines, it will not be published.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023037/IHACPA0160
QUERY TITLE	**Clarification of Example 3 in ACS 0206 *Pharmacotherapy for neoplasms***
QUERY SPECIALTY	NEOP - Neoplasms
DATE QUERY RECEIVED	24/04/2023
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3867
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by the WA Clinical Coding Authority:

QUERY
An error has been identified in the classification rationale in Twelfth Edition Example 3 in ACS 0206 *Pharmacotherapy for neoplasms*.

EXAMPLE 3:
Patient with breast cancer was admitted for same-day chemotherapy. Intravenous (IV) Doxorubicin was administered. The patient was also transfused with two units of packed cells for anaemia.

Codes: Z51.1 Pharmacotherapy session for neoplasm
C50.9 Malignant neoplasm of breast, unspecified part
M8000/3 Neoplasm, malignant
D64.9 Anaemia, unspecified
96199-00 **[1920]** *Intravenous administration of pharmacological agent, antineoplastic agent*
13706-02 **[1893]** *Administration of packed cells*

In this example, simultaneous pharmacotherapy is administered and includes treatment for a neoplasm (chemotherapy for breast cancer) and treatment for a non-neoplastic condition (packed cells for anaemia). Z51.1 is assigned as a principal diagnosis and C50.9 and D64.9 are assigned as additional diagnoses. 96199-00 **[1920]** is assigned to identify intravenous administration of pharmacotherapy agents for neoplasm. 13706-02 **[1893]** is assigned to identify administration of packed cells. See also ACS 0233 *Morphology*.

WACCA agree with the code assignment and sequencing in Example 3. However, WACCA disagree with the logic provided, particularly the statement **"simultaneous pharmacotherapy"**, because administration of blood products is **not**

pharmacotherapy as per definition:

ACS 0044 - *"Pharmacotherapy is the administration of a drug for treatment of a condition or for prophylaxis. For classification purposes, pharmacotherapy includes any therapeutic substance (usually a drug) but* ***excluding blood and blood products****".*

Below is the relevant query response provided by WACCA in April 2023, which provides the logic as to why Z51.1 is sequenced as principal diagnosis. Do IHACPA agree with WACCA interpretation, and if so, could consideration be given for issuing Errata for Example 3?

Query
How should a same day episode be classified where blood products are administered for anaemia, plus subcutaneous chemotherapy is administered for neoplasm?

Response
ACS 0206 *Pharmacotherapy for neoplasms* (and the previous version in Eleventh Edition – ACS 0044 *Pharmacotherapy*) infer that whenever Z51.1 is applicable in a same-day episode, it is sequenced as principal diagnosis. A chemotherapy ACHI code in a same-day episode goes hand-in-hand with Z51.1.

There are rare exceptions when Z51.1 may be sequenced as additional diagnosis:

- Cancelled procedure – as per Example 5 in ACS 0011 *Intervention cancelled or not performed*
- Where both Z51.1 and Z49.1 equally meet the definition of principal diagnosis – as per Q2721 *Same-day admission for both radiotherapy and chemotherapy*

Principal diagnosis is defined as "…chiefly responsible for occasioning an episode of admitted patient care". If blood products for anaemia and subcutaneous chemotherapy for neoplasm, are **both** planned/scheduled to be administered on the same day, then **both** have equally occasioned the same-day episode and meet the definition of principal diagnosis, noting that admission eligibility in this scenario (for the purpose of the Western Australian *Patient Activity Data Policy*) is based solely on the blood products ACHI code being "eligible for same-day admission".

Because ACS 0206 *Pharmacotherapy for neoplasms* is a specialty standard, it takes precedence over ACS 0001, and therefore Z51.1 defaults to being sequenced as principal diagnosis.

Assign:
Z51.1 *Pharmacotherapy session for neoplasm*
Neoplasm codes (anaemia may be inherent in this code)

Anaemia code (if not inherent in neoplasm code)
96200-00 *Subcutaneous administration of pharmacological agent, antineoplastic agent*
13706-02 *Administration of packed cells*

See also Victorian query response 2708 *Criteria for admission versus principal diagnosis*.

IHACPA RESPONSE

Re: Q3867

ACS 0206 *Pharmacotherapy for neoplasms* states:

> ***CLASSIFICATION***
>
> ***Same-day episodes of care***
>
> *Where pharmacotherapy is administered for a neoplasm, and the admission and discharge are on the same date, use the following guidelines.*
>
> …
>
> ***Simultaneous pharmacotherapy for neoplasms and conditions other than neoplasms***
>
> *Where pharmacotherapy is administered for a neoplasm and non-neoplastic condition (ie a condition other than a neoplasm) (see Example 3), assign codes in the following sequence:*
>
> - *Z51.1* Pharmacotherapy session for neoplasm *as principal diagnosis*
> - *additional diagnosis code(s) for the neoplasm(s) (see also ACS 0236* Neoplasm coding and sequencing*)*
> - *additional diagnosis code(s) for other condition(s) in accordance with ACS 0002* Additional diagnoses
> - *ACHI code(s) from block **[1920]** with extension - 00* Antineoplastic agent
> - *appropriate ACHI code(s) to indicate the treatment for the non-neoplastic condition (see also ACS 0042* Procedures normally not coded*)*

Example 3 was created to demonstrate the application of the guidelines for *Simultaneous pharmacotherapy for neoplasms and conditions other than neoplasms,* however, does not demonstrate these guidelines, as transfusion of packed cells is not classified as pharmacotherapy.

Amendments to ACS 0206 Example 3 will be included in Errata 5 for Twelfth Edition, eliminating the need for publication of a Coding Rule.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023036
QUERY TITLE	**Atrial fibrillation as indication for sleep study**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
DATE QUERY RECEIVED	30/03/2021
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3698
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

Query details

Please advise code selection and sequencing in an episode for overnight sleep study to investigate Obstructive Sleep Apnoea (OSA) as the cause of known AF.

ACS 0001 *Principal diagnosis* states:

Problems and underlying conditions

2. Coding the problem as the principal diagnosis

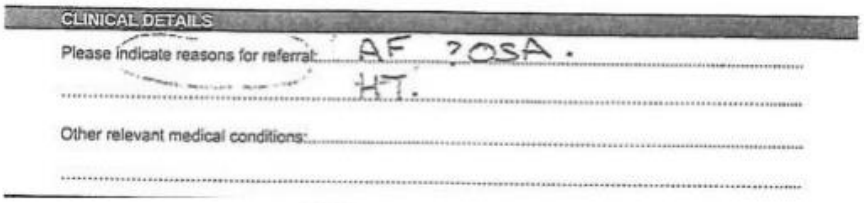
If a patient presents with a problem, and the underlying condition is known at the time of admission, and only the problem is being treated, then the problem should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code.

ACS 0002 *Additional diagnoses* states:

Problems and underlying conditions

If a problem with a known underlying cause is being treated, then both conditions should be coded.

Please see medical record documentation attached.



CLINICAL DETAILS

Please indicate reasons for referral: AF ?OSA.

HT.

Other relevant medical conditions:

Conclusion:
Severe supine REM related OSA. Absence of O2 sats monitoring at end of test, may underestimate the severity of disease, but is thought to not change the overall impression.

IHACPA RESPONSE

Re: Q3698

Obstructive sleep apnoea (OSA) has been associated with hypertension, heart failure, and atrial fibrillation (AF). OSA and AF share many common risk factors. The prevalence of both OSA and AF is rising likely due to increases in cardiovascular disease and obesity. The close association between cardiovascular disease and OSA, and cardiovascular disease and AF may obscure a directly causal relationship between OSA and AF. These chronic diseases are associated, and the interplay of their pathophysiology is complex and likely bidirectional. OSA may promote AF, and AF contributes to OSA development (Marulanda-Londoño & Chaturvedi 2017).

While the health care record provides evidence of a coexisting association, it does not clearly support a causal relationship between the OSA and AF. Therefore, do not apply the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions*.

Assign G47.32 *Obstructive sleep apnoea syndrome [OSAS]* in accordance with ACS 0001 *Principal diagnosis*.

Follow the ICD-10-AM Alphabetic Index:

Apnoea, apnoeic
- sleep
- - obstructive (OSA) G47.32

Assign codes for any other condition (eg AF) in accordance with the criteria in ACS 0002 *Additional diagnoses*.

As this response is based on existing classification guidelines, it will not be published.

References:

Marulanda-Londoño, E. & Chaturvedi, S. 2017, 'The Interplay between Obstructive Sleep Apnea and Atrial Fibrillation'. *Frontiers in neurology*, vol. 8, no. 668, <https://doi.org/10.3389/fneur.2017.00668>.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023035
QUERY TITLE	**Assigning multiple COVID-19 codes**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	21/10/2022
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3832
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

Query details

Scenario 1: Patient contracts COVID-19 multiple times in a single episode of care. For instance a patient with asymptomatic COVID-19 is diagnosed upon admission via PCR testing; several weeks into the admission they start displaying respiratory symptoms and again test positive for COVID-19 via PCR.

Is assigning U07.11 and U07.12 in the same episode the appropriate action in this instance or is the *Excludes* note in U07.11 intended to restrict these codes from being assigned?

Scenario 2: a symptomatic patient is suspected of having COVID-19 upon admission and tests negative in a PCR, and then several weeks later in the admission tests positive for COVID-19?

Is it appropriate to assign Z03.81 for the initial suspected COVID-19, ruled out, and then a U07.1x or U07.2 code for the subsequent positive COVID-19 diagnosis arising several weeks later, in the same episode of care?

IHACPA RESPONSE

Re: Q3832

In scenario 1, the patient has experienced two separate COVID-19 infections in the episode of care.

Excludes notes relate to the condition being classified, rather than an entire episode of care. Where clinical documentation confirms two separate conditions/infections, apply the *Excludes* note in relation to each individual condition/infection.

Assign U07.11 *Coronavirus disease 2019 [COVID-19], virus identified, asymptomatic* where the asymptomatic patient has been diagnosed upon admission via polymerase chain reaction (PCR) testing. Also assign U07.12 *Coronavirus disease 2019 [COVID-19], virus identified, symptomatic* where clinical documentation indicates that the patient is diagnosed with a separate symptomatic infection via PCR.

Do not follow the *Excludes* note at U07.11 as this applies to an infection where symptoms have developed after diagnosis. The *Excludes* note would only apply where the asymptomatic patient had progressed to develop symptoms related to the initial infection.

In scenario 2, the symptomatic patient has tested negative to a PCR. **Do not** assign Z03.81 *Observation for suspected coronavirus disease 2019 [COVID-19], ruled out*.

ACS 0113 *Coronavirus disease 2019 (COVID-19)* directs coders to assign Z03.81 in accordance with ACS 0012 *Suspected conditions/Observation for suspected diseases and conditions, ruled out (Z03.0–Z03.9)* which states:

> …
>
> *An observation code is not assigned with additional related codes. If symptoms related to the suspected condition are noted, then the symptom codes are assigned, not Z03.-.*

If symptoms are present, follow the guidelines in ACS 0113 which states:

> *Symptoms of COVID-19 are only assigned in accordance with ACS 0001* Principal diagnosis *and ACS 0002* Additional diagnoses.

Where the patient subsequently tests positive and clinical documentation indicates a separate infection, assign a code from subcategory U07.1 *Coronavirus disease 2019 [COVID-19], virus identified* in accordance with the guidelines in ACS 0113.

As this response is based on existing classification guidelines, it will not be published.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023040
QUERY TITLE	**Viral-induced wheeze due to COVID-19**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
DATE QUERY RECEIVED	25/07/2022
DATE QUERY RESPONDED TO	01/07/2023
IHACPA QUERY ID NUMBER	Q3802
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by the WA Clinical Coding Authority.

QUERY

Background

WACCA seeks IHPA's clarification on code assignment for viral-induced wheeze due to COVID-19 using ICD-10-AM 12th Edition.

As per Q3235 *Viral induced wheeze*, R06.2 *Wheezing* and a code from B97 *Viral agents as the cause of diseases classified to other chapters* are assigned to classify viral-induced wheeze.

In ICD-10-AM 12th Edition, B97.2 *Coronavirus as the cause of diseases classified to other chapters* is no longer applicable for COVID-19.

Queries

1. Should a U code for COVID-19 (as appropriate) be assigned with R06.2 to classify viral-induced wheeze due to COVID-19?
    a. How should R06.2 and the COVID-19 U code be **sequenced**? Is it correct to assign R06.2 followed by the U code using the previous logic with B97.2?

2. Will Q3235 be updated in line with 12th Edition changes?

IHACPA RESPONSE

Query response

Dear WA Health

Thank you for your query submission. Please find the response to your query below.

Re: Q3802

Coronavirus disease 2019 (COVID-19) is a disease caused by the SARS-CoV-2 virus and is classified using the guidelines in ACS 0113 *Coronavirus disease 2019 (COVID-19)*.

Follow the guidelines in ACS 0113 to assign one of the following codes for viral induced wheeze due to COVID-19:

U07.2 *Coronavirus disease 2019 [COVID-19], virus not identified* **or**

U07.12 *Coronavirus disease 2019 [COVID-19], virus identified, symptomatic*

Follow the ICD-10-AM Alphabetic Index:

COVID-19 (coronavirus disease 2019) (clinically diagnosed) (virus not identified) U07.2

- confirmed by laboratory testing U07.1-

- virus identified U07.1-

Apply the guidelines in ACS 0113 *Coronavirus disease 2019 (COVID-19)* which state:

> *Symptoms of COVID-19 are only assigned in accordance with ACS 0001* Principal diagnosis *and ACS 0002* Additional diagnoses.

See also Twelfth Edition FAQ: *Symptomatic versus asymptomatic coronavirus disease 2019* which states:

> Do not assign additional diagnosis codes for symptoms classified to Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified* (R00–R99).

IHACPA does not intend to amend Coding Rule *Viral induced wheeze* for Twelfth Edition which applies to viral induced wheeze NOS or due to a virus other than COVID-19.

As this response is based on existing classification guidelines, it will not be published.

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023033
QUERY TITLE	**Remplir™ collagen nerve wrap to tethered median nerve**
QUERY SPECIALTY	NERV – Diseases of the nervous system
DATE QUERY RECEIVED	12/06/2023
DATE QUERY RESPONDED TO	30/06/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What codes are assigned for median nerve neurolysis involving a Remplir™ collagen nerve wrap?

Operation report:
Procedure: Median nerve neurolysis at elbow, Right
Findings: tethered median nerve at fracture, one fascile swollen and neuromatous
Procedure: GA IVAB TQ, Anterior S incision, neurolysis, brachial artery explored, Remplir™ collagen wrap to tethered area, 3-0m, steris, dressing.

RESPONSE

Clinical information

The median nerve provides motor (movement) functions to the forearm, wrist and hand. It passes through the carpal tunnel to provide sensation to the thumb, index finger and thumb side of the ring finger. Carpal tunnel anatomy - Mayo Clinic

Normally a nerve glides smoothly with the movements of a joint which the nerve traverses. However, if there has been previous surgery or trauma, scar could form around or within the nerve. Trauma to the elbow, such as a fracture, can affect the median nerve. While the fracture is healing, the median nerve can be stretched, compressed, or even torn.

Scar tethering around the median nerve to surrounding structures can prevent normal nerve gliding, resulting in nerve pain.

Neurolysis refers to the procedure of ‘freeing up’ a nerve surgically and involves meticulously releasing any scar or constricting tissue around or within a nerve. Neurolysis (nerveclinic.co.uk)

A barrier wrap around the nerve can be beneficial in preventing scarring following neurolysis. Nerve wrapping materials are used to inhibit nerve tissue adhesions and diminish inflammatory and immunologic reactions in nerve surgery. Collagen nerve wrap is a biodegradable type I collagen material that acts as an interface between the nerve and the surrounding tissues. Its main advantage is that it stays in place during the period of tissue healing and is then gradually absorbed once tissue healing is completed. Collagen nerve wrap for median nerve scarring - PubMed (nih.gov)

Remplir™ collagen nerve wrap may be used to repair a nerve where it has been cut or damaged, as an alternative to using sutures in nerve repair, as demonstrated in the image below. https://www.asx.com.au/asxpdf/20220321/pdf/4576f0j0jbyywx.pdf

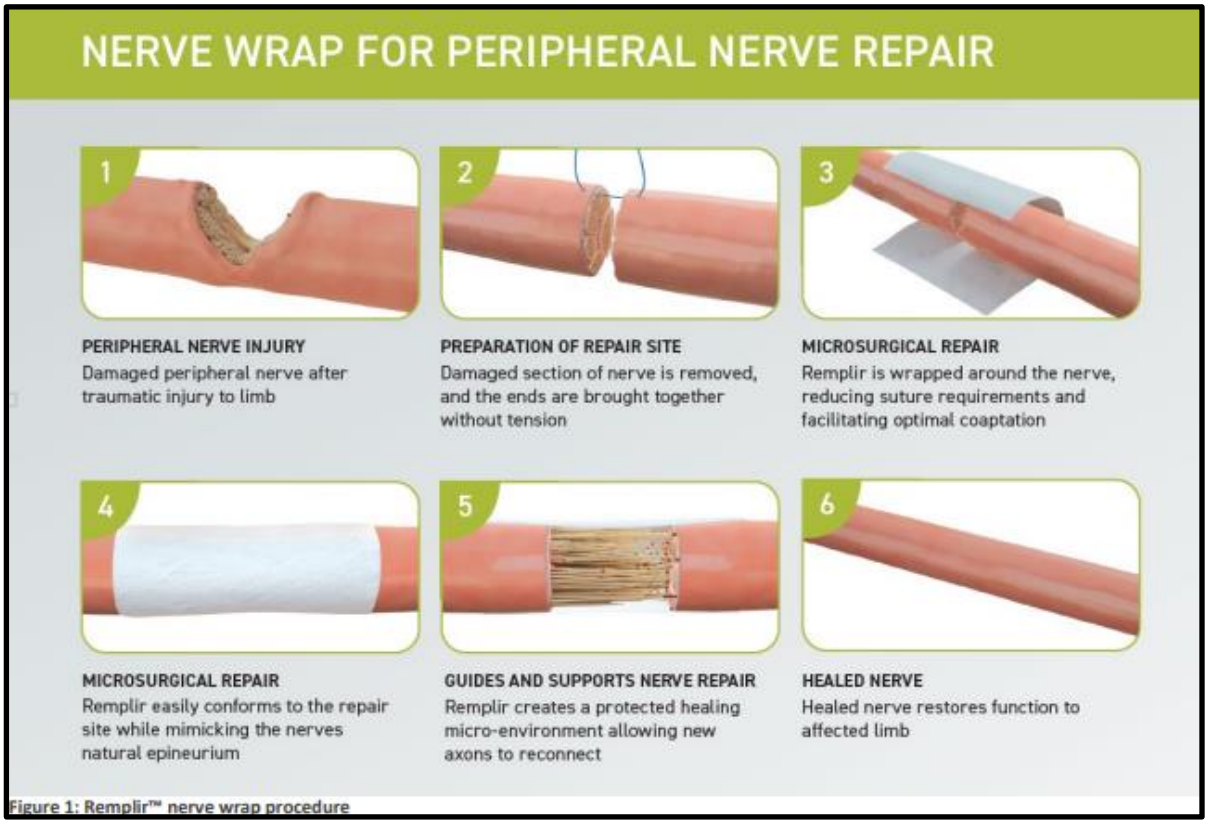


Figure 1: Remplir™ nerve wrap procedure

Remplir™ may also be used as a barrier that reduces the risk of adhesions and facilitating free gliding of a nerve.

Clinical documentation abstraction
‘Tethered median nerve at fracture’
‘neurolysis with Remplir™ collagen wrap to tethered area’

Classification
As per IHACPA Coding Rule (NCA) Q3443 *Hypothenar fat pad and nerve wrap performed with a revision procedure for carpal tunnel syndrome* (effective 1 Apr 2008 until current), collagen nerve wraps are used to prevent scars from recurring.

Where a collagen nerve wrap is performed during the neurolysis surgery for median nerve injury, it is not necessary to assign a separate code for the wrap as it is inherent in the neurolysis intervention. Therefore assign 39331-01 [76] *Release of carpal tunnel* only, following the ACHI Alphabetic Index at:

Neurolysis (open) (peripheral)
- carpal tunnel 39331-01 [76]

This response is consistent with WA Coding Rule 0613/08 *Intraperitoneal infusion of ADEPT* (effective 5 Jun 2013 until current) and IHACPA Coding Rule (NCA) TN204 *Seprafilm*® (effective 1 Jul 2008 until current).

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023034
QUERY TITLE	**Pseudomeniscus post total knee replacement**
QUERY SPECIALTY	MSCT -
DATE QUERY RECEIVED	12/06/2023
DATE QUERY RESPONDED TO	26/06/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What code(s) are assigned for pseudomeniscus post total knee replacement?

Operation report:

> **Diagnosis:** Pseudo meniscus
>
> **Operation:** right knee arthroscopy partial synovectomy and lateral and medial capsular release
>
> **Procedure details:** Under general anaesthetic the right leg was prepped and draped free. Arthroscopy was performed through the routine portals. The joint fluid looked clear. The articular surfaces of the joint replacement components looked satisfactory without damage but for a few minor scratches. A pseudo meniscus had formed around the peripatellar margins, this was debrided. Likewise there was a pseudo meniscus that had formed around the posterior aspect of the medial and lateral femorotibial joint margins and the adjacent joint capsule was very tight. The synovium was debrided and then the joint capsule debrided to release the tension at the posteromedial and posterolateral margins. Bleeding points were diathermied and the portals closed with both subcutaneous and percutaneous 3/O Monocryl.

RESPONSE

Clinical information

Pseudomeniscus is regeneration of meniscus-like fibro-cartilaginous tissue following meniscectomy, and meniscectomy is a component of knee arthroplasty. Meniscectomy may be incomplete and leave a remnant; or may be complete and subsequently regenerate/re-grow.

It is still unclear whether pseudomeniscus is a normal response after excision of the meniscus, or a pathological response that may become symptomatic. Pseudomeniscus after knee arthroplasty: A case series for arthroscopic management of this problem and systematic review of literature - Journal of Clinical Orthopaedics & Trauma (journal-cot.com)

Classification
Causal link - ACS 1904
In the documentation provided, there is no documented causal relationship between pseudomeniscus and an intervention.

Pseudomeniscus is not classified to T82-T85 because:

- there is no Indexed lead term ‘Pseudomeniscus’ (or synonym) with sub-term ‘device/implant/graft’, 'due to device/implant/graft’ etc.
- under lead term ‘Complication’, there is no Indexed sub-term ‘pseudomeniscus of device/implant/graft’.

The lack of Indexing of pseudomeniscus is most likely due to its rare nature. However, lack of 'device' Indexing is consistent with the clinical picture – pseudomeniscus is caused by meniscectomy, rather than a device/implant/graft. This is consistent with the classification logic in Q3723 *Lymphocele following femoral cannulation*:

> *"Do not follow the ICD-10-AM Alphabetic Index at Complication/vascular/device, implant or graft/infusion catheter/specified NEC to assign T82.89 Other specified complications of cardiac and vascular prosthetic devices, implants and grafts, as lymphocele following a femoral cannulation is a complication related to a body system"*.

Pseudomeniscus can only occur following meniscectomy, therefore it meets the following ACS 1904 criterion **enabling assumption of a causal link**:

- Certain conditions where the relationship is inherent in the diagnosis (e.g., infection or bleeding of a surgical wound, stoma or anastomosis, wound dehiscence, transfusion related acute lung injury)

Code assignment
In accordance with ACS 1904:

Where a condition is not related to a prosthetic device, implant or graft and:
• it is related to a body system, assign an appropriate code from the body system chapter

For pseudomeniscus following knee arthroplasty assign:

M96.8 Other intraoperative and postprocedural disorders of musculoskeletal system

via Index pathway

Complication(s) (from) (of)
- musculoskeletal
- -intraoperative or postprocedural M96.9
- - -specified NEC M96.8

Assign also external cause codes:
Y83.1 *Surgical operation with implant of artificial internal device*
Y92.2- *Health service area*
U73.8 *Other specified activity*

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website. Please note that Clinical Coding Guidelines for ACS 1904 *Procedural complications* are currently under development.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA Coding query response

WACCA QUERY ID NUMBER	Q2023041
QUERY TITLE	**Extra-adrenal paraganglionoma of bladder**
QUERY SPECIALTY	NEOP – Neoplasms
DATE QUERY RECEIVED	15/06/2023
DATE QUERY RESPONDED TO	26/06/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How should “extra-adrenal paraganglioma of bladder” be coded, when the pathologist has also noted: “There are no absolute markers that predict behaviour and malignant potential in extra-adrenal sites including the bladder is estimated at 10 – 20 %”?

It is proposed that D41.4 *Neoplasm of uncertain behaviour, bladder* and M8693/3 *Extra-adrenal paraganglioma NOS* be assigned to classify the uncertain malignant potential, in the absence of a behaviour /1 morphology code.

Histopathology report:

> **Date:** xx/xx/2023
> **Specimen:** bladder
> **Clinical history:** ?TCC bladder
> **Microscopic:** Sections of tissue fragments submitted confirm multiple fragments of tissue including surface urothelium, lamina propria and detrusor muscle. In many of the tissue fragments there is extensive infiltration of the tissue by a tumour which is composed of nests and cords of large polygonal cells with eosinophilic and in some areas amphophilic cytoplasm. The tumour is highly vascular and in many areas surrounds thin walled blood vessels. Moderate nuclear pleomorphism is noted and isolated mitotic figures are seen. There is no evidence of tumour necrosis. The surface urothelium is within normal limits. Immunostains were performed which confirm strong immuoreactivity of tumour cells to chromogranin A and focal staining to S100 protein. Stains for desmin and epithelial markers proved negative.

Comment: The histologic features are those of an extra-adrenal paraganglioma. Biological behaviour is related to tumour size, mitotic activity and necrosis. Some reports also indicate the mixed staining of S100 and

chromogranin as a favourable predictor of behaviour. There are no absolute markers that predict behaviour and malignant potential in extra-adrenal sites including the bladder is estimated at 10-20%.
Conclusion: Bladder – extra-adrenal paraganglioma.

RESPONSE

Clinical information
Paraganglioma and pheochromocytoma are both neuroendocrine tumours that form from the same type of cells known as chromaffin cells. Pheochromocytomas form inside the adrenal gland. Paragangliomas form outside the adrenal gland, usually along the arteries or nerves in the neck; but can also occur in the lower abdomen, retroperitoneum, pelvis, or bladder wall. Rare sites of occurrence in the genitourinary tract include the urethra, prostate, seminal vesicles, kidneys, and para-testis.

Behaviour of paragangliomas
Historically there has been difficulty predicting the behaviour of paragangliomas, including whether metastasis or recurrence would occur.

Prior to ICD-10-AM Twelfth Edition, 'extra-adrenal paraganglioma NOS' was classified to behaviour /1 *Uncertain whether benign or malignant / uncertain malignant potential*, with "malignant" being an essential modifier to assign behaviour /3 *Malignant*.

In Twelfth Edition this default was changed to /3 M*alignant*, in accordance with changes to the International Classification of Diseases for Oncology (ICD-O). ICD-O updates include changes from the World Health Organisation (WHO) *Classification of Tumours*.

The current WHO *Classification of Tumours – Urinary and male genital tumours (5th Edition)* classifies extra-adrenal paraganglioma to behaviour /3 *Malignant* and provides the following prognostic information:

> "There is no single histological finding or biomarker that reliably predicts metastatic spread in patients with paragangliomas. Paragangliomas tend to have a lifelong risk of metastases".

Clinical documentation abstraction
The purpose of comments in the histopathology report is for the pathologist to provide additional information to assist the clinician in treatment decision making. Coders should be cautious when reading such comments and be guided predominantly by the ICD-10-AM classification.

If “extra-adrenal paraganglioma of uncertain malignant potential” were so stated, only then could the ICD-10-AM default behaviour /3 *Malignant* be disregarded, applying the logic in WA Coding Rule 1022/01 *Malignant behaviour documented but*

no code available in ICD-10-AM. The closest available morphology code would be M8693/2, because M8693/1 was deleted in Twelfth Edition.

Classification
For extra-adrenal paraganglioma of bladder (not otherwise specified), assign:
C67.9 *Bladder unspecified*
M8693/3 *Extra-adrenal paraganglioma NOS*

C67.9 is assigned in accordance with ICD-10-AM *Appendix A: Morphology of neoplasms*, which instructs:

> ‘A documented neoplasm site may differ from the default site listed in the Alphabetic Index. In such instances, the listed default Chapter 2 code in the Alphabetic Index should not be assigned, and the more appropriate site-specific code should be assigned from the Neoplasm table.’

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023042
QUERY TITLE	**Seizures, brain tumour, ACS 0001, significant problems in own right**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	21/06/2023
DATE QUERY RESPONDED TO	0/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you apply:

- ACS 0001 *Principal diagnosis*, *PROBLEMS AND UNDERLYING CONDITIONS*, 1. *Coding the underlying condition as the principal diagnosis* and
- ACS 0002 *Additional diagnoses* and
- The *Note* at Chapter 18 *Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified*: (f) *certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right*

To classify:

Scenario 1
Principal diagnosis: Brain tumour
Admitted for investigation of seizures. CT brain shows brain tumour. Brain tumour documented as cause of seizures. Commenced on therapeutic treatment for seizures by medical officer.

Scenario 2
Principal diagnosis: Brain tumour
Admitted for investigation of tonic-clonic seizures. CT brain shows brain tumour. Brain tumour documented as cause of seizures. Commenced on therapeutic treatment for seizures by medical officer.

RESPONSE

This query was discussed by the WA Clinical Coding Technical Advisory Group (TAG).

The query and response has been published as WA Coding Rule 1023/02 *Seizures, brain tumour, ACS 0001 and ACS 0002* (effective 1 Oct – current). See the WA Clinical Coding Authority website for this Rule: 1023/02 Seizures, brain tumour, ACS 0001 and ACS 0002 (health.wa.gov.au)

The Rule will be submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0162
QUERY TITLE	**P24 Neonatal aspiration syndromes**
QUERY SPECIALTY	PERI – Certain conditions originating in the perinatal period
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	11/05/2023
IHACPA QUERY ID NUMBER	Q3877
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

How do you classify aspiration pneumonia following a choking event on breastmilk, in a 22-day old patient? This patient was admitted following the choking event and was commenced on intravenous antibiotics to treat the aspiration pneumonia. No oxygen supplementation was required.

Classification

WACCA have provided the following interim advice

The correct code assignment for aspiration pneumonia in a neonate following a choking event on breastmilk that is treated with antibiotics, however, is not treated with oxygen supplementation is **P24.3 *Neonatal aspiration of milk and regurgitated food***

Index pathway(s)

Pneumonia
…
- aspiration J69.0
- - due to
- - - food (regurgitated), **milk**, vomit **J69.0**

- - - gastric secretions J69.0
- - - oils, essences J69.1
- - - solids, liquids NEC J69.8
- - **newborn P24.9**

Tabular

J69 Pneumonitis due to solids and liquids
Use additional external cause code (Chapter 20) to identify cause.
Excludes: neonatal aspiration syndromes (P24.-)

P24 Neonatal aspiration syndromes
▼1613
Includes: neonatal pneumonia resulting from aspiration
…
P24.3 *Neonatal aspiration of milk and regurgitated food*
..
P24.9 *Neonatal aspiration syndrome, unspecified*
Neonatal aspiration pneumonia NOS

ACS 1613 MASSIVE ASPIRATION SYNDROME

Definition

Massive aspiration syndrome occurs when the fetus gasps while in the uterus or birth canal (post maturity may play an important role) and inhales amniotic, vaginal or oropharyngeal fluids, all of which may contain meconium...

Classification
Category P24 Neonatal aspiration syndromes should only be used in cases of 'massive aspiration syndrome'
(P24.9 Neonatal aspiration syndrome, unspecified), 'meconium aspiration syndrome' (P24.0 Neonatal aspiration of meconium), etc and cases who have a significant respiratory illness indicated by the requirement for supplemental oxygen for a period of at least 24 hours.
For conditions such as 'meconium aspiration syndrome' or 'massive aspiration syndrome' with supplemental oxygen required for less than 24 hours, code to P22.1 Transient tachypnoea of newborn…

Transitory tachypnoea of newborn/Transient tachypnoea of newborn (TTN)

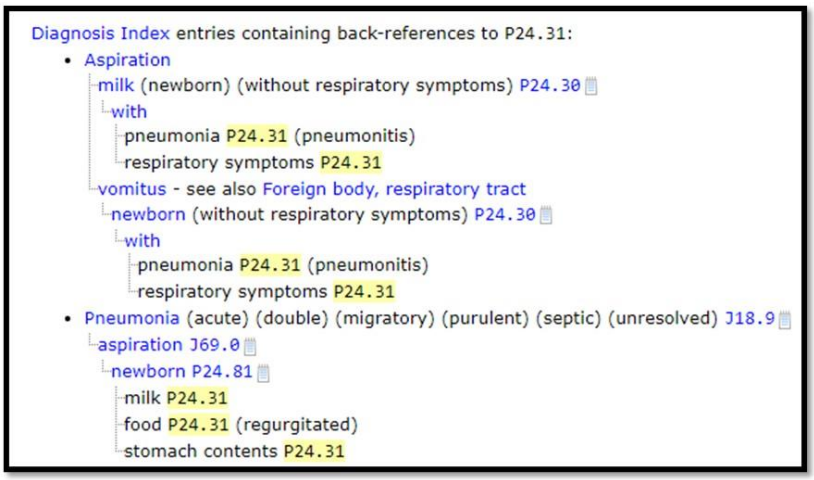
Definition

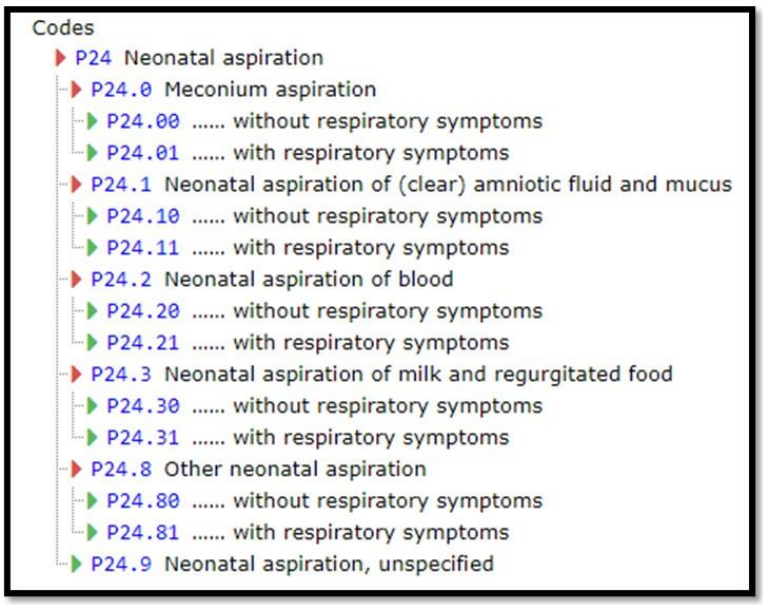
TTN is a well-recognised syndrome of the newborn with onset in the first minutes to hours of birth….

There should be no evidence of sepsis nor of cardiac disease. The chest x-ray should show evidence of increased fluid in the fissures and interstitium of the lungs. TTN is a benign condition without long term sequelae….

Review of other Classifications

ICD-10-CM (2023) classifies aspiration of milk with pneumonia to P24.31





ICD-11
KB26 Neonatal aspiration syndromes include pneumonitis and **P24 Neonatal aspiration syndromes** include neonatal pneumonia resulting from aspiration.

(In ICD-10-AM, the terms 'pneumonitis' and 'pneumonia' are used interchangeably. Aspiration pneumonia occurs when oropharyngeal contents, for example bacteria, food, liquids, are aspirated leading to infection of the lungs… (Q3202 published 15/03/2018. Current))

KB26 Neonatal aspiration syndromes

All ancestors up to top

- 19 Certain conditions originating in the perinatal period
  - Respiratory disorders specific to the perinatal or neonatal period
    - KB26 Neonatal aspiration syndromes

Hide ancestors

Description

Aspiration of meconium, blood, amniotic fluids and gastric contents in a neonate resulting in clinical symptoms from airway obstruction (atelectasis, air trapping and air leaks), parenchymal injury (pneumonitis), right-to-left shunting, and ventilation-perfusion mismatch.

KB26.Z Neonatal aspiration syndromes, unspecified

All ancestors up to top

- 19 Certain conditions originating in the perinatal period
  - Respiratory disorders specific to the perinatal or neonatal period
    - KB26 Neonatal aspiration syndromes
      - KB26.Z Neonatal aspiration syndromes, unspecified

This category is an 'unspecified' residual category

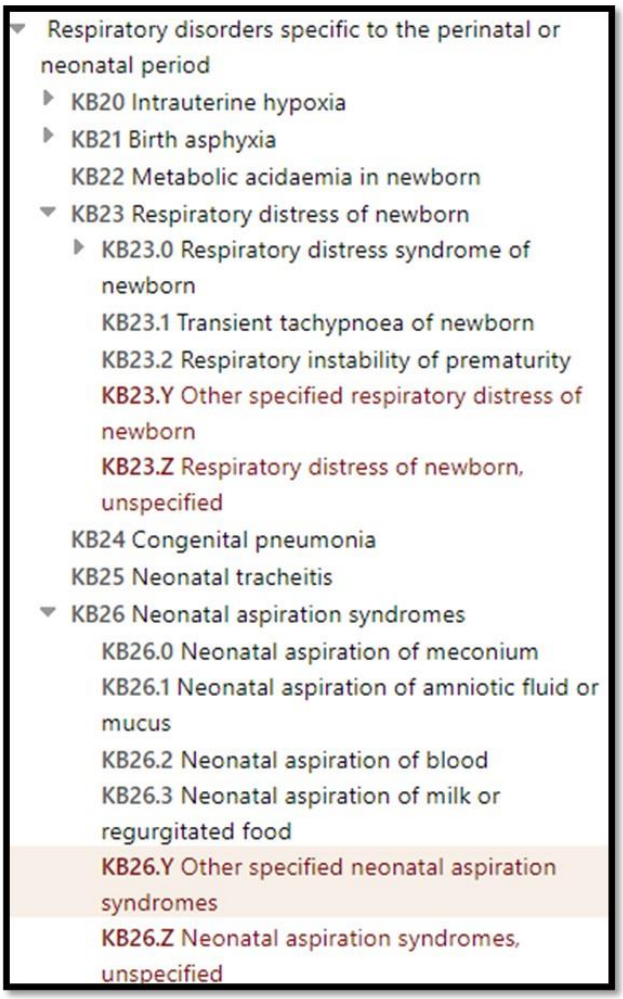
KB26.3 Neonatal aspiration of milk or regurgitated food

All ancestors up to top

- 19 Certain conditions originating in the perinatal period
  - Respiratory disorders specific to the perinatal or neonatal period
    - KB26 Neonatal aspiration syndromes
      - KB26.3 Neonatal aspiration of milk or regurgitated food

Description

Clinical symptoms of Neonatal aspiration syndrome due to aspiration of acidic gastric contest and/or milk



Rationale for code assignment

- **P24.9** ***Neonatal aspiration syndrome, unspecified*** would be assigned to classify neonatal aspiration pneumonia which is **not otherwise specified**. However, in this case, the neonatal pneumonia **is specified** as resulting from the aspiration of breast milk (at 22 days of age).
- The Includes Note at the category **P24 Neonatal aspiration syndromes** instructs that “neonatal pneumonia resulting from aspiration” is included in every code in this category.
- **ACS 1613** specifically provides instructions for aspiration **during birth** with onset in the first minutes to hours of birth and, **NOT** instruction for later milk aspiration in a neonate.
- Therefore, the correct code assignment for this episode of care is **P24.3** ***Neonatal aspiration of milk and regurgitated food***
- As the Alphabetic Index for Pneumonia/aspiration does not align with the Tabular List Includes Note, WACCA have forwarded this query to IHACPA for advice**.**

Note that WACCA believe 3M CodeFinder erroneously uses ACS 1613 logic for scenarios that occur after birth e.g., breast milk aspiration pneumonia in a neonate,

to assign **P22.1** ***Transient tachypnoea of newborn***. WACCA are also contacting 3M to advise them that our interpretation of ACS 1613 differs to the interpretation incorporated in the 3M pathway.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0163
QUERY TITLE	**Oxygen desaturations in neonate or intrauterine**
QUERY SPECIALTY	PERI – Certain conditions originating in the perinatal period
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	10/05/2023
IHACPA QUERY ID NUMBER	Q3876
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

We seek IHACPA's assistance about how to classify oxygen desaturation NOS (i.e., cause of desaturation not found) occurring in a neonate, or intrauterine (fetal pulse oximetry).

Oxygen desaturation is a clinical sign not specifically classified in ICD-10-AM. National coding rule Q3156 *Oxygen desaturation without mention of respiratory failure* instructs that the closest related lead term in the ICD-10-AM Index is 'hypoxia', but that hypoxia is clinically different to hypoxaemia/desaturations. Q3156 instructs that desaturations should be assigned R09.0 *Asphyxia* **as the best fit** when desaturations are not otherwise specified i.e., only the sign is to be coded, as it is not attributed to a condition/cause.

We interpret that R09.0 should be assigned regardless of patient age i.e., it is incorrect to follow sub-term "newborn" Indexed beneath lead terms such as Hypoxia or Anoxia, **unless those lead terms are specifically documented**.

We have also referred this issue to 3M for review, as the Codefinder pathways follow the sub-terms "newborn" and "intrauterine" for lead term Desaturation.

-- DESA
-- Desaturation, oxygen

-- * Birth or newborn
-- Other/unspecified

-- DESA
-- Desaturation, oxygen
-- * Intrauterine
-- Other/unspecified

Thank you for clarifying our interpretation of Q3156 *Oxygen desaturation without mention of respiratory failure* and Q3159 *Intrauterine hypoxia and fetal distress in labour***.**

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0161
QUERY TITLE	**Emotionally unstable personality disorder, unspecified**
QUERY SPECIALTY	MABD – Mental and behavioural disorders
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	08/05/2023
IHACPA QUERY ID NUMBER	Q3875
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

How do you classify Emotionally Unstable Personality Disorder (EUPD) that is unspecified (not otherwise specified) that cannot be clarified with a query to the clinician?

Classification

- There is no default code for EUPD unspecified.

  ICD-10-AM Index pathway:

  Personality (disorder)
  -emotionally unstable
  - - borderline type F60.31
  - - impulsive type F60.30

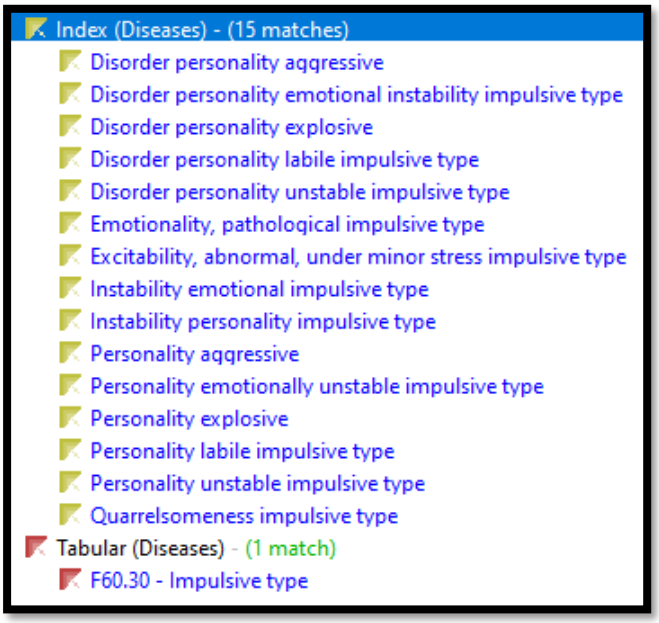
  F60.3 Emotionally unstable personality disorder

  F60.30 *Impulsive type*
  Personality (disorder):
  aggressive
  explosive

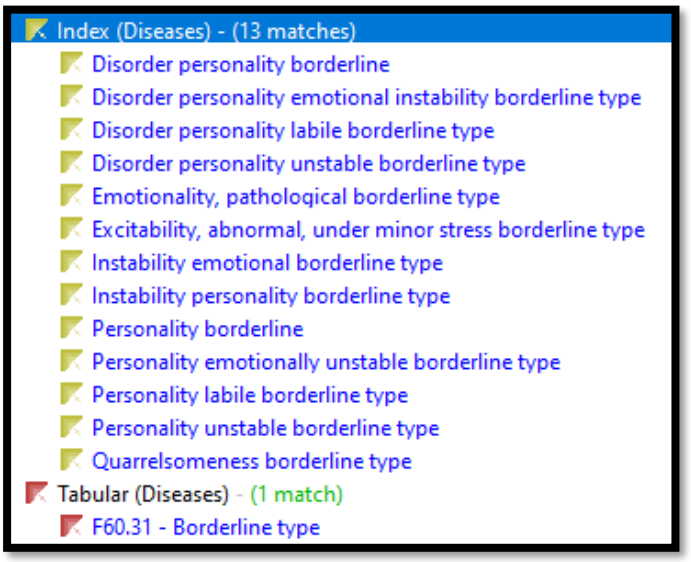
F60.31 *Borderline type*

- ICD-10-AM classifies:

  Explosive Personality Disorder to **F60.30** ***Emotionally unstable personality disorder, impulsive type***

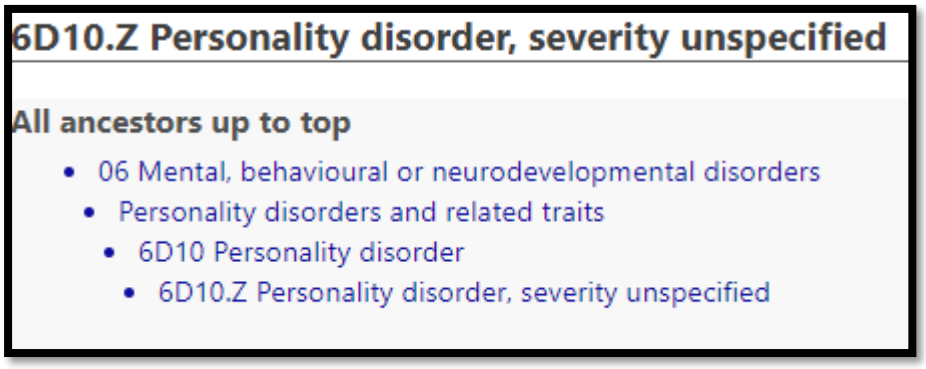


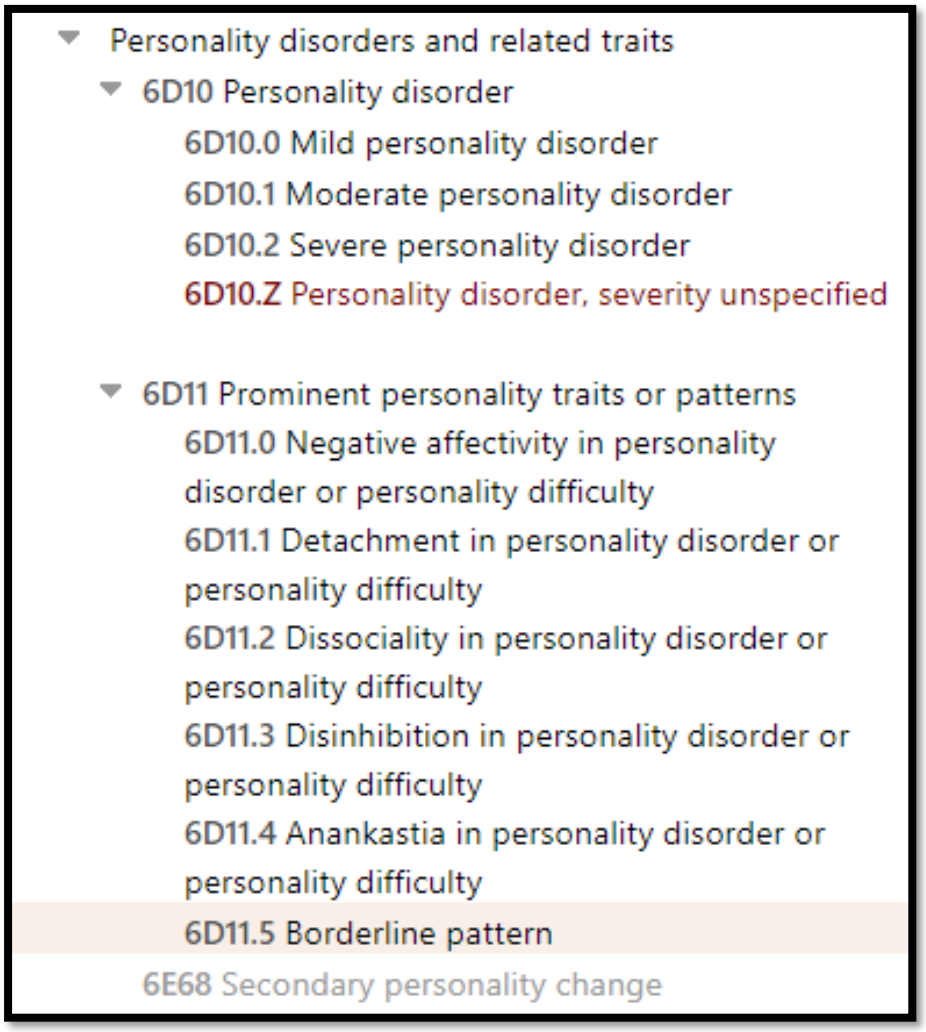
  Borderline Personality Disorder to **F60.31** ***Emotionally unstable personality disorder, borderline type***



- DSM-5, ICD-10, and ICD-10-CM consider EUPD and Borderline Personality Disorder synonymous and classify these to F60.3 (ICD-9-CM 301.83).

- ICD-11 classifies EUPD, borderline and explosive/aggressive personality disorders to **6D10.Z.** (with/without Borderline pattern qualifier 6D11.5)





Advice received from hospitals

"…mental health clinicians tend to document EUPD but do not specify the type of EUPD…"

"… Discussing with the mental health clinicians – the majority of EUPD patients have Borderline Personality Disorder (99%)…"

"…One hospital has got a blanket statement from the Head of Psychiatry to code F60.31 for any documentation of EUPD …"

"…advised by the…Clinical team that this condition should NOT be documented as "unspecified" and when it is to send a Coding Query for further clarification. This is our current practice…"

WACCA's current advice to hospitals

Coders are to send a Coding Query for documentation of EUPD, that is not further specified, before assigning an ICD-10-AM code for Impulsive Type (F60.30) or Borderline Type (F60.31).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023025
QUERY TITLE	**COF assignment for diabetes with hypoglycaemia (E1-.64) in unstable or poorly controlled diabetes**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	20/04/2023
DATE QUERY RESPONDED TO	22/12/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

What Condition Onset Flag (COF) is assigned for hypoglycaemia occurring during an admission, in a patient whose diabetes is unstable or poorly controlled at admission?

RESPONSE

IHACPA Coding Rule Q3210 *Unstable diabetes mellitus with hypoglycaemia* (1 Jan 2018 to current) instructs that unstable/poorly controlled diabetes with hypoglycaemia requires assignment of both E1-.65 *Diabetes mellitus with poor control* **and** E1-.64 *Diabetes with hypoglycaemia*.

Assignment of E1-.64 depends on:

- Documented evidence of 'hypoglycaemia,' i.e., not a blood sugar level (BSL) value in isolation
- Hypoglycaemia meeting ACS 0001 *Principal diagnosis* or 0002 *Additional diagnoses*.

Hypoglycaemia in diabetes is classified to a combination code, hence point 5 in ACS *0048 Condition onset flag* is applicable, which allows assignment of COF 1 to the combination code:

> ***5. For combination codes where a diagnosis within the code meets the criteria of COF 1, and is not represented by another code with a COF 1 value, then assign COF 1 to the combination code.***

From a clinical perspective, hypoglycaemia is inherent in unstable diabetes which is characterised by fluctuating (high and low) BSLs. However, for classification

purposes, hypoglycaemia is unbundled from unstable diabetes and requires independent determination of ‘condition onset’

E1-.64 COF assignment is informed by presence or absence of documented hypoglycaemia on/around the day of admission, and may include documentation generated immediately prior to admission (such as referral or transfer documentation).

BSL value(s) and/or clinician’s descriptions of BSL results, e.g., ‘sugars running high’ can be used to verify that absence of documented hypoglycaemia on/around the day of admission equates to it not being present on admission. For example: unstable diabetes documented in the clinician’s admitting notes, but hypoglycaemia is not documented. BSL values on the Blood Glucose Record verify the absence of hypoglycaemia on admission. On a subsequent day, hypoglycaemia is documented and treated - assign COF 1 for hypoglycaemia as it was verified as not being present on admission.

The following example from the COF 2 definition in ACS 0048 would **rarely (if ever)** be applicable for hypoglycaemia:

- ***A previously existing condition that is exacerbated during the current episode of admitted patient care (e.g. atrial fibrillation, unstable angina).***

This would only be applicable for hypoglycaemia if the patient is in a constant state of hypoglycaemia (which is improbable), with hypoglycaemia present on admission and exacerbated during the current episode.

Further actions
This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023023
QUERY TITLE	**Pelvic venous hypertension**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
DATE QUERY RECEIVED	19/04/2023
DATE QUERY RESPONDED TO	01/10/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How should pelvic venous hypertension/pelvic congestion syndrome be classified?

RESPONSE

This query was discussed by the WA Clinical Coding Technical Advisory Group (TAG).

The query and response has been published as WA Coding Rule 1023/01 *Pelvic congestion syndrome/pelvic venous congestion* (effective 1 Oct – current). See the WA Clinical Coding Authority website for this Rule: 1023/01 Pelvic congestion syndrome / pelvic venous hypertension (health.wa.gov.au)

The Rule will be submitted as a query to the Independent Health and Aged Care Pricing Authority (IHACPA).

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023020
QUERY TITLE	**Urinary tract infection (UTI) post insertion of indwelling catheter (IDC)**
QUERY SPECIALTY	GEUR – Diseases of the genitourinary system
DATE QUERY RECEIVED	13/04/2023
DATE QUERY RESPONDED TO	01/01/2024
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

How do you classify urinary tract infection (UTI), post insertion of indwelling catheter (IDC), without documentation of a causal link between the infection and catheter?

RESPONSE

This query was discussed by the WA Clinical Coding Technical Advisory Group (TAG).

The query and response has been published as WA Coding Rule 1024/02 *Urinary tract infection post insertion of indwelling catheter* (effective 1 Jan – current). See the WA Clinical Coding Authority website for this Rule: 1024/02 Urinary tract infection post insertion of indwelling catheter (health.wa.gov.au)

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0158
QUERY TITLE	**Ketosis and other transient conditions**
QUERY SPECIALTY	ENMD – Endocrine, nutritional and metabolic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	06/04/2023
IHACPA QUERY ID NUMBER	Q3861
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

Since our previously submitted query: *Ketotic hypoglycaemia in a non-diabetic patient (Q3851)*, WACCA received a different ketosis query. Please find below a supplementary query submission to be assessed in conjunction with the previous query Q3851.

Query
WA coders reported emergence of documentation of “ketosis/ketotic/ketonaemia” in paediatric patients and sought clinician clarification to gain insight about what this shift in documentation represented.

The below dot points by a hospital Coding Manager summarise the verbal discussion with their Emergency Department Consultant (Note: this is a different hospital/clinician to previous Emergency Department Consultant response about ketotic hypoglycaemia contained in Q3851).

- *Treatment for ketosis is the same as for dehydration e.g., if a patient was admitted with gastroenteritis, dehydration and ketosis, the treatment would be exactly the same for a patient who had gastroenteritis and dehydration and who was not ketotic.*

- *He considers ketosis to be part of the dehydration process*

- *Skin prick tests are performed to monitor for sugars and the test for ketosis is combined with this test. He considers this to be a bit of "practice creep".*

- *Clinical care is determined more by clinical presentation (how unwell the child looks). However, in the gastro/dehydration scenario, high ketones can occasionally be a determinant in whether or not a patient is admitted.*

- *He advised that he did consider ketosis to be a discrete condition when associated with hypoglycaemia.*

WACCA interpretation of the Consultant's response is that the increase in documentation of ketosis/ketotic/ketonemia may be attributed to skin prick tests now providing results for both blood sugar level and blood ketone level ("practice creep").

WACCA interpret some of the Consultant's responses to contain contradictory information: he considers ketosis to be part of the dehydration process (i.e. ketosis not a discrete condition in this context), however subsequently states that high ketones can occasionally be a determinant in whether or not a gastroenteritis patient is admitted.

Please see attachment containing documentation Examples 1-4, and our questions below.

Questions

Q1) Should documented "ketosis/ketotic/ketonemia" be coded when it meets ACS 0002 *Additional diagnoses*? Or is ketosis inherent in dehydration, and only dehydration needs to be coded?

Q2) If ketosis/ketotic/ketonemia is to be coded, which ICD-10-AM code is assigned?

Q2a) ICD-10-AM Alphabetic Index
Ketosis can be a transient process, or a characteristic of a metabolic disorder (e.g., inborn error of metabolism). Other examples of concepts that can be transient or characteristic of an actual disorder include "hypertensive" and "insomnia". The distinction between transient and actual disorder is important when deciding which Alphabetic Index pathway should be followed when a transient 'version' of an Indexed term is described in the documentation.

Examples

- Documentation of "hypertensive" during an episode which meets ACS 0002, but blood pressure subsequently normalised and no diagnosis of hypertension or anti-hypertensive medication prescribed, and no past history of hypertension.

Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (primary) (systemic) I10

High — see also Elevated, elevation
…
- blood pressure (see also Hypertension) I10
- - reading (incidental) (isolated) (nonspecific), without diagnosis of hypertension R03.0

→ Assign I10 as the term "hypertensive" is specifically documented? Or follow R03.0 pathway to represent the events documented?

- Documentation of "insomnia" during admitted episode (patient doesn't usually have insomnia, but unable to sleep due to being in hospital), commenced benzodiazepine which is discontinued prior to discharge.

Insomnia (organic) G47.0

→ Assign G47.0 as the term "insomnia" is specifically documented? Or should G47.0 not be assigned as patient doesn't have an insomnia disorder, and the trouble sleeping is transient?

- Documentation of "gastroenteritis with dehydration and ketosis"

Ketosis NEC E88.8

Acetonaemia R79.89
Acetonuria R82.4

→ For ketosis, assign E88.8 as the term "ketosis" is specifically documented? Or follow R79.89 or R82.4 pathway to represent the events documented i.e., patient doesn't have a metabolic disorder (nor is there diagnostic testing for a suspected metabolic disorder), just transient ketosis?

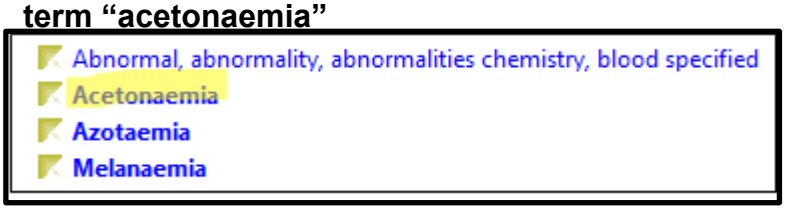
Q2b) ICD-10-AM Tabular List – which code to assign for ketosis/ketotic/ketonaemia?

- **E88.8 *Other specified metabolic disorders* – via Indexed term "ketosis"**
  (This code also classifies various other Endocrine conditions as listed below)

OR

- **A code from the SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS chapter of ICD-10-AM**

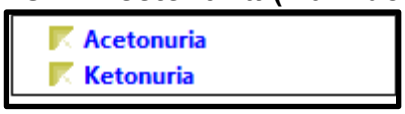
  R79.89 *Other specified abnormal findings of blood chemistry* – via Indexed term "acetonaemia"



Please clarify whether acetonaemia is synonymous with elevated ketones in blood?

OR

R82.4 *Acetonuria* (via Indexed terms "ketonuria")



Please clarify whether acetonuria is synonymous with elevated ketones in urine?

Q3) If only "elevated ketones" or similar is documented (and meets ACS 0002), without documented terms "ketosis/ketotic/ketonemia", should a code for ketosis be assigned?

WACCA coding query response

WACCA QUERY ID NUMBER	Q2023019
QUERY TITLE	**COF assignment for pressure injury when skin redness is present on admission**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	05/04/2023
DATE QUERY RESPONDED TO	22/12/2023
ICD-10-AM/ACHI/ACS EDITION	12th

Thank you for your query. Please find the response to your query below.

SUMMARISED QUERY

If 'skin redness' is documented on admission with a pressure injury diagnosed at the same anatomic site later during the admission, and the wound care specialist or nurse circles "not present on admission" on the Pressure Injury Alert sticker, which COF is assigned for the pressure injury?

RESPONSE

Documentation of skin redness is not synonymous with pressure injury, although a pressure injury **may** be diagnosed in such circumstances. It is the responsibility of the wound care specialist or nurse to determine and document whether a pressure injury was present on admission.

Skin redness documented on admission, with subsequent documentation of pressure injury "not present on admission" by the wound care specialist or nurse, is **not** considered conflicting documentation and COF 1 is appropriate. Such documentation **may** be queried by the coder as part of robust documentation clarification practice. Conflicting documentation should always be queried.

Further actions

This response will be published on the Western Australian Clinical Coding Authority (WACCA) website.

If you have any queries in relation to the above, please contact the WACCA at coding.query@health.wa.gov.au

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0156
QUERY TITLE	**Barth syndrome**
QUERY SPECIALTY	ENMD – Endocrine, nutritional and metabolic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	14/02/2023
IHACPA QUERY ID NUMBER	Q3857
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

How do you classify Barth syndrome?

Classification rationale

WACCA have provided the following interim advice:

For documentation of Barth syndrome assign **E71.1** ***Other disorders of branched-chain amino-acid metabolism*** following the Index pathway:

Disorder (of) — see also Disease
…
- branched-chain amino-acid metabolism
- - specified NEC E71.1

Clinical knowledge

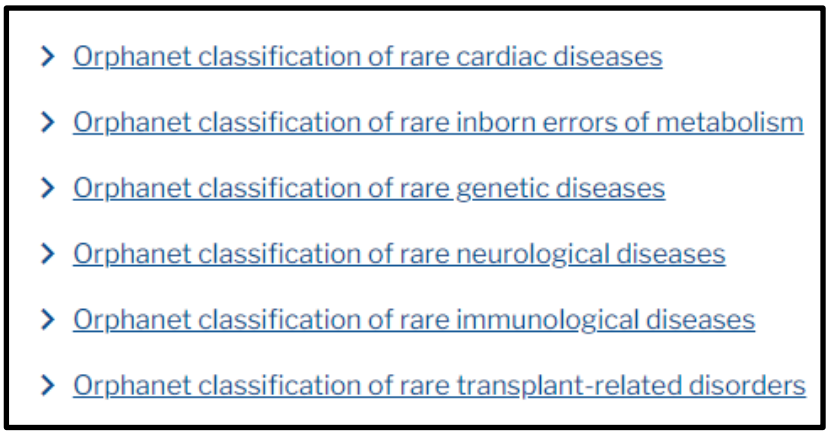
- Barth syndrome is described variously as a lipid metabolism abnormality, an inborn error of phospholipid metabolism and as an **inborn error of branched chain amino acid (BCAA) metabolism.**
- The most common synonym is **3-methylglutaconic aciduria, Type II** (MGA, Type II).

- 3-methylglutaconic acid is a product in the metabolism of certain **branched-chain amino-acids.**
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6516512/
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3249181/

Other Classifications

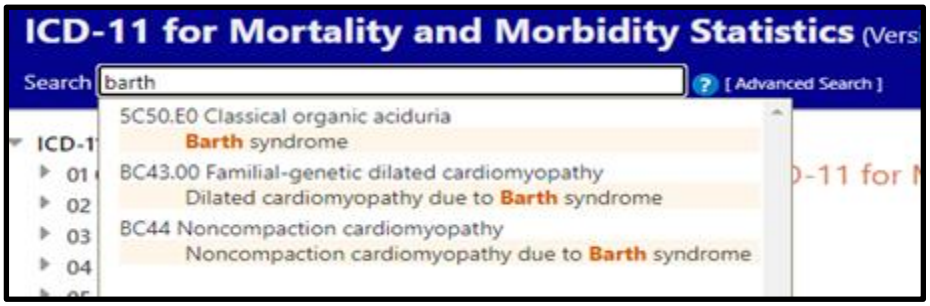
The classification of this syndrome as an error of BCAA metabolism aligns with the classification of this concept in both Orphanet/ICD-10 and ICD-11.

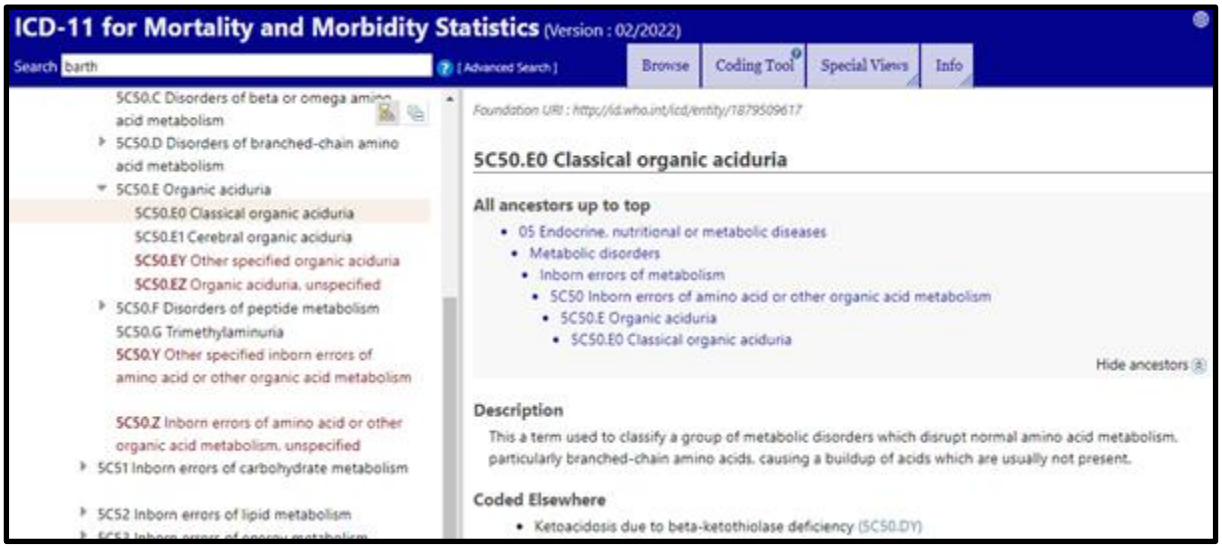
- **Orphanet and ICD-10**
  - Orphanet classifies Barth Syndrome to the ICD-10 code **E71.1** ***Other disorders of branched-chain amino-acid metabolism***
  - One of Orphanet's classifications of Barth Syndrome is as an **inborn error of amino acid metabolism**



Rare inborn errors of metabolism ORPHA:68367
- Disorder of amino acid and other organic acid metabolism ORPHA:79062
  - Organic aciduria ORPHA:289899
    - Classic organic aciduria ORPHA:79163
      - 3-methylglutaconic aciduria ORPHA:289902
        - **Barth syndrome ORPHA:111**

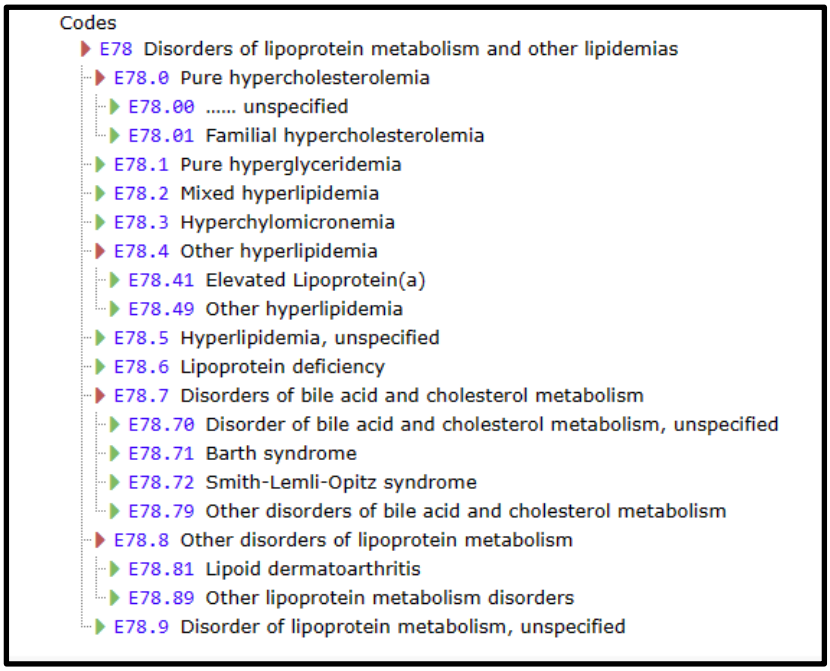
- **ICD-11**
  - ICD-11 classifies Barth Syndrome to **5C50.E0** ***Classic organic aciduria*** (ICD-11 inclusion terms has Barth syndrome).
  - Classic organic aciduria (5C50.E0) is described in ICD-11 as "…a term used to classify a group of metabolic disorders which disrupt normal amino acid metabolism, particularly **branched-chain amino acids**, causing a build-up of acids which are usually not present."





- **<u>ICD-10-CM</u>**

ICD-10-CM classification of Barth syndrome differs to that of Orphanet and ICD-11. ICD-10-CM classifies Barth syndrome in the category of **E78 Disorders of lipoprotein metabolism and other lipidaemias**.



ICD-10-AM Classification

- The Lead Term “aciduria” cannot be followed as the essential modifiers in the pathway preclude this.

  Aciduria
  - argininosuccinic E72.2
  - glutaric E72.3
  - orotic (congenital) (hereditary) (pyrimidine deficiency) E79.8
  - - anaemia D53.0

- The ICD-11 category **5C50 *Inborn errors of amino acid or other organic acid metabolism*** classifies Barth Syndrome.
- 3-methylglutaconic acid is a product in the metabolism of certain branched-chain amino-acids.
- To align with the future ICD-11 classification of Barth syndrome, the ICD-10-AM code chosen was assigned following Index pathway:

  Error
  - metabolism, inborn — see Disorder/metabolism

  Disorder
  …
  - branched-chain amino-acid metabolism
  - - specified NEC E71.1
  …
  - metabolism, metabolic NEC
  - - amino-acid NEC

…
- - - specified NEC

Barth syndrome is a **specified** branched-chain amino-acid metabolism disorde**r**, therefore follow:

Disorder (of) — see also Disease
…
- branched-chain amino-acid metabolism
- - specified NEC **E71.1** ***Other disorders of branched-chain amino-acid metabolism***

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023055
QUERY TITLE	**Referrals for admission for assignment of supplementary U codes**
QUERY SPECIALTY	ACSD – General standards for diseases
DATE QUERY RECEIVED	16/05/2022
DATE QUERY RESPONDED TO	01/01/2023
IHACPA QUERY ID NUMBER	Q3789
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

Query details

Is a referral for admission considered to be part of the documentation for the ensuing admitted episode?

Can Supplementary U codes be assigned based on current conditions listed in the referral or must these conditions be documented by the treating medical officer in the progress notes of the admission?

In the case of short-stay or Hospital in the Home admissions, where very little documentation in the progress notes occurs, can Supplementary U codes be assigned if a condition is listed in the current medical history of the patient in the referral letter?

IHACPA RESPONSE

Thank you for your query submission. Please find the response to your query below.

Re: Q3789

The Twelfth Edition amendments to ACS 0010 *Clinical documentation and general abstraction guidelines* refined the guidelines for *Abstraction in the current episode of care,* to clarify the primary sources of information that are used for code assignment.

ACS 0010 *Clinical documentation and general abstraction guidelines* states:

> *For classification purposes,* ***the primary sources of information are located within the current episode of care.***
>
> *Before classifying any documented clinical concept, the clinical coder must verify the presence and consistency of information on the front sheet and/or the discharge summary (or equivalent) with the* ***relevant documentation within the body of the current episode of care****.*

Advice published in September 2022 for the Twelfth Edition Frequently Asked Question (FAQ) *Referrals for admission* outlines when a referral for admission is considered a primary source of information within the current episode of care.

The advice clarified that if a patient is referred for admission and the referral is assessed as the most current or only admission information available (eg for a short stay or Hospital in the Home admission) and relates directly to the current episode of care, it is a primary source of information within the health care record.

As this response is based on existing classification guidelines, it will not be published.

IHACPA coding query response

WACCA QUERY ID NUMBER	J2023054
QUERY TITLE	**Complete hydatid mole with lung metastases**
QUERY SPECIALTY	NEOP – Neoplasms
DATE QUERY RECEIVED	17/05/2022
DATE QUERY RESPONDED TO	01/01/2023
IHACPA QUERY ID NUMBER	Q3790
ICD-10-AM/ACHI/ACS EDITION	12th

This query was submitted to IHACPA by a state other than Western Australia:

QUERY

Query details

Patient is diagnosed with Complete Hydatid Mole with lung mets.

In coding the hydatid mole, complete - index takes you to O01.0 *Classical hydatiform mole*.

However the documentation has also stated 'malignant' and 'invasive' which sends us to D39.2 *Neoplasm of Unknown and uncertain behaviour of Placenta*.

But we also want to add a code for the lung mets which will be C78.0. Then we need a C code for the primary site.

Any suggestions of how to code this?

Can we use malignancy of placenta (C58) because we do know the behaviour, even though the index sends us to D39.2?

By following the index we end up with D39.2 + C78.7

But we think C58 + C78.7 is more appropriate.

IHACPA RESPONSE

Thank you for your query submission. Please find the response to your query below.

Re: Q3790

Gestational trophoblastic disease (GTD) is the term for rare tumours that develop during the early stages of pregnancy. GTD is usually classified into one of two categories: hydatidiform moles and gestational trophoblastic neoplasia (The Johns Hopkins Hospital 2022).

Gestational trophoblastic neoplasia (GTN) is a collective term for gestational trophoblastic diseases that invade locally or metastasise (Hernandez 2021). GTN include:

- invasive hydatidiform mole
- choriocarcinoma
- placental-site trophoblastic tumour
- epithelioid trophoblastic tumour

Assign the following codes for malignant/invasive hydatidiform mole with lung metastases:

D39.2 *Neoplasm of uncertain or unknown behaviour of placenta*
M9100/1 *Invasive hydatidiform mole*
C78.0 *Secondary malignant neoplasm of lung*
M9100/6 *Choriocarcinoma NOS, metastatic*

Follow the ICD-10-AM Alphabetic Index:

Hydatidiform mole
- invasive (M9100/1) D39.2
- malignant (M9100/1) D39.2

Neoplasm, neoplastic
- lung…Malignant/secondary…C78.0

Sequence codes in accordance with ACS 0236 *Neoplasm coding and sequencing* and assign morphology codes in accordance with ICD-10-AM Tabular List Appendix A *Morphology of neoplasms*.

Note that although codes for secondary malignant neoplasms (C77–C79) are usually assigned with malignant neoplasms stated or presumed to be primary (C00–C75 and C80), there is nothing to preclude assignment of a secondary malignant neoplasm code with D39.2.

As this response is based on existing classification guidelines, it will not be published.

Amendments will be considered for a future edition.

References:

Hernandez, E. 2021, *Gestational trophoblastic neoplasia*, Medscape, viewed 10 November 2022, <https://emedicine.medscape.com/article/279116-overview>.

The Johns Hopkins University, The Johns Hopkins Hospital, and Johns Hopkins Health System (2022), Gestational trophoblastic disease, viewed 10 November 2022, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/gestational-trophoblastic-disease>.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0154
QUERY TITLE	**Ketotic hypoglycaemia in a non-diabetic patient**
QUERY SPECIALTY	ENMD- Endocrine, nutritional and metabolic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	21/12/2022
IHACPA QUERY ID NUMBER	Q3851
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

Which ICD-10-AM code(s) should be assigned for ketotic hypoglycaemia/accelerated starvation in a non-diabetic patient?

There is no code for “ketotic hypoglycaemia” or “accelerated starvation” in ICD-10-AM.

Our reading about this topic (see attached WA Coding Rule proposal) indicates the following main points:

- Idiopathic ketotic hypoglycaemia is defined as a collective set of signs (hypoglycaemia and ketosis), rather than a disease entity, hence the lack of its own specific disease code in various classifications and nomenclatures, including ICD and Orphanet.
- It is unknown why, but children with ketotic hypoglycaemia tend to use up energy stored in the liver and switch to making ketones for energy sooner than other children and are sometimes unable to use stored fat and muscle energy effectively to keep their blood sugar up.
- Some consider idiopathic ketotic hypoglycaemia to be a variant of normal pathophysiology.

Clinician clarification was sought which is also detailed in the attached WA Coding Rule proposal, along with interim code assignment which has been published as a WA Coding Rule while awaiting IHACPA response.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0150
QUERY TITLE	**Delirium in a patient with diagnosis of Dementia with Behavioural Disturbance**
QUERY SPECIALTY	MABD – Mental and behavioural disorders
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	09/11/2022
IHACPA QUERY ID NUMBER	Q3836
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Thank you for consideration of our query.

WACCA seeks IHACPA's assistance in clarifying classification of unspecified type of dementia, with psychological or behavioural disturbance (BPSD) in an episode where the patient also experiences delirium.

In preparation for this query, WACCA make the following observations:

1. Subdivisions were created at dementia codes F00-F03 to capture behavioural or psychological symptoms (BPSD) in a patient with dementia for Twelfth Edition. Consultation with CCAG members noted BPSD is increasing in frequency and results in increased clinical care and patient complexity. CCAG members supported the inclusion of BPSD as a modifier to dementia, with a generic 'with or without' psychological or behavioural disturbance code split.

2. With creation of the subdivisions, Q3396 *Behavioural and psychological symptoms of dementia (BPSD)* was retired 1 July 2022, and with it, the instruction that: where BPSD was documented with any type of dementia, codes for symptoms may be assigned where the symptom is significant in its own right and treated independently (as per the *Note* at the beginning of Chapter 18).

3. Q3625 *Delirium superimposed on dementia* was updated to include the new subdivisions of the dementia codes listed in the Rule. The Rule has retained the instruction: '*where dementia without further specification is documented with delirium, do not assign a code from subcategory F03 Unspecified dementia*'.

Considering the above observations WACCA seek IHACPA clarification of the following:

a. Is the intent of Q3625 *Delirium superimposed on dementia* that the concept of BPSD in a patient with unspecified dementia be excluded entirely, as the type of dementia (unspecified) does not add specificity as per the Multiple Coding convention?
b. Can the following codes:
   F05.1 *Delirium superimposed on dementia, and*
   F03.01 *Unspecified dementia, with psychological or behavioural disturbance*
   be assigned in the instance of a patient presenting in delirium on a background of unspecified dementia, with documentation to support BPSD after the delirium settles, to fully translate two clinical concepts i.e., delirium and unspecified dementia, with psychological or behavioural disturbance?
c. If the intent of point (a) is yes, can codes from Chapter 18, where the symptom is significant in its own right and treated independently, be assigned to capture those symptoms associated with BPSD in unspecified dementia?

Thank you.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0152
QUERY TITLE	**Anaemia in pregnancy**
QUERY SPECIALTY	OBST – Pregnancy, childbirth and the puerperium
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	09/11/2022
IHACPA QUERY ID NUMBER	Q3837
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Anaemia in pregnancy is a significant global health problem and is associated with low birth weight, premature birth and maternal mortality.

The physiological changes in pregnancy can cause anaemia; and have a compounding effect on pre-existing anaemia. Thus, anaemia screening and management is a routine part of obstetric management of all pregnant patients.

Anaemia is a non-obstetric condition, and ACS 1521 *Conditions and injuries in pregnancy* states:

> A nonobstetric condition is a condition that may occur in any patient; these conditions may or may not complicate pregnancy.

Although it is a non-obstetric condition because it can occur in any patient, due the physiological changes in pregnancy, perhaps anaemia ought to be considered an obstetric condition for classification purposes.

Examples 2 and 8 in ACS 1521 *Conditions and injuries in pregnancy* indicate that the criteria in ACS 1521 criteria determine whether pregnancy is to be coded as "incidental" or whether O99.0 can be assigned for "complicating pregnancy". Documentation rarely specifically specifies that anaemia has complicated pregnancy

because it is fundamentally obvious to clinicians that when there is investigation or treatment of anaemia in a pregnant patient, the pregnancy is not “incidental”.

Could IHACPA please review whether anaemia, in the context of the physiological changes in pregnancy, needs to meet the ACS 1521 criteria?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0151
QUERY TITLE	**Supportive (not antineoplastic) pharmacotherapy for neoplasm**
QUERY SPECIALTY	NEOP – Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	12/10/2022
IHACPA QUERY ID NUMBER	Q3829
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Is ACS 0206 *Pharmacotherapy for neoplasms* applicable for **supportive** (not antineoplastic) pharmacotherapy for neoplasm e.g., Aredia for bone metastases? Supportive pharmacotherapy does not appear to meet the ACS 0206 definition of prophylaxis, as it is not for prevention of neoplasia, rather for the prevention of other conditions such as fracture.

Aredia indications include bone pain; slowing destruction of bone; preventing fracture. Some such indications are unclassifiable and/or not documented – rather the neoplasm is usually the documented indication/diagnosis for the same day episode.

What diagnosis and procedure codes are assigned for same day admission for Aredia administration with neoplasm documented as principal diagnosis?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0146
QUERY TITLE	**Admission for pain management, without management of underlying condition**
QUERY SPECIALTY	ACSD – General standards for diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	28/09/2022
IHACPA QUERY ID NUMBER	Q3824
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Guidance is sought for diagnosis coding when a patient is admitted for pain management.

ACS 0001 *Principal diagnosis /Problems and underlying conditions/ Point 2. Coding the problem as the principal diagnosis* instructs*:*

> If a patient presents with a problem (pain), and the underlying condition is known at the time of admission, and only the problem (pain) is being treated, then the problem (pain) should be assigned as the principal diagnosis code. The underlying condition should be sequenced as an additional diagnosis code.

We interpret that for:

- Admission to manage pain with underlying condition known at the time of admission; AND
- Only pain managed this episode - no management or investigation of underlying condition

the ability to apply *ACS 0001/Problems and underlying conditions/Point 2* depends upon whether pain is documented as **acute/NOS** or **chronic**, as shown in table below.

CHRONIC	ACUTE or NOS
Documentation of **chronic/neoplastic/ neuropathic/nociceptive** pain ⇩ R52.2 *Tabular List* instruction: *Code first the underlying cause and/or site of chronic pain, if applicable* ⇩ rigid instruction to code first the underlying cause, and the problem (chronic pain) is sequenced as additional diagnosis i.e. ACS 0001*/Problems and underlying conditions/ Point 2. Coding the problem as the principal diagnosis* **cannot** be applied. **e.g. chronic low back pain due to spondylosis, admitted for steroid injection** **M47.86 *Other spondylosis, lumbar region*** **R52.2 *Chronic pain***	Documentation of **acute** pain (or **not otherwise specified** pain i.e. not specified as chronic/neoplastic/neuropathic/nociceptive) ⇩ no rigid instruction about coding underlying cause ⇩ ACS 0001/*Problems and underlying conditions*/*Point 2* **can** be applied The problem is coded in its own right and sequenced as principal diagnosis, with the underlying cause assigned as additional diagnosis. **e.g. long-standing low back pain due to spondylosis, admitted for steroid injection** **M54.5 *Low back pain*** **M47.86 *Other spondylosis, lumbar region***

Note: ACS *Chronicle* statement at ACS 1302 *Chronic low back pain syndrome* directs coder that ACS 0001 is applicable, which contradicts the R52.2 Tabular List *Code first* instruction.

1302 Chronic low back pain syndrome

Status: Deleted – Tenth Edition

TENTH EDITION

This standard was deleted as it was redundant, as the guidelines in ACS 0001 *Principal diagnosis/Problems and underlying conditions* apply to the classification of chronic low back pain syndrome.

1302 CHRONIC LOW BACK PAIN SYNDROME

If the underlying cause of the pain is stated, code only the underlying cause. If the underlying cause is not known, code to M54.5 *Low back pain* or M54.4 *Lumbago with sciatica.*

Q1a) Does the "and/or" in the instruction at R52.2 *Code first the underlying cause and/or site of chronic pain, if applicable* refer to:

- Those instances where both cause **and** site are inherent in a code description?
  Examples
  M47.86 *Other spondylosis, lumbar region* (cause: spondylosis, site: lumbar)
  M10.90 *Gout unspecified, multiple sites* (cause: gout, site: multiple)

  OR

- Is it an instruction to assign multiple codes to classify both underlying cause **and** site(s)?

Q1b) If the "and/or" is intended for assignment of multiple codes to classify both underlying cause **and** site, which order should these be sequenced in the following Examples?

Example 1
Neoplastic pain - bone metastases scapula and pelvis

Sequence **underlying cause** first?
C79.5 *Secondary malignant neoplasm of bone*
M25.51 *Pain in joint, shoulder region*
R10.2 *Pain in pelvis*
R52.2 *Chronic pain*

Or sequence **site** first?
M25.51 *Pain in joint, shoulder region*
R10.2 *Pain in pelvis*
C79.5 *Secondary malignant neoplasm of bone*
R52.2 *Chronic pain*

Example 2
Coeliac plexus block for chronic abdominal pain due to chronic pancreatitis

Sequence **underlying cause** first?
K86.1 *Other chronic pancreatitis*
R10.4 *Abdominal pain*
R52.2 *Chronic pain*

Or sequence **site** first?
R10.4 *Abdominal pain*
K86.1 *Other chronic pancreatitis*
R52.2 *Chronic pain*

Q2) For acute/NOS pain, where a concept known to involve pain is involved (such as "radiculopathy"), how should the problem "pain" be classified in its own right, in order to apply ACS 0001/*Problems and underlying conditions*/*Point 2*)?

e.g. low back pain due to spondylosis with radiculopathy – admitted for steroid injection

Assign:
M47.26 *Other spondylosis with radiculopathy, lumbar*

or

M54.5 *Low back pain*
M47.26 *Other spondylosis with radiculopathy, lumbar*

Relevant Alphabetic Index pathway:
Spondylosis M47.9-
- with
- - compression (of)
- - - nerve root or plexus M47.2-†, G55.2*
- - disproportion (fetopelvic) O33.0
- - - affecting
- - - - fetus or newborn P03.1
- - - - labour or delivery O65.0
- - myelopathy NEC M47.1-
- - radiculopathy M47.2-

Q3) Headache due to known benign intracranial hypertension

Q3a) Acute

- Admission to manage acute pain (or pain not specified as chronic/neoplastic/neuropathic/nociceptive) – underlying condition known at the time of admission.
- Only pain managed this episode - no management or investigation of underlying condition.

How would the following example be coded?
Principal diagnosis: Benign intracranial hypertension
Presented to ED with severe headache – CT scan in ED NAD. Decision to admit overnight for pain management of headache. No management or investigation of underlying condition (benign intracranial hypertension) during the admitted episode.

Assign:
R51 *Headache*
G93.2 *Benign intracranial hypertension*

or
G93.2 *Benign intracranial hypertension*

Q3b) Acute on chronic

- Admission to manage acute exacerbation of chronic pain – underlying condition known at time of admission
- Only pain managed this episode – no management or investigation of underlying condition in the admitted episode

How would the following example be coded?
Principal diagnosis: Benign intracranial hypertension – subacute on chronic headaches.
Presented to ED with severe headache – CT scan in ED was NAD. Decision to admit overnight for pain management of headache. No management or investigation of underlying condition (benign intracranial hypertension) during the admitted episode.

Assign:
R51 *Headache*
G93.2 *Benign intracranial hypertension*

or
G93.2 *Benign intracranial hypertension*
R52.2 *Chronic pain*

or
G93.2 *Benign intracranial hypertension*

or
G93.2 *Benign intracranial hypertension*
R51 Headache
R52.2 *Chronic pain*

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0148
QUERY TITLE	**Changing the documented principal diagnosis**
QUERY SPECIALTY	ACSD – General standards for diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	23/09/2022
IHACPA QUERY ID NUMBER	Q3823
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

ACS 0010 *Clinical documentation and general abstraction guidelines* states:
"The listing of clinical concepts (e.g., diseases and interventions) on the front sheet and/or discharge summary (or equivalent) for an episode of care is the responsibility of the treating clinician. These responsibilities also include identifying and documenting the principal diagnosis…"

WACCA interpret that it is, however, the coder's responsibility to verify the documented principal diagnosis against ICD-10-AM and ACS, and change the principal diagnosis if necessary, in order to satisfy classification instructions.

Could IHACPA please advise if our interpretation and application of coding standards and conventions is correct in Examples 1-5 below?

Example 1
Principal diagnosis: Benign intracranial hypertension
Admitted for pain management of headache due to known benign intracranial hypertension (causal link documented). No management of benign intracranial hypertension in the episode.

The documented principal diagnosis cannot be verified against ACS 0001 *Principal diagnosis/Problems and underlying conditions/Point 2*.
The clinician is not expected to know or apply *Problems and underlying conditions* classification instructions. Hence it is up to the coder to apply these instructions and change the principal diagnosis to headache, and code benign intracranial hypertension as additional diagnosis (underlying condition – causal link documented).

Example 2
Principal diagnosis: Lipin 1 deficiency
Patient has myoglobinuria which is documented to be a manifestation of Lipin 1 deficiency (E88.8 *Other specified metabolic disorders)*.

There is an Instructional note at E88.8 in the Tabular List, instructing:
Code first the manifestation(s), if known.

The clinician is not expected to know or apply Tabular List instructions. The documented principal diagnosis cannot be verified against an ICD-10-AM Instructional note. Hence it is up to the coder to apply the instruction and change the principal diagnosis to myoglobinuria, and code Lipin 1 deficiency as additional diagnosis.

Example 3 (documentation attached)
Principal diagnosis: Cat bite – wound
Documentation in ED by doctor: Infected cat bite wound with spreading cellulitis

Patient presented with cellulitis of both hands, following cat bite which occurred one day prior and had at that time been assessed in ED with oral antibiotics commenced.

Admitted for treatment with IV antibiotics and elevation of hands. Dressing of wound was not performed in this episode.

Wound and cellulitis are interrelated conditions; and the clinician has indicated which diagnosis best meets the principal diagnosis definition: '*Cat bite - wound*.' There is no relevant classification instruction for this circumstance requiring the coder to change the principal diagnosis. The principal diagnosis can be verified with the circumstances of the admission - the antibiotic management in the episode is potentially treating both conditions (wound or cellulitis) hence the clinician's choice of the principal diagnosis that occasioned the episode cannot be overturned. Instances such as this are where WACCA emphasises: "*The responsibility for identifying and documenting the principal diagnosis lies with the treating clinician"* to highlight that coders cannot overturn the clinician's selection but may instead seek clinician clarification where appropriate.

Example 4
Principal diagnosis: Urinary retention
Chronic/recurrent constipation dating back at least four months prior to the episode,

for which patient was prescribed aperients. The patient had been suffering with the current bout of constipation for 4-5 days prior to the episode and presented with urine retention. Suppositories and IDC were initiated in ED, then admitted to ward for trial of void once bowels opened, plan to discharge home once trial of void passed and bowels opened. Further suppositories and PR exam were required. Once the IDC was removed there were high post void residuals, hence regular post void scanning was required and double voiding recommended. Urine retention and constipation were listed as actively managed issues on the discharge summary and listed in ward round progress notes.

Urine retention and constipation are interrelated conditions; and the clinician has indicated which diagnosis best meets the principal diagnosis definition: 'Urinary retention'. There is no relevant classification instruction for this circumstance requiring the coder to change the principal diagnosis. The principal diagnosis can be reconciled with the circumstances of the admission, hence the clinician's choice cannot be overturned. Both conditions were managed in the episode hence the clinician's choice of the principal diagnosis that occasioned the episode cannot be overturned.

Instances such as this are where WACCA emphasises: "*The responsibility for identifying and documenting the principal diagnosis lies with the treating clinician"* to highlight that coders cannot overturn the clinician's selection but may instead seek clinician clarification where appropriate.

Example 5
Principal diagnosis: 1) Type 2 diabetes mellitus 2) Cellulitis
Patient presented with R) thumb cellulitis which was treated with IV antibiotics. During the admission, patient was noted to have high glucose levels and was newly diagnosed with type 2 diabetes mellitus (no documentation to support diabetes being suspected in ED or prior to admission).

The documented principal diagnosis cannot be verified against ACS 0001 *Principal diagnosis* which defines principal diagnosis as *"The diagnosis established after study to be chiefly responsible for* ***occasioning*** *an episode…"*. Cellulitis meets the definition as it is what brought the patient to hospital and was the reason for admission for antibiotic therapy. Therefore, in this specific situation where the incidentally diagnosed diabetes was unrelated to the presentation to hospital, it is up to the coder to change the principal diagnosis sequencing because diabetes cannot meet the definition of principal diagnosis.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0134
QUERY TITLE	**Breast Implant Associated Anaplastic Large Cell Lymphoma (ALCL)**
QUERY SPECIALTY	NEOP – Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	23/09/2022
IHACPA QUERY ID NUMBER	Q3821
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

WACCA note that in ICD-10-AM 12th Edition, in line with updates to ICD-O-3.2, a new Index pathway will exist

Lymphoma (malignant) (M9590/3) C85.9
- anaplastic
- - diffuse large B-cell (M9680/3) C83.3
- - - with small
- - large cell (M9714/3) C84.6
- - - ALK
- - - - negative (M9715/39702/3) C84.7
- - - - positive (M9714/3) C84.6
- - - breast implant-associated (M9715/3) — *see also Neoplasm/breast/malignant*

We would like to pose the following questions:

1) Will breast implant associated ALCL be classified to this Indexed code?
    - Noting the essential modifier includes “implant-associated” is this essential modifier adequate to capture the concept of implant complication?

Or

Is ACS 1904/Overview/dot point 3 applicable?

2) Is there any circumstance where breast implant associated ALCL will be classified as a procedural complication?

   Noting that indexing to either a morphology or a site code has no implications for code assignment per ACS 1904, there would never be a “See/See also” *complications* instruction at a morphology term, it always provides directions to a topographic code.

3) Is it appropriate to assign a site code from C50.- *Malignant neoplasm of breast* to capture that these cases are arising from the breast implant site?

   As per Appendix A Morphology of neoplasms, “a documented neoplasm site may differ from the default site listed in the Alphabetic Index. In such instances, the listed default Chapter 2 code in the Alphabetic Index should not be assigned, and the more appropriate site specific code should be assigned from the Neoplasm table”.

   The primary site for breast implant associated ALCL by definition will always be of breast, hence why is ‘See also’ Indexed, rather than an explicit ‘See’ instruction?

4) Please clarify whether a status code (Z code) for presence of the breast implants is required as the implants are no longer present?

Thank you

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0143
QUERY TITLE	**Bartholin's cyst complicating pregnancy**
QUERY SPECIALTY	OBST – Pregnancy, childbirth and the puerperium
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	25/07/2022
IHACPA QUERY ID NUMBER	Q3804
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

WACCA seeks IHPA's assistance in classifying conditions in N00-N99 *Diseases of the genitourinary system*, when complicating pregnancy, when a specific condition is documented such as Bartholin's cyst.

The indexing for conditions in N00-N99, when complicating pregnancy is complex and requires coders to follow multiple *see also* Instructional notes and NEC modifiers.

To classify Bartholin's cyst complicating pregnancy, is it correct to follow the ICD-10-AM Index as follows?

1. Pregnancy/complicated by/conditions in N00-N99 NEC (see also Pregnancy/complicated by/diseases of genitourinary system)

then

2. Pregnancy/complicated by/diseases of/genitourinary system (conditions in N00-N99) (see also Pregnancy/complicated by/diseases of/genital organs)

then

3. Pregnancy/complicated by/disease of genital organs NEC (see also Pregnancy/complicated by/abnormal, abnormality/by site)

then

4. Pregnancy/complicated by/abnormal, abnormality/vagina O34.6

to assign O34.6 *Maternal care for abnormality of vagina*?

N75.0 *Cyst of Bartholin's gland* would be assigned in combination with O34.6 to add specificity.

Note: 3M Codefinder assigns O26.81 *Kidney disorders in pregnancy, childbirth and the puerperium* and N75.0 *Cyst of Bartholin's gland* for Bartholin's cyst complicating pregnancy. 3M's rationale being that 'Pregnancy/complicated by/conditions in N00-N99 NEC O26.81' is a valid Index pathway that does not list N75.0 as a separate exception (e.g., as with N10-N12).

WACCA believes that this pathway should not be used when the condition is known (e.g., Bartholin's cyst) as it is classified elsewhere.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0144
QUERY TITLE	**Malignant behaviour documented but no corresponding code available in ICD-10-AM**
QUERY SPECIALTY	NEOP – Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	21/07/2022
IHACPA QUERY ID NUMBER	Q3801
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	No

QUERY

Q3429 *Malignant and metastatic melanotic neuroectodermal tumour* and Q3252 *Benign juvenile granulosa cell tumour of the testis* were retired for Twelfth Edition. However, the logic in these responses was not incorporated in the classification or Australian Coding Standards.

We have a case of malignant diffuse leptomeningeal glioneuronal tumour of the brain. Glioneuronal tumour of brain is classified
D43.2 *Brain, unspecified*
9509/1 *Papillary glioneuronal tumour*

9509/3 does not exist in ICD-10-AM. Hence the logic in Q3429 and Q3252 has been applied in order to assign:
C71.9 *Brain, unspecified*
9509/1 *Papillary glioneuronal tumour*

We seek confirmation that the logic in the retired rules is still applicable, and consideration for this logic to be formally published.

IHACPA RESPONSE

Publication of IHACPA Coding Rule/NCA Q3801 *Malignant diffuse leptomeningeal glioneuromal tumour* (effective 1 Oct 2023)

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0142
QUERY TITLE	**Pneumonitis due to vaping**
QUERY SPECIALTY	RESP – Diseases of the respiratory system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	01/04/2022
IHACPA QUERY ID NUMBER	Q3785
DATE QUERY RESPONDED TO	17/06/2024
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	Yes

NOTE

IHACPA responded to this query on 17 June 2024 by publishing National Coding Advice (NCA): Q3785 *Pneumonitis due to vaping* (effective 1 Jul 2024). To view this NCA, see IHACPA's Australian Classification Exchange (ACE) portal: Home | Australian Classification Exchange (ihacpa.gov.au)

QUERY

Could IHPA please advise code assignment for pneumonitis secondary to vaping?

Interim code assignment

- J68.0 *Bronchitis and pneumonitis due to chemicals, gases, fumes and vapours*
  U07.0 *Emergency use of U07.0*

- Instructional note at J68:
  Use additional external cause code (Chapter 20) to identify cause

As there is no available external cause code that would provide the required specificity, no external cause code has been assigned as per logic in Q2389 *Aspiration pneumonia.*

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0141
QUERY TITLE	**Clarification of Q3669 Nonmalignant neoplastic polyps detected during screening for family history of malignant neoplasm**
QUERY SPECIALTY	NEOP – Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	01/04/2022
IHACPA QUERY ID NUMBER	Q3784
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

The International Classification of Diseases for Oncology (ICD-O) 3rd edition provides the following definition:

> **BEHAVIOR**
> The behavior of a tumor is the way it acts within the body. Pathologists use a variety of observations to determine the behavior of a tumor. Table 18 shows the spectrum of behaviors. A tumor can grow in place without the potential for spread (/0, benign); it can be malignant but still growing in place (/2, noninvasive or in situ); it can invade surrounding tissues (/3, malignant, primary site); or even disseminate from its point of origin and begin to grow at another site (/6, metastatic).
> https://apps.who.int/iris/handle/10665/42344

The ICD-O definitions assist to categorise the following:

- In situ tumour at colonoscopy = **malignant neoplasm** (albeit early stage; will continue to grow/invade if left untreated)
- Adenoma at colonoscopy (Indexed to behaviour /0) = **benign neoplasm**
- Colonic polyp at colonoscopy (K code) = **not neoplasm** because there is no behaviour i.e., classified outside of Chapter 2.

Applying the ACS 0052 instruction:
Assign as principal diagnosis:

- *the condition under surveillance (follow-up/screening) if detected at screening…*

The condition under surveillance is malignant neoplasm ("family history malignant neoplasm"). Therefore, our interpretation is:

- In situ tumour found → Malignant → Condition has been detected and is assigned as principal diagnosis (consistent with advice in Q3669)
- Adenoma found → Not malignant → Condition has not been detected hence Z12 assigned (**inconsistent** with advice in Q3669)

- Polyp found (K code) → Not malignant → Condition has not been detected hence Z12 assigned (consistent with advice in Q3669)

Although carcinoma has potential to arise in an adenoma, there is no justification in ACS 0052/*Classification* to code a precursor (benign adenoma which does not yet contain carcinoma) as principal diagnosis when the condition being screened for (malignant neoplasm) is not detected in this episode. If it is to be coded this way, Q3669 needs to be amended to instruct this specifically, rather than pointing to ACS 0052 as the reason for adenoma to be assigned as principal diagnosis.

Also, Q3669 incorrectly indicates that in situ = malignant pre-cursor. In situ is not a precursor – it is malignant. This will cause confusion for WA coders who have previously been provided advice that in situ is malignant, which aligns with ICD-O definitions and also the TNM classification. Could the wording in Q3669 please be amended to clarify the in situ definition?

Please also see attached previous ACCD response to WA which instructs:

Code assignment is based on documentation in the clinical record. The purpose of the above guidelines is to prevent the clinical coder from having to decide what the 'clinical reason' is for surveillance. That is, where there is documentation that the reason for admission is 'Barrett's oesophagus' or 'Barrett's follow up', it is not the role of the clinical coder to interpret this as 'screening for dysplasia/malignancy' without supportive documentation.

Does the logic about preventing coder from having to decide still apply? If yes, does it also apply for the end part of the coding process i.e., assessing the finding (benign adenoma) to see if it links to the indication (family history of malignant neoplasm)?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0136
QUERY TITLE	**Bacteraemia**
QUERY SPECIALTY	INFD – Certain infectious and parasitic diseases
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	24/01/2022
IHACPA QUERY ID NUMBER	Q3777
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

WACCA seek advice regarding the classification of Bacteraemia.

There is an Excludes note at Category *A49 Bacterial infection of unspecified site*:

A49 Bacterial infection of unspecified site

Excludes: bacterial agents as the cause of diseases classified to other chapters (B95–B96)
chlamydial infection NOS (A74.9)
meningococcal infection NOS (A39.9)
rickettsial infection NOS (A79.9)
spirochaetal infection NOS (A69.9)

Q1) Does the Excludes Note at A49 direct the coder that if they are trying to classify a bacterial agent, they are in the wrong code category and thus redirected to B95-B96? (WACCA's interpretation). If not, please advise what the Excludes note is instructing?

ACS 0111 *Healthcare associated staphylococcus aureus bacteraemia*, Example 1 was amended in the 9th Edition Errata.

Chronicle: ACS

NINTH EDITION ERRATA 1
Minor amendments were made (to the Classification section and Example 1) for Errata 1, June 2015.
Source of recommended change:
ACCD

9th ed errata

Page 56

Amend wording in Classification section and example 1 in ACS 0111 *Healthcare associated Staphylococcus aureus bacteraemia*

0111 HEALTHCARE ASSOCIATED *STAPHYLOCOCCUS AUREUS* BACTERAEMIA

...

CLASSIFICATION

...

U90.0 *Healthcare associated Staphylococcus aureus bacteraemia* is a supplementary code. The manifestation of the bacteraemia, such as ~~localised and/or generalised infection~~ endocarditis or sepsis, or the bacteraemia if no site is specified, together with any appropriate external cause codes should be coded according to normal coding practice and sequenced before U90.0. See also ACS 0110 *SIRS, sepsis, severe sepsis and septic shock* and ACS 1904 *Procedural complications*.

EXAMPLE 1:
A 64 year old woman was readmitted with a diagnosis of septic arthritis due to a previous internal fixation of bimalleolar left ankle fracture. Clinical documentation and ~~blood~~ cultures from joint aspiration and blood samples during this admission confirmed healthcare associated *Staphylococcus aureus* bacteraemia. Vancomycin was started and the patient received treatment for 6 weeks.

Codes:	T84.6	*Infection and inflammatory reaction due to internal fixation device [any site]*
	M00.07	*Staphylococcal arthritis and polyarthritis, ankle and foot*
	~~B95.6~~	~~*Staphylococcus aureus as the cause of diseases classified to other chapters*~~
	A49.01	*Staphylococcus aureus infection, unspecified site*
	Y83.1	*Surgical operation with implant of artificial internal device*
	Y92.22	Health service area
	U90.0	*Healthcare associated Staphylococcus aureus bacteraemia*

Q2) Please clarify rationale for B95.6 being deleted and A49.01 being added in Example 1? Was original assignment of B95.6 to represent bacteraemia, or to add specificity of agent to M00.07?

Q3) Please clarify why in updated Example 1, B95.6 is not assigned to add specificity to M00.07? Is it because "aureus" specificity is captured via A49.01?

Q4) Please clarify the following ACS 0111 instruction:
"The manifestation of the bacteraemia, such as endocarditis or sepsis, or the bacteraemia if no site is specified…should be coded…"

What is "if no site is specified" referring to?

- Manifestation; or

- focus/source of infection; or
- something else?

Q5) Does the Q3522 statement:

"For guidelines regarding multiple clinical concepts (i.e., multiple infections) see Coding Rule Q3332 *E. coli* UTI and *E. coli* bacteraemia"

indicate that Q3332 *E. coli UTI and E. coli bacteraemia* is generalisable to **any** bacteraemia with identified focus of infection/source? i.e., Q3332 is not only specific to **E. Coli** bacteraemia?

Is the following code assignment correctly applying the logic of Q3332 for multiple clinical concepts: wound infection and bacteraemia?

e.g., Klebsiella pneumoniae knee open wound infection, leading to Klebsiella pneumoniae bacteraemia.

Assign:

S81.0	*Open wound of knee*
T89.02	*Open wound with infection*
B96.1	*Klebsiella pneumoniae, as cause of disease classified elsewhere*
X59	*Unspecified external cause*
Y92.9	*Unspecified POO*
U73.9	*Unspecified activity*
A49.8	*Other bacterial infections of unspecified site*
B96.1	*Klebsiella pneumoniae, as cause of disease classified elsewhere* (is this B96.1 required? Or not assigned as already coded with T89.02?)

The following highlighted statements in Q3522 *Bacterial, viral and other infectious agents* do not align with the Conventions used in the Tabular List of Disease and the ICD-10-AM Tabular Note at *Block B95–B97 Bacterial, viral and other infectious agents*.

Q3522

"…Codes in block B95–B97 Bacterial, viral and other infectious agents are assigned to identify certain organisms as the cause of diseases classified to other chapters. Therefore, they are **never** *assigned with another code from Chapter 1 Certain infectious and parasitic diseases* ***to classify a single clinical concept*** *(i.e. a single infection)…"*

"…Note also that the Conventions used in the ICD-10-AM Tabular List state: If, by following the Alphabetic Index, a residual code is assigned (i.e. other or unspecified), do not assign an additional code to further classify the ***condition***

unless directed by an Instructional note/term in the Tabular List *or an Australian Coding Standard*…"

Block B95-B96 Instructional Note
"Note: A code from these categories ***must be assigned*** *if it provides more* ***specificity about the infectious agent****. Do not assign a code from these categories if the same* ***agent has been identified*** *in the infection code (e.g. streptococcal sepsis in A40.-)."*

WACCA interpret that omission of B95-B97 codes in the examples in Q3522 contradicts the Conventions used in the ICD-10-AM Tabular List as the applicable Instructional Note is not followed. The Instructional Note uses a Chapter 1 code as an example, hence the Instruction is intended to also be applicable to Chapter 1 codes.

Q6) Please clarify if/when codes from *B95-B97 Bacterial, viral and other infectious agents* can be assigned with Chapter 1 Diseases?

Q7) What code(s) are assigned for generalised Respiratory Syncytial Virus infection (no site specified)?

Infection, infected (opportunistic) (see also Infestation) B99
- virus NEC B34.9
…
- - respiratory syncytial, as cause of disease classified elsewhere B97.4
…
- - specified type NEC B33.8
…
- - - unspecified site B34.8

WACCA interpret that B97.4 *Respiratory syncytial virus* ought to be added after B34.8 to add specificity of the infectious agent (RSV), as per the Instructional note at B95-B97. However, Q3522 precludes the assignment of B97.4.

Q8) Please clarify if code assignment is correct in these examples?

a) ☒ **Focus/source of infection**
☑ **Bacteraemia**
☒ **Manifestation**
e.g. Streptococcus bacteraemia.
Assign:
A49.1 Streptococcal and enterococcal infection, unspecified site

b) ☑ **Focus/source of infection**
☑ **Bacteraemia**
☒ **Manifestation**
e.g. Streptococcal pneumonia leading to streptococcal bacteraemia.

Assign:
J15.4 Pneumonia due to streptococcus pneumoniae
A49.1 Streptococcal and enterococcal infection, unspecified site

c) ☑ **Focus/source of infection**
☑ **Bacteraemia**
☑ **Manifestation**
e.g. Infected open wound due to Klebsiella pneumoniae, leading to Klebsiella pneumoniae bacteraemia and endocarditis.
Assign:

Sxx	*Open wound*
T89.02	*Open wound with infection*
B96.1	*Klebsiella pneumoniae, as cause of disease classified elsewhere*
X59	*Unspecified external cause*
Y92.9	*Unspecified POO*
U73.9	*Unspecified activity*
I33.0	*Acute and subacute infective endocarditis* (manifestation (endocarditis) of bacteraemia coded in lieu of bacteraemia (A49.8)?)
B96.1	*Klebsiella pneumoniae, as cause of disease classified elsewhere* (is this B96.1 required? Or not assigned as already coded with T89.02?)

e.g. Infected open wound (streptococcus) causing streptococcus bacteraemia with subsequent seeding to left knee, causing streptococcal septic arthritis
Assign:

Sxx	*Open wound*
T89.02	*Open wound with infection*
B95.5	*Unspecified streptococcus as the cause of diseases classified to other chapters*
M00.96	*Pyogenic arthritis, unspecified, lower leg* (manifestation (septic arthritis) of bacteraemia coded in lieu of bacteraemia (A49.1)?)
B95.5	*Unspecified streptococcus as the cause of diseases classified to other chapters* (is this B95.5 required? Or not assigned as already coded with T89.02?)

Q9) Block A49 codes are not specific for bacteraemia. These codes are assigned for any 'bacterial infection, of unspecified site'.

Neither are B95-B96 codes specific for bacteraemia. These codes are assigned to provide specificity of the bacterial agent.

In future, it may be deemed necessary to identify other specific types of bacteraemia (as has occurred for HCASAB), for clinical and epidemiological reasons. Does IHPA

propose to identify bacteraemia in the data and if so, how? Will IHPA revisit introduction of *R78.71 Bacteraemia*?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0135
QUERY TITLE	**ACS 0604 Cerebrovascular Accident (CVA)**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	24/01/2022
IHACPA QUERY ID NUMBER	Q3778
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

WACCA seek advice regarding the classification of stroke deficits and associated conditions as instructed in ACS 0604 *Cerebrovascular accident (CVA)*

Can IHPA please clarify the following;

1. **Stroke deficits. Classification dot point 1 and example 1.**

Classification Dot Point 1
"…Assign a code from categories I60–I64 (cerebrovascular diseases) ***with codes for any deficit(s)*** *(e.g. hemiplegia) regardless of the period of time elapsed since the CVA occurred, or care type changes that occur, during the initial episode(s) of care…"*

Example 1
"…A patient is admitted following a cerebral infarction on 1 January and is transferred to a rehabilitation facility on 7 January for rehabilitation for residual ***hemiparesis and aphasia****…"*

In Dot Point 1 (and Example1) the **deficits in the initial treatment period** are not required to meet the criteria in ACS 0002 Additional diagnoses.

While in Dot Point 2 (and Example 2) the ACS 0604 *Cerebrovascular accident (CVA)* clearly instructs that **residual deficits after initial treatment period is complete** must meet the criteria in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses* for code assignment.
In facility 1, hemiparesis and dysphasia codes are assigned. There is no documentation in the example that the deficits need to meet criteria in ACS 0002 *Additional diagnoses* for facility 1 (part of the initial treatment period).

- Are ALL the CVA deficits (excluding "associated conditions") in the initial treatment period automatically assigned a code per Dot Point 1?

  Or

- Irrespective of whether a condition is documented as a deficit, residual deficit, or is one of the certain "associated conditions" that indicate severity of stroke described in ACS 0604, the condition needs to meet ACS 0002 *Additional diagnoses* for code assignment?

2. Associated conditions and the severity of a CVA.

"…The severity of a CVA is indicated by certain ***associated conditions*** *present during the episode of care. Each condition must meet the criteria for an additional diagnosis as per ACS 0002. …"*

For 10th Ed, ACS 0604 listed aphasia/dysphasia with dysphagia in the Table of Stroke additional diagnoses indicating severity. For 11th Ed dysphagia remains in the list of associated conditions while aphasia/dysphasia were removed.

In the literature deficits and associated conditions have been variously described. E.g.

A "deficit" is the expression of ***direct neurological damage*** due to the CVA e.g., paralysis, apraxia/dyspraxia, aphasia/dysphasia, anarthria/dysarthria, aphonia/dysphonia, (dysphagia), hemianopia/quadrantanopia, diplopia, neurogenic neglect, etc.

An "associated condition" is *a* ***multifactorial condition*** arising in a (non-nervous system) body system in a patient with a CVA episode e.g., aspiration pneumonia, pressure injury, incontinence, urinary retention, sepsis, pulmonary embolism and venous thrombosis etc.

Can IHPA

- Provide a definition for "deficit" and "associated condition"?
- Explain why dysphagia is listed as an associated condition? Should dysphagia be considered a deficit and automatically coded as per dot point 1, since dysphagia arises from direct neurological damage unlike the other listed

- conditions (i.e., aspiration pneumonitis, pressure injury (ulcer), incontinence and urinary retention)?
- Often incontinence or urine retention will be multifactorial and therefore considered an associated condition for classification purposes. However, if documentation indicates incontinence or urine retention is a deficit of the stroke (i.e., arises from direct neurological damage), should they be considered deficits for classification purposes, and automatically coded as per dot point 1?

Thank you

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0139
QUERY TITLE	**Reticulohistiocytoma morphology**
QUERY SPECIALTY	NEOP - Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	06/01/2022
IHACPA QUERY ID NUMBER	Q3770
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

The ICD-10-AM Alphabetic Index lists morphology code M8831/0 *Histiocytoma NOS* for reticulohistiocytoma (D76.3).

However, ACS 0233 *Morphology* indicates that a morphology code is assigned only for:
C00-D48
O01.0
O01.1
O01.9
Q85.0

Other conditions Indexed to D76.3 (e.g., reticulohistiocytic granuloma, histiocytosis and xanthogranuloma) do not have a morphology code listed in the Index.

Please clarify whether reticulohistiocytoma requires a morphology code? If yes, would any of the other conditions Indexed to D76.3 also require the same morphology code?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0140
QUERY TITLE	**Chapter 15 codes to add specificity to O08 *Complications following abortion and ectopic/molar pregnancy***
QUERY SPECIALTY	OBST – Pregnancy, childbirth and the puerperium
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	06/01/2022
IHACPA QUERY ID NUMBER	Q3771
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

For a missed abortion with ruptured uterus, the codes O02.1 *Missed abortion* and O08.6 *Damage to pelvic organs and tissues following abortion and ectopic and molar pregnancy* are assigned. Should O71.0 *Rupture of uterus* also be assigned to provide further specificity to O08.6?

WACCA interpret that O71.0 *Rupture of uterus* ought to be assigned based on highlighted logic in attached retired Coding Rule Q2893 *ACS 1544 Complications following abortion and ectopic molar pregnancy.*

When ACS 1544 was revised and Q2893 retired, an instruction was added to "Assign an additional diagnosis code from another chapter, where it adds specificity". However, in this instance, the code that adds specificity is **not** from another chapter.

All the examples in the ACS 1544 involve conditions from other chapters and unfortunately the original uterine perforation example was removed when ACS 1544 was updated.

Can codes from the same chapter (Chapter 15) be added following O08 to add specificity?

IHACPA coding query response

WACCA QUERY ID NUMBER	IHACPA0125
QUERY TITLE	**Palmar space abscess**
QUERY SPECIALTY	SKSC - Diseases of the skin and subcutaneous tissue
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au.
DATE SUBMITTED	06/01/2022
IHACPA QUERY ID NUMBER	Q3768
DATE QUERY RESPONDED TO	17/06/2024
ICD-10-AM/ACHI/ACS EDITION	12th
ACCOMPANYING ATTACHMENTS	Yes

NOTE

IHACPA responded to this query on 17 June 2024 by publishing National Coding Advice (NCA): Q3768 *Palmar space abscess* (effective 1 Jul 2024). To view this NCA, see IHACPA's Australian Classification Exchange (ACE) portal: Home | Australian Classification Exchange (ihacpa.gov.au)

QUERY

Which ICD-10-AM code should be assigned for abscess of palm under palmar fascia?

Which ACHI code should be assigned for drainage of abscess beneath palmar fascia (if clinician clarification is not possible)?

Please see clinical documentation (attached) and interim advice provided by WACCA (summarised below).

Summary of WACCA interim advice

- PD documented on the discharge summary: ***Abscess of palm of hand (left)***.
    - Considering the circumstances of the episode (incision and drainage, antibiotics) the PD documented on the summary is consistent with the definition of principal diagnosis in ACS 0001 *Principal diagnosis*.
    - For ***Abscess of palm of hand (left)*** assign L02.41 *Cutaneous abscess, furuncle and carbuncle of upper limb*, following Index pathway: **Abscess**; -palmar (space).
    - Although the operation report indicates the abscess is deeper than cutaneous tissue (i.e., there is ***thick pus - under palmar fascia***), L02.41 is to be assigned because 'space' is included as a non-essential modifier in L02.41's Index pathway. This indicates L02.41 is assigned for palmar abscesses that are deeper than cutaneous tissue. The palmar spaces (i.e., midpalmar, thenar and hypothenar) are deeper than the palmar fascia (aponeurosis).
    - The palmar abscess is ***under palmar fascia***, not of palmar fascia.
    - The ICD-10-AM Tabular List *Code first* instruction at T89.0 *Complications of open wound* and ACS 1917 *Open wounds* does not provide PD sequencing instruction. These instructions provide a sequencing directive for the open wound code versus the complicated open wound code, i.e., sequence the open wound code (S61.88) before the complicated open wound code (T89.02). Sequencing of an open wound code (S61.88) versus a specific infection code (L02.41) as PD will differ on a case by case basis in accordance with ACS 0001 *Principal diagnosis*. The content in retired ACCD Coding Rule Q2870 *Cellulitis with recent injury* (effective 1 Jul 2015 to 1 Jul 2017) illustrates this.
- The PP documented on the operation report is: ***Left palm abscess – Incision and drainage*** (sic).
    - Other documentation includes ***thick pus – under palmar fascia – 5ml, no pus in sheath, nerves intact, wash***.
    - To view under the palmar fascia, the tendon sheath and the nerve, the palmar fascia would likely have been incised.
    - The palmar fascia (aponeurosis) is connective tissue and connective tissue is soft tissue. Tendons and nerves are also soft tissue. See ACS 1916 *Superficial and soft tissue injuries*, *Soft tissue injuries* for a definition of soft tissue.
    - Given the aforementioned dot points, the abscess is likely of soft tissue.
    - For ***Left palm abscess – Incision and drainage,*** assign 30223-03 [1559] *Incision and drainage of abscess of soft tissue*, following Index pathway: **Drainage**; -abscess; --soft tissue.

- Documentation on the operation report is scant, so the PP code assigned is on a best endeavour basis. The medical officer ought to clarify the specific anatomic site of the abscess, to verify or otherwise that 30223-03 is the appropriate PP code. Other possible PP codes may include: 30223-01 [1606] *Incision and drainage of abscess of skin and subcutaneous tissue* or 46519-00 [1440] *Incision and drainage of middle palmar, thenar or hypothenar spaces of hand*.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0132
QUERY TITLE	**Shockwave intravascular lithotripsy/lithoplasty**
QUERY SPECIALTY	CIRC – Diseases of the circulatory system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	04/08/2021
DATE QUERY RESPONDED TO	15/03/2024
IHACPA QUERY ID NUMBER	Q3741
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

NOTE

IHACPA responded to this query on 15 March 2024 by publishing National Coding Advice (NCA): Q3741 *Shockwave intravascular lithotripsy* (effective 1 Apr 2024). To view this NCA, see IHACPA's Australian Classification Exchange (ACE) portal: Home | Australian Classification Exchange (ihacpa.gov.au)

QUERY

Thank you for your consideration of our query.

To ensure consistent coding practice, can IHPA advise as to the correct ACHI code to assign for the procedure **shockwave intravascular lithoplasty/-tripsy**?

Research indicates that shockwave intravascular lithoplasty/-tripsy is designed to deliver localised pulsatile sonic pressure waves, 'modifying' calcified lesions in a safe and reproducible manner.

'Lithoplasty Technology utilises a treatment system which includes Lithoplasty Technology Balloon Catheters, a connector cable and generator. These are familiar devices for interventionalists, making the technology inherently familiar, easy to

learn, adopt, and use on a day-to-day basis. Lithoplasty Balloon Catheters ***are prepared and delivered exactly like traditional balloon angioplasty devices****. The catheters have proximal and distal markers, so they can be accurately placed within the lesion.*
See: http://www.io.nihr.ac.uk/wp-content/uploads/migrated/Lithoplasty-balloon-catheter-for-PAD-FINAL.pdf

WACCA note that the Victorian Coding Committee (VICC) have a similar query. As research indicates lithoplasty/-tripsy is performed to assist angioplasty, WACCA agree with the Victorian Coding Committee's (VICC) Query 3103 *Shockwave lithoplasty*, and that shockwave lithoplasty/-tripsy is performed via a balloon catheter and should be assigned an ACHI code for angioplasty by following the Index at: Angioplasty, -transluminal balloon, by site.

Can IHPA please inform the correct classification of shockwave intravascular lithoplasty/-tripsy as there is no specific ACHI code to classify shockwave intravascular lithoplasty/-tripsy?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0149
QUERY TITLE	**Flexible Endoscopic Evaluation of Swallowing (FEES) performed by speech pathologist**
QUERY SPECIALTY	RESP – Diseases of the respiratory system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	04/08/2021
IHACPA QUERY ID NUMBER	Q3813
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	Yes

Dear IHACPA

Thank you kindly for taking the time to consider and respond to this query from the Western Australia Clinical Coding Authority.

Regards, WACCA

QUERY

WACCA require assistance in assigning the correct ACHI code for Fibreoptic Endoscopic Evaluation of Swallowing or FEES.

Fibreoptic Endoscopic Evaluation of Swallowing (FEES):

- is an instrumental assessment tool used to evaluate swallowing function and guide the treatment of swallowing disorders (dysphagia).
- involves passing the nasendoscope transnasally to allow direct visualisation of the oropharynx, pharynx and larynx during swallowing.

Historically, nasendoscopy has routinely been used by Ear, Nose and Throat surgeons to assess the larynx. However, as FEES is an assessment to determine swallow safety, speech pathologists are now trained to perform FEES independently.

WACCA note the ACHI Tabular List Introduction states:

> "6. *The Interventions in ACHI are provider neutral. That is, the same code is assigned for a specific intervention regardless of which health professional performs the intervention."*

Since there is no indexed procedure for Fibreoptic Endoscopic Evaluation of Swallowing (FEES), we propose assigning the following codes depending on the extent on the scope, regardless of which health professional performs the intervention:

Where the scope extends into the larynx, assign 41764-03 [520] *Fibreoptic laryngoscopy* by following the pathway:

Endoscopy, endoscopic
-larynx (direct) (with biopsy) 41849-00 [520]
- - by operating microscope 41855-00 [520]
- - - with removal of lesion 41864-00 [523]
- - - - by laser 41861-00 [523]
- - with removal of lesion 41852-00 [523]
- - fibreoptic 41764-03 [520]

If examination indicates extension into the pharynx only, assign 41764-02 [416] *Fibreoptic examination of pharynx* by following the pathway;

Endoscopy, endoscopic
- nasopharynx 41764-02 [416]
- pharynx 41764-02 [416]

Could IHPA please advise if WACCA's choice of codes is correct?

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0119
QUERY TITLE	**Postpartum haemorrhage (PPH) with anaemia or low haemoglobin**
QUERY SPECIALTY	OBST – Pregnancy, childbirth and the puerperium
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	02/08/2021
IHACPA QUERY ID NUMBER	Q3738
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

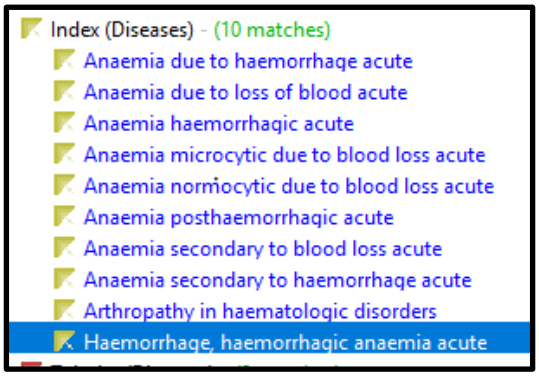
QUERY

WACCA seeks IHPA's assistance in classifying postpartum haemorrhage (PPH) with anaemia or low haemoglobin.

Does a causal link need to be documented between PPH and low haemoglobin or anaemia in order to assign D62 *Acute posthaemorrhagic anaemia*?

If PPH is documented in an episode and there is no indication that patient was anaemic on admission, can blood loss from PPH be assumed to be acute and therefore, any subsequent documentation of anaemia or low haemoglobin be classified as acute blood loss anaemia?

D62 *Acute posthaemorrhagic anaemia* requires the essential modifier "acute" to be documented as per the Index:


Index (Diseases) - (10 matches)
Anaemia due to haemorrhage acute
Anaemia due to loss of blood acute
Anaemia haemorrhagic acute
Anaemia microcytic due to blood loss acute
Anaemia normocytic due to blood loss acute
Anaemia posthaemorrhagic acute
Anaemia secondary to blood loss acute
Anaemia secondary to haemorrhage acute
Arthropathy in haematologic disorders
Haemorrhage, haemorrhagic anaemia acute

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0124
QUERY TITLE	**Spondylosis unspecified**
QUERY SPECIALTY	MSCT – Diseases of the musculoskeletal system and connective tissue
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	15/07/2021
IHACPA QUERY ID NUMBER	Q3736
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

To ensure consistent coding practice, can IHPA advise as to the correct ICD-10-AM diagnosis code assignment for spondylosis that is *unspecified* e.g., cervical spondylosis with no further specification?

The indexing for spondylosis unspecified is confusing. WACCA have provided the following advice. Example case: 'cervical spondylosis'. Please confirm (or otherwise) our advice.

Advice:

For documentation of cervical spondylosis, assign **M47.82 *Other spondylosis, cervical region***, following the Index pathway:

Spondylosis M47.9-
- with
- - compression (of)
- - - nerve root or plexus M47.2-†, G55.2*
- - disproportion (fetopelvic) O33.0
- - - affecting
- - - - fetus or newborn P03.1
- - - - labour or delivery O65.0

- - myelopathy NEC M47.1-
- - radiculopathy M47.2-
- cervical M47.82
- cervicothoracic M47.83
- coccyx M47.88
- lumbar M47.86
- lumbosacral M47.87
- sacral, sacrococcygeal M47.88
- specified NEC M47.8-
- thoracic M47.84
- traumatic M48.3

Note:

- **Osteoarthritis** and **osteoarthrosis** of the spine have the following indexing:
  Osteoarthritis
  - spine (see also Spondylosis) M47.9-
  Osteoarthrosis
  - spine (see also Spondylosis) M47.9-
  Therefore, when osteoarthritis and osteoarthrosis of the cervical spine is documented, follow the 'See also' instruction above, then progress through the subterms under Spondylosis to assign **M47.82** ***Other spondylosis, cervical region.***

- **M47.92** ***Spondylosis, unspecified, cervical region*** is NOT assigned for the example above (cervical spondylosis).
  Codes in **M47.9-** ***Spondylosis, unspecified*** are assigned for spondylosis not otherwise specified (NOS, i.e., spondylosis not further specified by any of the indexed subterms below the lead term Spondylosis).

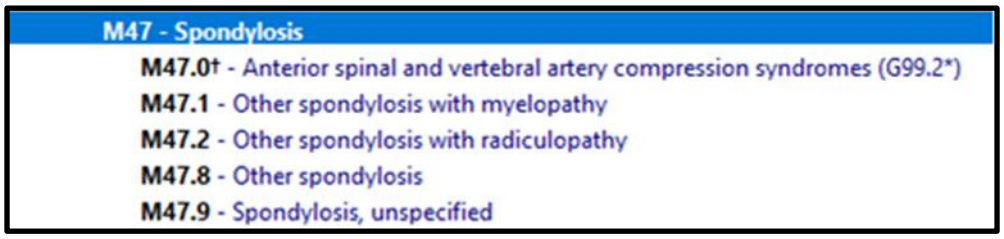
- Codes in M47.9- are also assigned for several nonspecific indexed terms. Some nonspecific terms/conditions of the cervical spine, that are assigned to **M47.92** ***Spondylosis, unspecified, cervical region*** are:

  - cervical **arthrosis** of spine
  - cervical **degenerative changes** of the spine
  - cervical **hypertrophic spondylitis**
  - cervical **spondylitis deformans**
  - cervical **degenerative joint disease**
  - cervical **senile spondylitis**

  Example indexing of a nonspecific term/condition: 'Degenerative changes of cervical spine'
  Degeneration, degenerative
  - changes, spine or vertebra M47.9-

then follow the instructions in the Tabular List to assign fifth digit '2' to denote the 'cervical' site.

- When following the Index at Spondylosis, the subterm "with" takes precedence. If no applicable subterm is listed under "with," progress further to the subterms below 'with'. If no applicable subterm is listed there, default to assigning a code from **M47.9- *Spondylosis, unspecified***
- **M47.8- *Other spondylosis*** is for the classification of spondyloses that are *other than* compression syndromes (M47.0†), with myelopathy (M47.1), with radiculopathy (M47.2) or unspecified/NOS (M47.9-).



- WACCA recognise there may be issues when following 3M CodeFinder to assign a code for **other** or **unspecified spondylosis**.
  As per diagram 1 below, option 'B. Other specified' is selected to assign a code for spondylosis by site (see Diagram 2), including those sites not listed in this first menu (i.e., site specified not elsewhere classified, e.g., the sites: multiple, occipito-atlanto-axial, thoracolumbar).

Diagram 1 – First menu

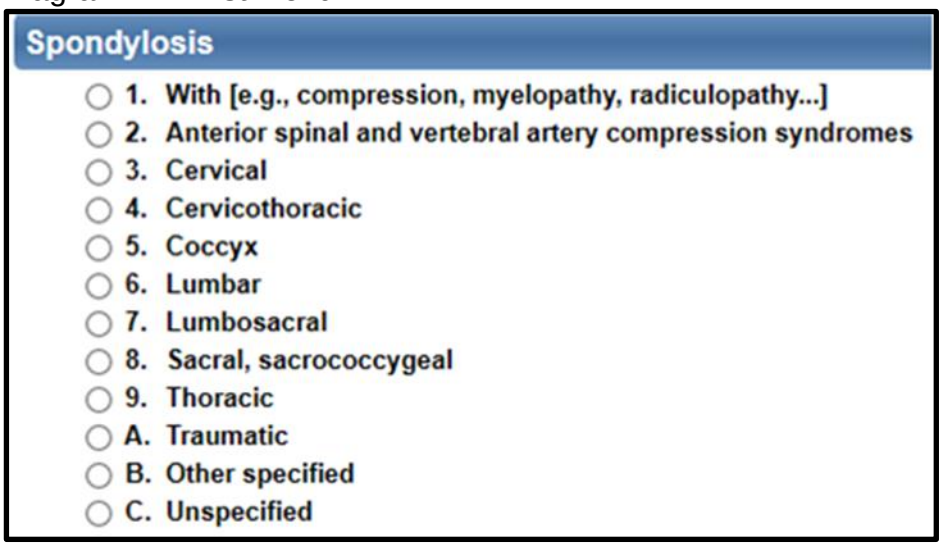


Diagram 2 – Second menu, seen when option 'B. Other specified' is selected from the first menu

Site

- ○ 1. Cervical
- ○ 2. Cervicothoracic
- ○ 3. Lumbar
- ○ 4. Lumbosacral
- ○ 5. Multiple
- ○ 6. Occipito-atlanto-axial
- ○ 7. Sacral and/or sacrococcygeal
- ○ 8. Thoracic
- ○ 9. Thoracolumbar
- ○ A. Unspecified

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0121
QUERY TITLE	**Multistage external ear reconstruction**
QUERY SPECIALTY	SKSC – Diseases of the skin and subcutaneous tissue
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	29/06/2021
IHACPA QUERY ID NUMBER	Q3731
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	Yes

QUERY

(See attached operation reports and query to surgeon):

Over-arching query
What is/are the correct ACHI procedure code(s) to assign for the third (and sometimes further subsequent) stage of a reconstruction of the external ear (e.g., for Microtia)?

Background information/research
Microtia ear reconstruction procedures are classically two stage but may need to be multi-stage. The ear lobe reconstruction component tends to vary from stage to stage and is determined by the degree/type of deformity.

Research:
https://www.nagata-microtia.com/method.html
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772554/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5950715/

- The first stage of a reconstruction of the external ear typically includes: cartilage harvest from the chest wall, banking of extra cartilage in the abdominal wall, a cartilage framework is created and located at the new ear site within a skin pocket.

- The second stage of a reconstruction of the external ear typically includes: elevation of the created ear from the side of the head, (performed several months after the first stage) with the banked cartilage from the first operation. The new groove behind the ear is covered with a post auricular FTSG from the inguinal region.
- Thereafter, other procedures are performed as necessary in third and subsequent stages. For the third stage operation report attached: a FTSG from the right ear was used to create a left ear lobe, an area of the left ear was debrided of necrotic tissue, a FTSG was harvested from the region of the right ear (with a left ear lobe incision and an extruded nagata wire removal). A right ear setback otoplasty was performed.

WACCA's advice
When asked how to code the attached operation reports, WACCA's advice was:

- For Op 1, Stage 1, assign:

45660-00 [1684] *Reconstruction of external ear, first stage*

- For Op 2, Stage 2, assign:

45661-00 [1684] *Reconstruction of external ear, second stage*
with
an additional procedure code for the chest wall scar excision

- For Op 3, Stage 3:

There is no ACHI code for a 'Reconstruction of external ear third stage.'

As ear reconstruction procedures were classically two staged procedures, the ACHI procedure classification only has specific codes for:

45660-00 [1684] *Reconstruction of external ear, first stage*
45661-00 [1684] *Reconstruction of external ear, second stage*
There is no specific ACHI procedure code for subsequent stages.

WACCA advised that a query should be forwarded to the surgeon to determine the most appropriate code assignment (suggested content for the query is attached). Queries may need to be sent on a case by case basis as the procedures performed in a multistage reconstruction will vary.

For the third stage of an ear reconstruction, the options for ACHI code assignment are:

- Option 1

Left ear: Assign 45661-00 [1864] *Reconstruction of external ear, second stage* as a best fit ACHI procedure code.
Right ear: Assign an ACHI procedure code for otoplasty.

- Option 2

Left ear: Assign individual ACHI procedure codes for each significant procedural component of the third stage reconstruction.
Right ear: Assign an ACHI procedure code for otoplasty.

Specific query
Could IHPA confirm WACCA's advice (or otherwise) for the code assignment for a third and subsequent stage of a multistage external ear reconstruction?

Request for ACHI code creation
Given that external ear reconstruction is increasingly being performed in multiple stages, WACCA suggest the creation of an ACHI code for "third and subsequent

- stages."**M47.89 *Other spondylosis, site unspecified*** is assigned for those spondyloses not associated with trauma, compression syndromes, myelopathy, or radiculopathy AND without a site specified.

ICD-11 and ICD-10-CM (USA) have addressed this Indexing confusion by changing M47.9- from a Category to a Code; ICD-10-CM **M47.9 *Spondylosis NOS*** and ICD-11 **FA8Z *Degenerative condition of spine, unspecified.***

(WACCA note there is a public submission P504 18/12/2020 similarly querying the indexing of 'spondylosis unspecified')

Thank you.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0122
QUERY TITLE	**Closure of postoperative urethrocutaneous fistula**
QUERY SPECIALTY	GEUR – Diseases of the genitourinary system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	29/06/2021
IHACPA QUERY ID NUMBER	Q3730
DATE QUERY RESPONDED TO	15/03/2024
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	Yes

NOTE

IHACPA responded to this query on 15 March 2024 by publishing National Coding Advice (NCA): Q3730 *Closure of postoperative urethrocutaneous fistula* (effective 1 Apr 2024). To view this NCA, see IHACPA's Australian Classification Exchange (ACE) portal: Home | Australian Classification Exchange (ihacpa.gov.au)

QUERY

(See attached example clinical documentation):

Over-arching query
Could IHPA advise on the correct ACHI procedure code for the closure of a postoperative urethrocutaneous fistula?

Background information/research
WACCA note that the ACHI Index Pathway for closure of postoperative urethral fistula has the Essential Modifier (EM) '*…following repair for hypospadias…*'. This would indicate that the ACHI Classification accepts that postoperative urethral fistulae are common after a repair of hypospadias. However, the EM excludes this pathway for other postoperative urethral fistulae.

Our research shows that repair of postoperative urethral fistulae following repair of hypospadias is not dissimilar to repair of these fistulae after other operative interventions such as repair of paediatric bladder exstrophy. Postoperative urethrocutaneous fistulae may be small fistulae (<2 mm) closed with a simple closure, larger ones (>2 mm) with good vascular surrounding skin requiring a local skin flap, or large recurrent fistulae with impaired local surrounding skin requiring a waterproofing interposition layer repair technique.

Specific query
Can IHPA confirm (or otherwise) the following code assignment for closure of a cvpostoperative urethrocutaneous fistula when the surgery preceding it is not the repair of a hypospadias?

Do not assign **37833-00** ***Hypospadias, repair of postoperative urethral fistula*** following Index pathway:

Closure
- fistula
- - urethral
- - - postoperative, following repair for hypospadias 37833-00 [1198]

Instead, assign **90364-00** ***Other repair of urethra*** following the Index Pathway

Repair
- urethra NEC 90364-00 [1122]

Request for Index pathway creation
WACCA suggest the creation of a generic ACHI Index Pathway for repair of **any** postoperative urethral fistulae.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0115
QUERY TITLE	**Subconjunctival blocks administered for cataract extraction**
QUERY SPECIALTY	EYEA – Diseases of the eye and adnexa
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	10/06/2021
IHACPA QUERY ID NUMBER	Q3725
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

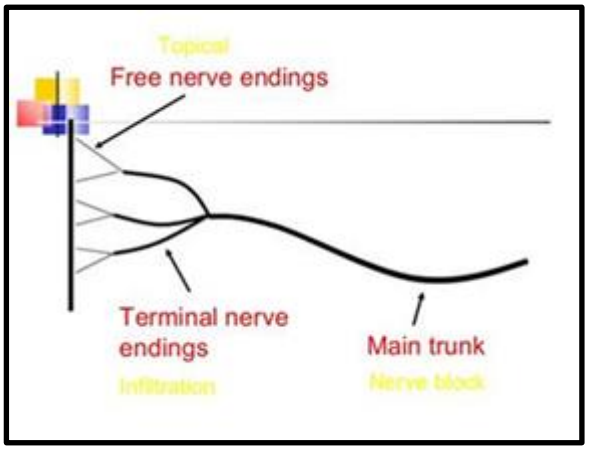
WACCA request advice on the correct classification of subconjunctival blocks administered for cataract extraction.

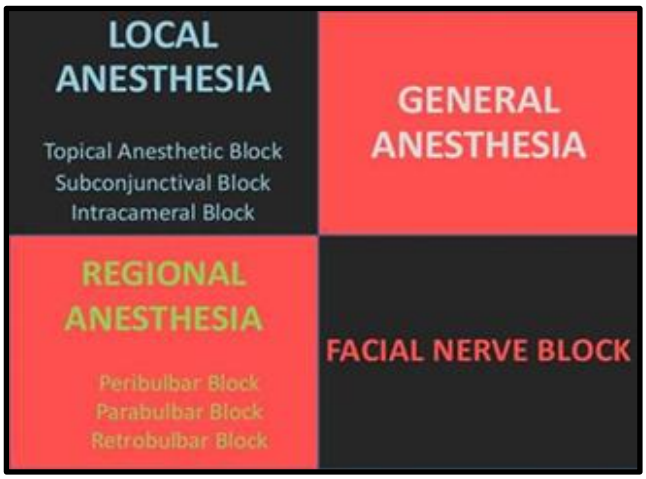
WACCA's clinical interpretation of Subconjunctival "Block" for operative anaesthesia is that these are an example of Local Anaesthetic (LA) infiltration rather than "Block". LA is injected into subconjunctival space. LA infiltrates through the space and small peripheral terminal nerve fibres are flooded with local anaesthetic solution anaesthetising the area. There is no direct placement of LA adjacent to a nerve or its major branch (a nerve block) resulting in blockade of the signals in the nerve for anaesthesia of the region of that nerve supplies.

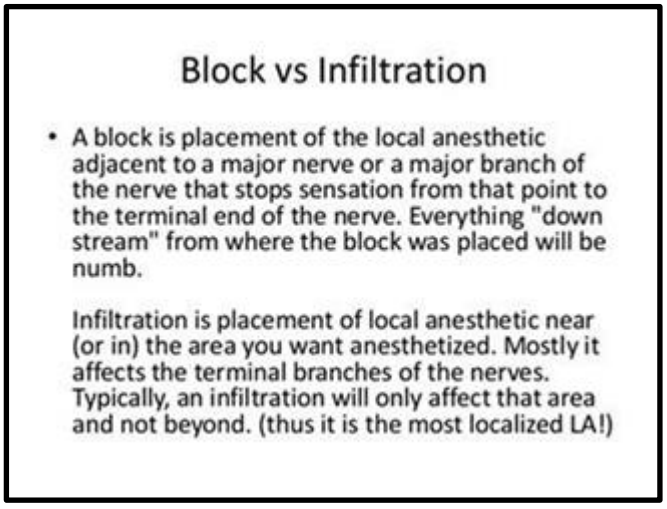
Research:
https://www.nysora.com/regional-anesthesia-for-specific-surgical-procedures/head-and-neck/ophthalmic/local-regional-anesthesia-ophthalmic-surgery/

"…Subconjunctival anaesthesia
Subconjunctival injection of LA, a technique relatively unfamiliar to many anesthesiologists, provides anesthesia of the anterior segment without akinesia. Also known as "perilimbal" anesthesia, it is, in effect, a form of episcleral injection and can also be thought of as a "very anterior" or "very superficial" Sub-tenon's nerve block.

This nerve block is useful for cataract, pterygium, and superficial glaucoma surgery. After pretreatment with one drop of topical anesthetic, a fine-bore (27- to 30-gauge) needle is used to lift the superotemporal or inferotemporal conjunctiva at least 5–8 mm from the limbus (Figure 13). A surgical microscope or loupes can be used to avoid conjunctival vessels and hematoma. Once the needle is under the conjunctiva, 0.5–0.8 mL of local anesthetic solution will cause chemosis, which is dispersed with gentle, constant pressure, either using fingers or a purpose-specific weight or balloon. Hyaluronidase can be added to assist with the spread of solution and dispersal of chemosis. Compared to retrobulbar injection, this technique is less painful and reduces the need for supplemental anesthesia during cataract surgery. Injection at the superotemporal conjunctiva appears to be less painful than injection at the inferotemporal conjunctiva. Subconjunctival injection results in reliable and substantial concentrations of local anesthetic in the aqueous humor…"







Hospitals encounter documentation issues. The Anaesthetic Records in question may contain a section entitled Regional Anaesthesia, however there is often no section for Local Anaesthesia. This has led to some Anaesthetists documenting their subconjunctival technique in the Technique box of the Regional Anaesthesia section or the Notes section.

WACCA's advice has been that, when there is conflicting documentation such as this, a coding query is warranted. If clarification with the clinician is not possible, then follow the logic in WA Coding Rule 0311/03 *Retrobulbar or peribulbar block* which advises that if the documentation is unclear, do not code the block.

https://ww2.health.wa.gov.au/-/media/Files/Corporate/general-documents/Clinical-coding/Index-coding-rules/WACR-031103.pdf

WACCA request IHPA to clarify the classification of retrobulbar, peribulbar and subconjunctival ***"blocks"*** to

- regional nerve block (affecting major nerves or branches of major nerves for anaesthesia of the anatomical region they supply), or
- infiltration of LA (affecting terminal branches of nerves for anaesthesia at the localised tissue level)?

Thank you.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0113
QUERY TITLE	**Neoplasms of transplanted organs**
QUERY SPECIALTY	NEOP - Neoplasms
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	07/04/2021
IHACPA QUERY ID NUMBER	Q3702
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

Could the Independent Hospital Pricing Authority (IHPA) advise on the correct site code assignment for a neoplasm arising in a transplanted organ?

WACCA has provided the following interim advice and seeks your confirmation or otherwise.

A transplanted organ is considered analogous to a locus of ectopic tissue. Therefore, follow the instructions in ICD-10-AM Chapter 2 Neoplasms Notes Point 6

Malignant neoplasms of ectopic tissue
Malignant neoplasms of ectopic tissue are classified to the site where they are found, e.g. ectopic pancreatic malignant neoplasms of ovary are classified to C56 Malignant neoplasm of ovary.

Code the site of a neoplasm in a transplanted organ to the location of the transplanted organ, i.e., code the neoplasm site to where the neoplasm currently resides or lies.

Examples:

- For a diagnosis of a neoplasm in a transplanted section of colon conduit serving as an oesophagus. Code the neoplasm site as oesophagus.
- For a diagnosis of a neoplasm in a transplanted section of colon serving as part of a bladder wall reconstruction. Code the neoplasm site as bladder.

Interim decision: For a neoplasm arising in a transplanted organ the neoplasm is classified to the site where the transplanted organ is located.

Could the IHPA confirm this decision or otherwise?

IHACPA RESPONSE

Publication of IHACPA Coding Rule/NCA Q3702 *Neoplasm in transplanted organ/tissue* (effective 1 Oct 2023).

IHACPA public submission

WACCA QUERY ID NUMBER	IHACPA0164
QUERY TITLE	**Catatonia due to mental disorder other than schizophrenia**
QUERY SPECIALTY	MABD – Mental and behavioural disorders
SUBMITTER NAME	WA Clinical Coding Authority
SUBMITTER ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	14/01/2021
IHACPA QUERY ID NUMBER	P505
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

The Diagnostic and Statistical Manual of Mental Disorders recognises catatonia associated with another mental disorder (e.g., depression) separately to catatonic disorder due to another medical condition. The relevant Tabular entries in the current edition (DSM-5) are:

Catatonia associated with another mental disorder 293.89 (F06.1)
Catatonic disorder due to another medical condition 293.89 (F06.1)

Also, in the change from DSM-4 to DSM-5, the catatonic subtype of schizophrenia (F20.2) was deleted and F06.1 used instead as a specifier in addition to the appropriate schizophrenia code.

ICD-10 has not kept pace with DSM changes to catatonia classification, as there is no equivalent code for catatonia associated with another mental disorder. In ICD-10 the default code for “catatonia” is F20.2 Catatonic schizophrenia. With the current limitations in ICD-10-AM, F20.2 is the only code that can be assigned as the index entry (with the non-essential modifier) cannot be ignored.

IHACPA coding query

WACCA QUERY ID NUMBER	IHACPA0116
QUERY TITLE	**Retrograde double balloon enteroscopy with ileal biopsy and colonic polypectomy**
QUERY SPECIALTY	DIGS – Diseases of the digestive system
SUBMITTER NAME	WA Clinical Coding Authority (WACCA)
ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	29/06/2020
IHACPA QUERY ID NUMBER	Q3732
ICD-10-AM/ACHI/ACS EDITION	11th
ACCOMPANYING ATTACHMENTS	No

QUERY

Over-arching query

Can IHPA advise on the correct classification of Retrograde Double Balloon Enteroscopy (RDBE)?

There is some confusion as to the correct ACHI Index Pathway for coding interventions with RDBE that are classified to the colonoscopy blocks.

The new code 30680-00 [1005] *Balloon enteroscopy* (includes via antegrade/retrograde approach) was created with a *Code also* instruction for endoscopic interventions performed on the **small** intestine (classified to blocks [892], [1005] to [1008]), but not with endoscopic interventions performed on the **large** intestine (classified to blocks [905, 908, 911]). WACCA seek confirmation that:

- the ACHI classification assumption is that balloon enteroscopy will be routinely performed for procedures on the small intestine, hence the 'Code also' for these small intestine intervention blocks.
- the ACHI Classification's intent is to 'Code also' **any endoscopic procedure** performed with a RDBE.

Specific queries

WACCA received the following queries and require confirmation or otherwise that our advice was correct.

QUERY ONE

- "...What procedure code would be correct to assign for an ileum biopsy (small intestine) via (Retrograde) DBE? ..."

WACCA advice

For Retrograde Double Balloon Enteroscopy with ileal biopsy, assign:
30680-00 [1005] *Balloon enteroscopy* and
32090-01 [911] *Fibreoptic colonoscopy to caecum, with biopsy*

Following:
1.
ACHI Index pathway
Enteroscopy (double balloon) (single balloon) 30680-00 [1005]

2.
ACHI Tabular instruction at 30680-00 [1005]
Code also when performed:
endoscopic procedure(s) performed on duodenum, jejunum and ileum (see blocks [892], [1005] to [1008])

3.
ACHI Index pathway
Biopsy, ileum, endoscopic via (closed), colonoscopy, long (beyond hepatic flexure) (to caecum) 32090-01 [911]

QUERY TWO

- "…What procedure code would be correct to assign if a polyp was removed from the ileum via (Retrograde) DBE? ..."

WACCA advice

For Retrograde Double Balloon Enteroscopy with ileal polypectomy, assign:
30680-00 [1005] *Balloon enteroscopy*
30478-18 [1008] *Panendoscopy to ileum with excision of lesion*
(Panendoscopy to ileum with excision of polyp)

Following:
1.
ACHI Index pathway

Enteroscopy (double balloon) (single balloon) 30680-00 [1005]

2.
ACHI Tabular instruction at 30680-00 [1005]
Code also when performed:
endoscopic procedure(s) performed on duodenum, jejunum and ileum (see blocks [892], [1005] to [1008])

3.
ACHI Index pathway
Polypectomy, ileum, endoscopic 30478-18 [1008] (the default code when 'via/colonoscopy' not Indexed)

QUERY THREE

- "…Do we need to add a procedure code for interventions performed on the large intestine during (Retrograde) DBE for ileum lesion as well? ..."

WACCA advice

Yes, interventions performed on the large intestine should be coded also, as per ACS 0020 *Bilateral/multiple procedures/Point 3: The same procedure repeated during a visit to theatre involving ONE ENTRY POINT/APPROACH and different lesions*.

E.g., For Retrograde Double Balloon Enteroscopy with ileal biopsy and colonic polypectomy, assign
30680-00 *Balloon enteroscopy* and
32090-01 *Fibreoptic colonoscopy to caecum, with biopsy* and
32093-00 *Fibreoptic colonoscopy to caecum, with polypectomy*

IHACPA public submission

WACCA QUERY ID NUMBER	IHACPA0012
QUERY TITLE	**Triplegic spastic cerebral palsy**
QUERY SPECIALTY	NERV – Diseases of the nervous system
SUBMITTER NAME	WA Clinical Coding Authority
SUBMITTER ORGANISATION	WA Department of Health
SUBMITTER EMAIL	clinical.coding@health.wa.gov.au
DATE SUBMITTED	15/09/2017
IHACPA QUERY ID NUMBER	P325
ICD-10-AM/ACHI/ACS EDITION	10th

QUERY

There is currently no index entry for triplegic spastic cerebral palsy.

Following the ICD-10-AM Alphabetic index pathway:

Palsy
- **cerebral**
- - **spastic** G80.00
- - - diplegic G80.01
- - - hemiplegic G80.02
- - - monoplegic G80.09
- - - paraplegic G80.09
- - - quadriplegic G80.03
- - - specified NEC G80.09
- - - tetraplegic G80.03

The WA Clinical Coding Authority has advised to assign G80.09 *Other spastic cerebral palsy.*

Can the ACCD please review the classification and amend the index to include this specified spastic cerebral palsy diagnosis?

User guide

1. This document contains:

    a. queries received by the Western Australian Clinical Coding Authority (WACCA) from 1 June 2023 and their responses.
    b. queries received by WACCA that have been progressed for discussion by the WA Clinical Coding Technical Advisory Group.
    c. queries submitted to the Independent Health and Aged Care Pricing Authority (IHACPA) via the Australian Classification Exchange (ACE) portal by WACCA. These queries are pending a response from IHACPA.
        i. Where it's indicated that the IHACPA coding query submission included an 'accompanying attachment,' the accompanying attachment is not included in this document.
    d. queries responded to by IHACPA that will not be published as Coding Rules (NCA - National Coding Advice) on the ACE portal.

2. The purpose of this document is to facilitate transparency, coding discussion and the production of high quality coding data by promoting consistent coding practice.

3. *WACCA coding queries* are:

    a. current at the time of publication and will not be updated retrospectively. If you have further information from your health service to supplement a query, please submit it as per the WA Coding Query Process.
    b. not mandatory classification instruction or a substitute for WA Coding Rules or WACCA Clinical Coding Guidelines.
    c. a tool to promote discussion. If you believe a query response is incomplete, ambiguous or conflicting with other coding instruction, please submit a query as per the WA Coding Query Process.
    d. published on the first Monday of each month, regardless of whether they have been responded to. Query responses to unanswered queries will be published in subsequent months.

4. Interpretation and application of information in this document:

    a. In the first instance, contact your health service's coding coordinator/educator/manager/team leader for assistance with interpreting and applying the information in this document.
    b. Where queries and issues cannot be resolved at your health service, e-mail them to WACCA at coding.query@health.wa.gov.au
    c. Please ensure you're viewing the current version of this document.