As per the guidelines in ACS 0010, ‘dermal cyst’ or ‘angiomyoma’?

Report, the question is, would the documentation confirm the diagnosis with the benefit of the histology? Original clinical diagnosis. If the ‘angiomyoma’, which appears contradictory to the histological examination. However, histology reveals an clinical diagnosis of ‘dermal cyst’ in the absence of conditions. In the scenario cited, the clinician has documented a result for code assignment guidelines as justification for using the histopathology published for elevated PSA which cites the latter conditions. Particularly in light of previous advice they clearly add specificity to already documented and other diagnostic results should be assigned in the future edition of ACHI.

Clinical diagnosis versus histology

Q: What is the correct code to assign for aspiration of peritonsillar abscess?

A: The correct code assignment for ‘aspiration of peritonsillar abscess’ is 41807-00 [409] Incision and drainage of peritonsillar abscess, by following the index pathway:

Drainage
- abscess
- - peritonsillar 41807-00 [409]

or

Incision
- peritonsillar abscess 41807-00 [409]

The NCCC will consider improvements to the Tabular List and Alphabetic Index for this procedure for a future edition of ACHI.

Aspiration of peritonsillar abscess

Q: What is the correct code to assign for aspiration of peritonsillar abscess?

A: The correct code assignment for ‘aspiration of peritonsillar abscess’ is 41807-00 [409] Incision and drainage of peritonsillar abscess, by following the index pathway:

Closed reduction of acetabulum

Q: What is the correct code to assign for closed reduction of the acetabulum?

A: The acetabulum is part of the pelvis, specifically, the socket of the ball-and-socket hip joint. Acetabular fractures have conventionally been treated with open reduction and internal fixation (ORIF). However, the procedure is often associated with significant blood loss, infection, lengthy operative times and neurovascular complications (Crowl & Kahler, 2002). More recently a less invasive alternative to the conventional treatment has been closed (percutaneous) reduction and fixation, facilitated by image guided surgical navigation (Crowl & Kahler, 2002).

Currently there is no specific code in ACHI for this procedure, therefore, 90552-00 [1491] Other repair of hip should be assigned for this procedure, following the index pathway:

Repair
- hip NEC 90552-00 [1491]

The NCCC does not endorse the assignment of 47501-00 [1486] Open reduction of fracture of acetabulum with internal fixation as it is not an open reduction. Code 47498-00 [1479] Internal fixation of fracture of acetabulum cannot be assigned due to the excludes note which specifies ‘that with reduction of fracture’. However, NCCC will consider modifying the instructional notes at 47498-00 [1479] so that this code may be assigned in the future.

References
Crowl, A & Kahler, D, 2002, Closed Reduction and Percutaneous

Drainage
- abscess
- - peritonsillar 41807-00 [409]

or

Incision
- peritonsillar abscess 41807-00 [409]

"In the event that an investigation result varies from the clinical documentation..., the case should be referred to the clinician." ACS 0010 also states, "It is important to seek clinical advice where necessary for clarification of discrepancies between investigation results and clinical documentation.” Therefore, where there is discrepancy between the clinical diagnosis and histology, as cited in this scenario, clinical verification should be sought prior to code assignment.

The previous query response regarding elevated PSA, published in Coding Matters Vol 16 No 1 June 2009, is not the same, as elevated PSA is an abnormal test result indicative of other conditions not a clinical diagnosis in itself.

The NCCC will consider amendments to ACS 0010 General abstraction guidelines in a future edition of ACS.

As the guidelines in ACS 0010 General abstraction guidelines, be followed, which states, “In the event that an investigation result varies from the clinical documentation, such as a clinical diagnosis of gastric ulcer with ‘no evidence of ulcer’ reported on histopathology, the case should be referred to the clinician.” Or should the ACS 0010 guideline, be followed, which states, “Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions.” Particularly in light of previous advice published for elevated PSA which cites the latter guideline as justification for using the histopathology result for code assignment?

A: In the scenario cited, the clinician has documented a clinical diagnosis of ‘dermal cyst’ in the absence of histological examination. However, histology reveals an ‘angiomyoma’, which appears contradictory to the original clinical diagnosis. If the clinician was asked to confirm the diagnosis with the benefit of the histology report, the question is, would the documentation be ‘dermal cyst’ or ‘angiomyoma’?

As per the guidelines in ACS 0010 General abstraction guidelines, “In the event that an investigation result varies from the clinical documentation..., the case should be referred to the clinician.” ACS 0010 also states, “It is important to seek clinical advice where necessary for clarification of discrepancies between investigation results and clinical documentation.” Therefore, where there is discrepancy between the clinical diagnosis and histology, as cited in this scenario, clinical verification should be sought prior to code assignment.

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References
Crowl, A & Kahler, D, 2002, Closed Reduction and Percutaneous

- Incision
- peritonsillar abscess 41807-00 [409]
Coding of basal cell papilloma/seborrhoeic keratosis

Q:
We have received advice that basal cell papilloma and seborrhoeic keratosis are synonymous terms and the use of the different wording can be based on the surgeon’s preference. Could you advise if we should code L82 Seborrhoeic keratosis or D23. - M8050/0 Papilloma NOS? There is no indexed pathway to reach code L82 using ‘papilloma’ as the lead term.

A:
The terms basal cell papilloma and seborrhoeic keratosis may be synonymous and used interchangeably, however, they are classified separately in ICD-10. Therefore, NCCC advises that code assignment should be based on the documentation in the histology report.

NCCC will consider submitting a proposal to the WHO Update Reference Committee (URC) about this issue so it can be considered in a future update of ICD-10 or ICD-11.

Coding of multiple radiotherapy sessions

Q:
When radiotherapy is performed multiple times during an episode of care could you advise if it should be coded only once or should a code be assigned for each treatment?

In Fifth Edition, radiotherapy was coded only once according to ACS 0020 Multiple/bilateral procedures which stated ‘procedures performed without anaesthesia should be coded once only’.

However, following updates to ACS 0020 in Sixth Edition, radiotherapy appears to fall under classification point (1) ‘A procedure which is repeated during the episode of care should be coded as many times as it is performed.’ Also ACS 0229 Radiotherapy does not specify whether the procedure code for radiotherapy should be assigned only once or for each treatment.

A:
It was not intended that the Sixth Edition amendments to ACS 0020 Bilateral/multiple procedures would alter coding practice with respect to the number of times radiotherapy is coded during an episode of care. The instruction in ACS 0020 regarding classification of the same procedure repeated during the episode of care, provides ‘Examples of exceptions to this rule’ so it cannot be considered an exhaustive list. Therefore, similarly to chemotherapy, dialysis and blood transfusions, where the same procedure code applies, assign the procedure code for radiotherapy once only.

The NCCC will consider amending ACS 0020 Bilateral/multiple procedures and ACS 0229 Radiotherapy to specifically address coding of multiple radiotherapy sessions for a future edition of ICD-10-AM.

Diabetes mellitus with peripheral vascular disease

Q:
Can chronic venous insufficiency, and/or varicose veins with diabetes mellitus be coded to diabetes mellitus with peripheral vascular disease (E1-.51 or E1-.52)?

A:
While it can be argued that peripheral vascular disease (PVD) is definitionally inclusive of varicose veins and chronic venous insufficiency, these conditions with diabetes mellitus should not be classified to diabetes mellitus with peripheral vascular disease (E1-.51 or E1-.52). Clinical advice states that categories E1-.5- are intended for arterial complications of diabetes mellitus.

The NCCC will consider indexing improvements for chronic venous insufficiency, and/or varicose veins with diabetes mellitus in a future edition of ICD-10-AM.

Healthcare associated Staphylococcus aureus bacteraemia (HA SAB)

Q:
a) Should Y95 Nosocomial condition be assigned in addition to U90.0 Healthcare associated Staphylococcus aureus bacteraemia, or is it implicit in U90.0?

b) Is a condition onset flag (COF) of 1 assigned in the first admitted episode of care where HA SAB is diagnosed and a COF of 2 assigned for any subsequent admitted episode of care relating to the previously diagnosed HA SAB?

A:
a) There is no requirement to assign Y95 Nosocomial condition in addition to U90.0 Healthcare associated Staphylococcus aureus bacteraemia. U90.0 is an additional code which already specifies ‘healthcare associated’ and thereby makes the assignment of Y95 unnecessary.

b) ACS 0048 Condition onset flag states, "The condition onset flag is a means of differentiating those conditions which arise during, or arose before, an admitted patient episode of care." Therefore, NCCC agrees that a condition onset flag of 1 should be assigned in the episode of care where Healthcare associated Staphylococcus aureus bacteraemia (HA SAB) first arose and that a condition onset flag of 2 should be assigned in any subsequent episode of care relating to the previously diagnosed HA SAB, as it arose before the current admitted patient episode of care.
High flow nasal cannula

Q: What is the correct code to assign for high flow nasal cannula?

A: High flow nasal cannula (HFNC), more commonly referred to as 'High flow' is a novel means of respiratory support, introduced as an alternative to noninvasive ventilation (NIV) as it delivers air and oxygen at flow rates greater than those traditionally used with a nasal interface (Groves & Tobin, 2007; Shoemaker et al. 2007). HFNC is more than simple oxygen enrichment as it involves the administration of ventilatory support (Australia and New Zealand Intensive Care Society, 2011, personal communication). HFNC allows sufficient warmth and high levels of humidification to breathing gas and permits higher flow rates from nasal cannula devices to be applied to patients (Dysart et al., 2009). This form of respiratory support is generally referred to as high flow therapy (HFT) (Dysart et al., 2009).

Clinical advice from the Australian and New Zealand Neonatal Network and published literature defines HFNC as the administration of (heated and humidified) oxygen or blended oxygen and air via nasal cannula at flow rates of >1L/min (A/Prof Peter Marshall, personal communication, 2011; Wilkinson et al. 2011). HFNC is used on patients ranging in ages from preterm infants to adults who receive flow rates ranging from 2–40L/min for respiratory support in a variety of conditions (Dysart et al., 2009).

Uses of HFNC:
- Newborns: management of respiratory distress or apnoea and weaning from invasive forms of respiratory support.
- Paediatrics: used in typical situations that might have otherwise required intubation or CPAP. Diseases such as viral bronchiolitis, bacterial pneumonia and reactive airway disease are being treated with HFNC.
- Adults: used in a variety of clinical care settings and benefits patients suffering from respiratory diseases such as type 1 (hypoxic) respiratory failure, pulmonary oedema, chronic obstructive pulmonary disease (COPD) and acute respiratory distress syndrome (ARDS) (Australian and New Zealand Intensive Care Society, 2011; Dysart et al., 2009; Thoracic Society of Australia and New Zealand, 2011).

HFNC should be identified by the clinician as a specific respiratory therapy and administered via intranasal prongs at:
- 1L / minute or more for neonates (generally 2–7 L/ min)
- 4L / min or more for infants and young children (generally 4–12L/min)
- 20–40L / min for adults (generally 30L/min) (A/Prof Peter Marshall, personal communication, 2011; Australia and New Zealand Intensive Care Society, personal communication, 2011)

When 'high flow', high flow therapy or high flow nasal cannula is documented in the clinical record, assign a code from block 570 Noninvasive ventilatory support following the index pathways:

Management (of)
- airway
  - with ventilatory support — see Management, ventilatory support
- ventilatory support (nonintubated) — see block [570]

Ventilation
- noninvasive
  - mask ventilation (NIMV) — see block [570]
  - pressure ventilation (NIPV) — see block [570]

NCCC will consider indexing improvements for a future edition of ACHI.

References:

Hypertension due to acute kidney disease

Q: Can I15.0 Renovascular hypertension and I15.1 Hypertension secondary to other kidney disorders be caused by acute kidney disease? When can I15.0 and I15.1 be assigned?

A: Hypertension can arise due to acute kidney disease, therefore I15.0 Renovascular hypertension and I15.1 Hypertension secondary to other kidney disorders can be assigned as per the guidelines in ACS 0928 Secondary hypertension (I15) which states, "Assign these codes when hypertension is stated to be ‘due to’ or ‘secondary to’ another condition."

Therefore, I15.0 may be assigned when hypertension is documented as being due to a renovascular disorder, such as renal artery stenosis and I15.1 may be assigned when hypertension is documented as being due to a kidney disorder NEC, such as nephrotic syndrome due to poststreptococcal glomerulonephritis.

The Use additional code note at I15.0 and I15.1 should be followed in those instances where the presence of chronic kidney disease is also documented.
Intervention code for spontaneous vertex delivery

Q: Should 90467-00 [1336] Spontaneous vertex delivery be assigned when this is the only procedure that occurs in a delivery episode?

A: The NCCC has considered this issue at length and confirms that the advice published in Coding Matters October 1998, Vol. 5, No. 2 is no longer applicable.

The advice stated “the assignment of 90467-00 [1336] Spontaneous vertex delivery duplicates the diagnosis code O80 and need not be used with this code.”

In Seventh Edition, the concept within O80 Single spontaneous delivery was broadened to include single spontaneous breech delivery. Consequently assigning 90467-00 [1336] can no longer be considered duplication of O80; therefore, the assignment of 90467-00 [1336] Spontaneous vertex delivery is optional as directed by jurisdictional coding guidelines.

NCCC will consider improvements for spontaneous vertex delivery in a future edition of ICD-10-AM and ACS.

Morphology code for C94.6 Myelodysplastic and myeloproliferative disease, not elsewhere classified?

Q: What is the correct morphology code to assign with C94.6 Myelodysplastic and myeloproliferative disease NEC?

A: The correct morphology code to assign with C94.6 Myelodysplastic and myeloproliferative disease, not elsewhere classified is M9989/3 Myelodysplastic syndrome NOS.

The NCCC will amend the index entry for ICD-10-AM Eighth Edition for C94.6 Myelodysplastic and myeloproliferative disease, not elsewhere classified to include the correct morphology code.

Morphology of recurrent mediastinal tumour

Q: a) What is the appropriate morphology code to assign in the following scenario?

Patient admitted with recurrence of mediastinal tumour where original biopsy revealed “malignant cystic histiocytoma – M8830/3”. Supplementary histology report states morphology to be “malignant ossifying fibromyxoid tumour – M8842/3”. Note only 0 and 1 are contained in Appendix A: Morphology of neoplasms. Approximately a year later, the recurrence is resected and histology now states “high grade undifferentiated sarcoma – M8805/3”. Clinician states it is a recurrence of original tumour.

b) Would NCCC also clarify whether the sentence in ACS 0233 Morphology - “If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific” applies to a morphological diagnosis from one biopsy or two biopsies taken at different times for a recurrent tumour?

A: a) The NCCC advises that where there is doubt about the correct morphology code to assign due to ambiguous documentation in the clinical record, clinical coders should be guided by the principles in ACS 0010 General abstraction guidelines, which state:

“It is important to seek clinical advice where necessary for:
- verification of diagnoses recorded on the front sheet and/or the discharge summary which are not supported in the clinical record, and
- clarification of discrepancies between investigation results and clinical documentation”

For the scenario cited, NCCC agrees that:

1. the original morphology code (M8830/3 Malignant fibrous histiocytoma) should not be assigned as it appears to have been superseded by the supplementary report.

2. in the first instance, confirmation should be sought from the clinician as to the correct morphology code to assign.

3. where clinical confirmation is not possible clinical coders should be guided by the histopathology report in the current episode of care and assign M8805/3 Undifferentiated sarcoma.

b) The statement in ACS 0233 Morphology – “If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific” applies to one histological sample which describes a neoplasm using more than one histological term for which there are separate morphology codes. It does not apply to multiple histological diagnoses from different timeframes or different episodes of care, even if in reference to the same tumour.

Multiple skin biopsies

Q: What is the correct code assignment for multiple skin (punch) biopsies performed on:

1. Separate skin lesions (eg. skin lesion of face and back)
2. Same lesion (eg. multiple biopsies of single lesion of nose)

b) Would NCCC also clarify whether the sentence in ACS 0233 Morphology - “If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific” applies to a morphological diagnosis from one biopsy or two biopsies taken at different times for a recurrent tumour?
A:

ACS 0020 Bilateral/multiple procedures states:

“ACHI generally refers to organs, diseases and sites using the singular tense. This is done for consistency and ease of updating… examples includes wart(s), skin tag(s), biopsy/biopsies, lesion(s)”.

For the scenarios cited:
1. **Multiple (punch) biopsies of skin lesions on separate skin lesions**: code as many times as it is performed.
2. **Multiple (punch) biopsies of the same lesion**: code once only.

The NCCC will consider amending Point 5 (skin or subcutaneous lesion removal) in ACS 0020 Bilateral/multiple procedures in a future edition of ACS.

**Open door laminoplasty**

Q:

What is the correct code assignment for ‘open door’ laminoplasty, performed for cervical stenosis with myelopathy?

A:

A cervical laminoplasty is performed to repair a restricted spinal canal. The procedure creates more space for the spinal cord and nerve roots immediately relieving the pressure. This method is sometimes called an ‘open door’ laminoplasty, because the back of the spine is made to swing open like a door.

The correct code to assign for cervical open door laminoplasty is the appropriate code from Block 46 Decompression of cervical spinal cord, by following the index pathway Decompression, spinal, cord, cervical.

NCCC will consider indexing ‘open door’ laminoplasty for a future edition of ACHI.

Reference:

**Procedures on the left atrial appendage (LAA)**

Q:

What are the correct codes for the following procedures?
- Ligation of the left atrial appendage (LAA)
- Percutaneous occlusion of the left atrial appendage (LAA)

A:

Thrombus formation in the left atrial appendage (a muscular pouch arising from the left atrium) is a major risk factor for stroke in patients with atrial fibrillation. Ligation and occlusion of the left atrial appendage (LAA) are procedures used to prevent emboli, as an alternative to oral anticoagulopathy.

Ligation of the LAA involves many techniques, including, creating an ‘endoloop’, suturing, clipping or stapling of the atrial appendage.

Occlusion of the LAA is usually performed via a catheter, crossing the inter-atrial septum and using a guidewire to advance the device into the left atrium which is then deployed into the LAA.

The NCCC sought clinical advice which confirms that while the techniques used in this procedure may be similar to those used for closure of an atrial septal defect, it is not the correct code to assign. Clinical advice also confirmed that in the absence of a specific code for this procedure, the appropriate code to assign is 38456-13 [606]. Other intrathoracic procedures on atrium without cardiopulmonary bypass or 38653-01 [606]. Other intrathoracic procedures on atrium with cardiopulmonary bypass, as appropriate, following the index pathway:

**Procedure**
- atrium, heart (intrathoracic) (without cardiopulmonary bypass) NEC 38456-13 [606]
- - with cardiopulmonary bypass 38653-01 [606]

Any additional procedures, such as the following, should also be assigned:

38203-00 [667] Left heart catheterisation
55116-00 [1942] 2 dimensional real time transoesophageal ultrasound of heart
38209-00 [665] Cardiac electrophysiological study, ≤ 3 catheters or
38212-00 [665] Cardiac electrophysiological study, ≥ 4 catheters

The NCCC will consider creating new codes for these procedures in a future edition of ACHI.

**Prophylactic salpingo-oophorectomy**

Q:

What is the correct principal diagnosis to assign in the following scenarios?

a) Bilateral salpingo-oophorectomy (BSO) performed prophylactically due to risk of ovarian cancer after being found to have the BRCA2 gene fault on predictive gene testing

b) Bilateral salpingo-oophorectomy performed prophylactically due to a family history of ovarian cancer

A:

a) **Prophylactic BSO due to risk of ovarian cancer**

The correct principal diagnosis to assign when a bilateral salpingo-oophorectomy is performed prophylactically due to risk of ovarian cancer is Z40.01 **Prophylactic surgery for risk factors related to malignant neoplasms, ovary**, following the index pathway:

**Prophylactic**
- - surgery
- - - for risk factors related to malignant neoplasm
- - - ovary Z40.01
b) Prophylactic BSO due to family history of ovarian cancer
The correct principal diagnosis to assign when a prophylactic bilateral salpingo-oophorectomy is performed due to a family history of ovarian cancer is Z40.01 Prophylactic surgery for risk-factors related to malignant neoplasms, ovary with the addition of Z80.4 Family history of malignant neoplasm of genital organs, to specify the risk factor (family history of ovarian cancer), following the index pathway noted in scenario 1.

There is a principle for prophylactic surgery in ACS 1204 Plastic surgery, prophylactic mastectomy, which states:

“When the reason for the prophylactic mastectomy can be assigned a code (eg fibrocystic disease, family history, this should be sequenced as the principal diagnosis (even if all evident disease has been previously resected). Z40.00 Prophylactic surgery for risk-factors related to malignant neoplasm, breast or Z40.8 Other prophylactic surgery should be assigned as an additional diagnosis.”

However, this principle should not be followed for prophylactic BSO in the scenarios cited. The principal diagnosis to assign in these instances is the appropriate code from Z40.0–Prophylactic surgery for risk-factors related to malignant neoplasms to indicate the organ being removed. Risk factors noted to be related to the prophylactic organ removal should be assigned as additional diagnoses, as appropriate.

ACS 1204 Plastic surgery will be reviewed for Eighth Edition, with the ‘prophylactic’ part of this ACS removed and the creation of a general standard for prophylactic surgery which standardises the sequencing guidelines for prophylactic organ removal.

Recurrence of transitional cell carcinoma (TCC) of the bladder
Q: When a previously resected TCC of the anterior wall of the bladder represents with a recurrence in the dome of the bladder, what is the correct neoplasm code to assign? Following ACS 0237 Recurrence of malignancy would you assign C67.3 Malignant neoplasm of anterior wall of bladder or C67.1 Malignant neoplasm dome of bladder as the principal diagnosis?

A:
ACS 0237 Recurrence of malignancy states:

“If the primary malignancy previously eradicated has recurred, assign a code for the original primary site using the appropriate code from C00–C75. Code also any secondary sites mentioned.”

Clinical advice also confirms that, for the scenario cited, this is usually considered a recurrence of the primary bladder tumour and not as two primary invasive bladder tumours or a secondary tumour. Therefore, the correct code to assign in this scenario is C67.3 Malignant neoplasm of the anterior wall of the bladder.

However, if there is any uncertainty concerning code assignment then confirmation should be sought from the clinician, as per the guidelines in ACS 0010 General abstraction guidelines.

Same-day admission for both radiotherapy and chemotherapy
Q: What is the correct principal diagnosis to assign in a same day episode of care when both radiotherapy under general anaesthetic and intravenous chemotherapy is given for treatment of a neoplasm?

A:
For the scenario cited assign the principal diagnosis according to the guidelines in ACS 0001 Principal diagnosis, which states:

“Two or more diagnoses that equally meet the definition for principal diagnosis
When two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic work-up and/or therapy provided, and the Alphabetic Index, Tabular List or the standard does not provide sequencing direction, the clinician should be asked to indicate which diagnosis best meets the principal diagnosis definition.

If no further information is available, code as the principal diagnosis the first mentioned diagnosis.”