Coding Notes

HIPE & NPRS Unit
Health Research & Information Division
ESRI

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Back to School

After a glorious Summer, Autumn is here and the students are back at their classes. Similarly, in this edition of Coding Notes, we go back to school to review some basic or common coding guidelines that can sometimes be overlooked.

Some of the seemingly easiest cases to code, particularly with day cases, need to be coded using very specific coding standards. Often new coders will start on coding day cases and it is important that everyone is aware of the guidelines. For example, day case **endoscopies** are a regular starting point for new coders. There are regular workshops held on the coding of endoscopies and we would encourage everyone to attend this (see Page 8).

The feature on pages 2-3 focuses on endoscopies and particularly the area of **follow up** examinations following previous treatment. The use and sequencing of codes Z08 *Follow-up examination after treatment for malignant neoplasms* and Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms* are discussed with examples to further explain their correct use.

Another area that all coders will have experience of is **Diabetes**. There is a feature on the coding of Diabetes with foot ulcer and Diabetic foot ulcer on page 4. This follows on from queries received to hipecodingquery@esri.ie on this complex topic. This article focuses on the relevant information in ACS 0401 *Diabetes.*

While the article on Diabetic Foot came about from coders' queries, the article on ACS 0011 ***Admission for Surgery not performed*** has been included as some recent reviews of HIPE data indicate that there is some confusion over the difference between coding a case where the procedure is cancelled and when a procedure is interrupted or not completed according to the plan. There are specific guidelines for when the procedure is cancelled prior to the patient going to theatre even though the patient has already been admitted e.g. patient is too ill or an administration issue in the hospital means the procedure is cancelled. There are different guidelines for when the procedure is interrupted or not completed. It is important to reflect all the different scenarios correctly in order to ensure that each coded HIPE case accurately reflects the activity in the hospital.

We were asked to do a national review on the coding of **Noninvasive Ventilatory Support** and arising out of this review, the piece on page 5 offers coding guidelines from ACS 1006 on the coding of these interventions.

As always 'Cracking The Code' on pages 6-7 of this issue provides a selection of the queries answered recently, including one on the coding of **e-cigarettes**. Remember also to always code **tobacco use** regardless of whether it is cigarette, cigars, pipes or e-cigarettes.

With so much coding information in this issue we are all well and truly back to school. **Upcoming training** courses are listed on Page 8 for those who want to really get back into the classroom.

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Coding Endoscopies

Three Key Australian Coding Standards

The coding of endoscopies is guided by 3 Australian Coding Standards and it is important for all coders collecting this information to be aware of the guidelines. Please ensure that all coders have read and understood these ACS.

- **ACS 0046 Diagnosis Selection for Same-day Endoscopy**

  Admitted for investigation of symptoms and signs.

- **ACS 2111 Screening for Specific Disorders**

  Screening is the testing or examination for disease or disease precursors in asymptomatic individuals so that early detection and treatment can be provided for those who test positive for the disease.

- **ACS 2113 *Follow-up Examinations for Specific Disorders***

  Examination following treatment of a condition. See below for further information on ACS 2113.

ACS 2113 Follow-up Examinations for Specific Disorders

Z08 & Z09

Follow up examinations with no recurrence (Z08 & Z09) accounted for a total of 15,511 day cases in 2012 (see Table 1 page 3). ACS 2113 *Follow-up Examinations for Specific Disorders* provides very specific coding guidelines to be followed when a patient is admitted for follow-up examination. Many of these cases will involve endoscopies.

ACS 2113 Follow-Up Examinations for Specific Disorders
This standard contains coding guidelines to be followed where a patient is admitted for follow-up examination.

Z08 *Follow-up examination after treatment for malignant neoplasms* or

Z09 *Follow-up examination after treatment for conditions other than malignant neoplasms*

These codes should be assigned as the principal diagnosis when a patient is admitted for follow-up of a condition and no residual condition or recurrences are found.
Record the appropriate code from categories Z85–Z87 for the personal history as an additional diagnosis, where there is no recurrence.

Where there is **no recurrence** of the condition being followed up use the code from **Z08 or Z09 as the principal diagnosis**.

Example 1
Patient admitted for a follow-up examination (cystoscopy). They had a malignant tumour of the bladder removed six months ago. There was **no** recurrence of the malignancy. Code as follows:
Code:
Z08.0 *Follow-up examination after surgery for malignant neoplasm*
Z85.5 *Personal history of malignant neoplasm of urinary tract*
36812-00 [1089] *Cystoscopy*
Note: C67.- Malignant neoplasm of the bladder is **not** assigned when there is no recurrence of the malignancy of the bladder

FOLLOW UPS
Z08 & Z09

Example 2
Patient admitted for a follow-up examination (colonoscopy). They had colonic polyps removed six months ago. There was **no** recurrence of the polyps.
Code:
Z09.0 *Follow-up examination after surgery for other conditions*
Z87.12 *Personal history of colonic polyps*
32090-00 [905] *Fibreoptic colonoscopy to caecum*

If the condition has **recurred or a residual condition** is present, assign a **code for the condition as the principal diagnosis.** The Z08 can be assigned as an *additional diagnosis* to indicate a recurrence was found during the follow-up.

Example 3
Patient admitted for a follow-up examination (cystoscopy). They had a malignant tumour of the bladder removed six months ago. There **was** recurrence of the malignancy.
Code:
C67.9 *Malignant neoplasm of bladder, unspecified*
Z08.0 *Follow-up examination after surgery for malignant neoplasm*
36812-00 [1089] *Cystoscopy*
Assigning Z08.- as an additional diagnosis code flags episodes of care where there is a recurrence of the malignancy found at follow-up examination.

Please note that incidental findings at follow-up examinations are not coded unless they meet the criteria in ACS 0002 *Additional Diagnoses*. (See also ACS 0046 *Diagnosis selection for same-day endoscopy*.)

Training
Training courses are run regularly on same day endoscopies. If this is an area that you code and you haven't already participated in one of these courses, or you would like a refresher in the area please register to join the next course. The course includes training on Anatomy & classification guidelines relevant to endoscopies and provides an opportunity to discuss the classification of de-identified sample copies of endoscopy reports.

Please refer to page 8 for details of the next course. HIPE Coders who would like a copy of the Endoscopy workbook can contact us at hipe.training@esri.ie

Table 1 "Follow up" (no recurrence) day cases 2012

PDX ICD-10-AM	Follow-up examination after..	Total
Z080	surgery for malignant neoplasm	4,734
Z081	radiotherapy for malignant neoplasm	91
Z082	pharmacotherapy for malignant neoplasm	170
Z087	combined treatment for malignant neoplasm	1,838
Z088	other treatment for malignant neoplasm	627
Z089	unspecified treatment for malignant neoplasm	72
Z090	surgery for other conditions	4,207
Z091	radiotherapy for other conditions	7
Z092	pharmacotherapy for other conditions	421
Z094	treatment of fracture	5
Z097	combined treatment for other conditions	86
Z098	other treatment for other conditions	3,191
Z099	unspecified treatment for other conditions	62
TOTAL		15,511

Source: 2012 HIPE National file (Data Source: 2012_ASOF_0613_V18)

Foot Ulcers in Diabetes
&
Diabetic Foot

Foot ulcers in Diabetes & Diabetic Foot

ACS 0401 *Diabetes Mellitus and Impaired Glucose Regulation* provides classification guidelines for code assignment for foot ulcers in Diabetes and Diabetic Foot. The code for a Diabetic Foot is E1-73 *Diabetes Mellitus with foot ulcer due to multiple causes*. There were 758 of these reported to HIPE in 2012 with most adult hospitals reporting cases.

Foot ulcers in Diabetes

The presence of an ulcer of the lower extremity by itself does not necessarily signify 'Diabetic Foot' (see below). Therefore, when the aetiology of a foot ulcer in a diabetic patient is unclear, the clinician should be asked for further clarification.

CLASSIFICATION

Diabetic ulcer of the lower extremity is assigned the following code:

E1-.69 **Diabetes mellitus with other specified complication*
L97 *Ulcer of lower limb, not elsewhere classified*

***Note:* E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes* should not be assigned for foot ulcer as this code is used for the condition 'diabetic foot'.**

Diabetic foot

This term is used to define diabetic patients with an ulcer or infection of the foot with peripheral and/or neurological complications and/or other distinct clinical factors. Such patients have an ulcer and/or infection in category 1 below and a **condition from at least one other of the following numbered categories 2–5**:

1.	**Infection and/or ulcer**	
	Diabetes with foot ulcer	E1-.69
	Cutaneous abscess, furuncle and carbuncle of limb	L02.4
	Cellulitis of toe	L03.02
	Cellulitis of lower limb	L03.11
	Decubitus ulcer and pressure area of foot (stage III & IV)	L89.2-L89.3
2.	**Peripheral vascular disease**	
3.	**Peripheral neuropathy**	
4.	**Conditions causing deformity and excessive 'loading' of affected foot**	
5.	**Previous amputation(s) of affected and/or other lower limb**	

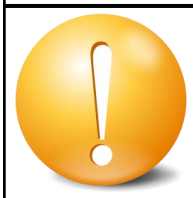
Please refer to ACS 0401 Diabetes Mellitus and Impaired Glucose Regulation for the full list of conditions in 2 – 5 above.

CLASSIFICATION

Assign E1-.73 **Diabetes mellitus with foot ulcer due to multiple causes* when:

- 'Diabetic foot' is documented in the clinical record, **or**
- the criteria above are met i.e. The patient has an ulcer and/or infection in category 1 above and a **condition from at least one other of the categories 2–5.**

Additional codes for the specific complications (e.g. polyneuropathy (G62.9), peripheral angiopathy (I70.2-), cellulitis of toe (L03.02)) should also be assigned.



Osteomyelitis of the foot in Diabetes

Osteomyelitis of the foot, a common and serious problem in diabetic patients, results from diabetes complications, especially peripheral neuropathy. Infection generally develops by spread of contiguous soft-tissue infection to underlying bone. Source: *http://cid.oxfordjournals.org/content/25/6/1318.full.pdf*

Classification guidelines

If there is documentation of osteomyelitis of the foot in a diabetic patient and they have a condition from at least one other of the categories numbered categories 2–5 above, consult with the attending physician before assigning E1-.73 *Diabetes mellitus with foot ulcer due to multiple causes.* Code also the osteomyelitis.

Procedure cancelled
Versus
Procedure not completed or interrupted

It is important to accurately record activity in relation to procedures performed to reflect resources used in hospitals. There is a difference in coding a case where a patient's procedure is cancelled before surgery and a case where the procedure is not completed or interrupted for some reason. Please refer to the guidelines below for clarification on the coding of these different scenarios.

1. Procedure cancelled - ACS 0011 *Admission for Surgery not performed*

If a patient has been admitted to hospital for surgery which for some reason has not been performed and the patient is discharged, code as follows:

Assign a code for the principal diagnosis (ACS 0001) followed by:

- The appropriate code from Z53.x *Persons encountering health service for specific Procedure not carried out*
- A code is **NOT** assigned for the planned procedure that was cancelled

Example 1:

Diagnosis: Patient admitted for insertion of grommets for glue ear. Surgery postponed due to unavailability of surgeon.

PDx: H65.3 *Chronic mucoid otitis media*

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

Example 2:

Diagnosis: Patient admitted with tonsillitis for a tonsillectomy. Surgery postponed due to an URTI.

PDx: J35.0 *Chronic tonsillitis*

ADx: Z53.0 *Procedure not carried out because of contraindication*
J06.9 *Acute upper respiratory infection, unspecified*

2. Procedure not completed or interrupted – ACS 0019 *Procedure not completed or interrupted*

If a surgical procedure was interrupted or not completed for any reason, code to the extent of the procedure performed.

Example 3:

If a laparotomy had been done in order to perform an appendicectomy, but the appendicectomy was not done due to the patient having a cardiac arrest, **assign a code for the laparotomy only** (do not assign a code for the appendicectomy).

Example 4:

If a patient was admitted for an OGD but the endoscope only reached the Oesophagus assign a code for the Oesophagoscopy. Do not assign a code for OGD.

Noninvasive Ventilatory support

Ventilatory Support

ACS 1006 *Ventilatory support* provides definitions and guidelines for coding ventilatory support. It includes the following information in relation to noninvasive ventilation

Definition

Ventilatory support is a process by which gases are moved into the lungs by a device that assists respiration by augmenting or replacing the patient's own respiratory effort. Ventilatory support can be administered via noninvasive or invasive devices.

Noninvasive Ventilation (NIV)

Noninvasive ventilation refers to all modalities that assist ventilation without the use of an Endotracheal Tube (ETT) or tracheostomy.

For the purpose of this standard, noninvasive devices include: face mask, mouthpiece, nasal mask, nasal pillows, nasal prongs, nasal tubes and nasopharyngeal tubes.

Guidelines on coding the method of delivery for Noninvasive Ventilation NIV (ACS 1006)

- Do not code any method of intubation for ventilatory support. (This applies to invasive ventilation also)
- Do not code any noninvasive airway (e.g. mask, nasal prong).

Clarification on coding Noninvasive Ventilatory support

Coders have sought clarification regarding the use of face masks and nasal prongs for ventilatory support.

- It is appropriate to assign a code from block [570] *Management of noninvasive ventilatory support* for noninvasive ventilatory support that is delivered via face mask or nasal prong.
- Face masks or nasal prongs that are used to administer oxygen therapy are not coded as non-invasive ventilation.
- Administration of oxygen is not a form of ventilation and is not routinely coded, except in neonates as per guidelines in ACS 1615 *Specific Interventions for the sick neonate.*

Cracking the Code

Q. Q. Patient was admitted for OGD to investigate abdominal pain. No cause was found/documented. The CLO test was positive for *Helicobacter pylori* (h-pylori). What diagnosis (es) codes are assigned?

A. Assign a code for the abdominal pain R10.- . A code for the *Helicobacter pylori* is not assigned. Please refer to ACS 0112 *Helicobacter pylori* for classification guidelines.

Q. What procedure code is assigned for a patient who had a L4/L5 microdiscectomy.

A. To look up the procedure code follow the lead term Discectomy (as there is no lead term for Microdiscectomy). L4/L5 is one level. Depending on the approach assign either 40300-00 [52] *Discectomy, 1 level* or if it is via a percutaneos approach assign 48636-00 [52] *Percutaneous lumbar discectomy*. Check also all exclusion notes.

Q. If a patient is described as smoking an e-cigarette with nicotine do we still code this using the Z72.0 *Tobacco use, current*?

A. E-cigarettes deliver vapour, often with nicotine and may be used as a substitute for conventional cigarettes. We advise that the current use of e-cigarettes with nicotine be coded as Z72.0 *Tobacco use, current*. This advice is based on the look up for the main term 'Nicotine' in the Alphabetical index where the index instructs us to '*see Tobacco'.* This brings you through to the regular range of smoking codes and we assign Z72.0 *Tobacco use, current* (or whatever the circumstances are).
Also where patients are using the e-cigarettes for cessation of smoking ACS 0503 states: "Z72.0 includes documentation of 'smoker', 'on patches', 'trying to quit'." Once a patient is a smoker or an ex-smoker this must be recorded in HIPE.

Q. What diagnosis codes are assigned for an MRSA infected Hickman line and what procedure code is assigned for removal of same?

A. For the infected Hickman line please assign:

T82.7 *Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts, together with a code for any specific condition, if known (e.g. cellulitis)*

B95.6 *Staphylococcus aureus as the cause of diseases classified to other chapters*

Z06.32 *Methicillin resistant agent*

Y84.8 *Other medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (if the insertion was not performed as an open surgical procedure)*

Y92.22 *Place of occurrence, health service area*

Also remember to assign the HADx flag if this infection arose during this admission.
The procedure code for removal of a Hickman line is 34530-04 [738] *Removal of venous catheter*.

Q. What diagnosis code is assigned for an upper lobe lesion described by histology as intrapulmonary localised fibrous tumour of uncertain malignant potential.

A. As the histology states "uncertain" as the behaviour assign D38.1 *Neoplasm of uncertain or unknown behaviour of middle ear and respiratory and intrathoracic organs, Trachea, bronchus and lung*.

Q. Patient admitted for a colonoscopy and OGD. The colonoscopy wasn't carried out because the patient hadn't taken the required prep. The OGD was however carried out. Should I assign Z53.0 *Procedure not carried out because of contraindication* in addition to the PDX?

In addition to the patient's conditions assign additional diagnoses codes of Z53.0 *Procedure not carried out because of contraindication* and Z91.1 *Personal history of noncompliance with medical treatment and regimen.* See ACS 0517 *Noncompliance With Treatment.* For the procedures, code the OGD only.

See Page 5 of this issue for further information on coding cancelled or interrupted procedures.

Q. I've come across a neonate diagnosed with transient abnormal myelopoiesis. The baby also has Down Syndrome.

A. Transient Abnormal Myelopoiesis (TAM) is a unique disorder that occurs in newborns with Down syndrome. It is characterized by an increase in the number of myeloblasts—cases often meet the diagnostic criteria for AML. TAM has morphologic and immunophenotypic features characteristic of megakaryoblastic leukemia. (http://emedicine.medscape.com/article/2008782-overview).
Please assign D47.7 *Other specified neoplasms of uncertain or unknown behaviour of lymphoid, haematopoietic and related tissue* for the diagnosis of Transient Abnormal Myelopoiesis.

Cracking the Code

Continued

Q. A patient had a BCC removed on their last admission. The patient returned for a local excision. The histology stated a dermal scar. What is the PDx?

A. Following the guidelines in ACS 0236 *Neoplasms coding and sequencing*, the BCC will be coded as the PDx as this was continued treatment of the original condition by further excision. The fact that there was no longer any BCC found is not relevant as the admission and surgery were for the treatment of the BCC i.e. they were doing a further excision to be sure the entire BCC was removed.

Q. What codes are assigned for Endoscopic clipping of gastric and duodenal ulcers?

A. Follow the Index Look up:

Clipping (of)

- peptic ulcer, endoscopic (duodenal) (gastric) 90296-00 [887]

Assign code: 90296-00 [887] *Endoscopic control of peptic ulcer or bleeding*

Note that the specific sites (duodenal and gastric) are nonessential modifiers in the alphabetic index.

Q. A patient was admitted for a Hysterectomy because she had a LETTZ for CIN 3 six months ago. The Hysterectomy was performed and the histology was clear. Will we assign a code for the CIN 3 as the PDx?

A. Yes assign a code for the CIN3 as it was the reason for the procedure. ACS 0236 *Neoplasm Coding and Sequencing* gives the following guideline:

The primary malignancy should be coded as a current condition if the episode of care is for:

- subsequent admissions for wider excision (even if there is no residual malignancy on histopathology)

Q. Our hospital has recently begun carrying out a new procedure called peritonectomy /cytoreduction surgery. It is very complex and we are finding we need a lot of codes to cover all the components. Is there any single code we could assign for this complex surgery?

A. The latest edition of ACHI (8th Edition—July 2013) has a code for this procedure and this is now available for use within the HIPE Portal data entry system. The code is 96211-00 *Peritonectomy* in block [989] *Other excision procedures on abdomen, peritoneum or omentum (see below, note this is not in 6th edition copies of the classification)* and please note the extensive "*Code also*" notes:

989 Other excision procedures on abdomen, peritoneum or omentum

96211-00 Peritonectomy
Cytoreduction surgery (CRS)

Note: Multimodal procedure performed for the treatment of peritoneal neoplasms, with the aim of removing all peritoneal tumours. The combination of surgical procedures required for cytoreduction varies with each patient.

Code also when performed:

- excision of abdominal, peritoneal or pelvic lesion (see Alphabetic Index)
- intraperitoneal chemotherapy:
  - early postoperative [EPIC] (96201-00 **[1920]**)
  - heated (intraoperative) [HIPEC] (92178-00 **[1880]** and 96201-00 **[1920]**)
  - postoperative [IPEC] (96201-00 **[1920]**)
- removal abdominal, peritoneal or pelvic organ (see Alphabetic Index)
- repair procedures (see Alphabetic Index)
- resection procedures (see Alphabetic Index)

Do you have a coding query? Please email your query to:

hipecodingquery@esri.ie

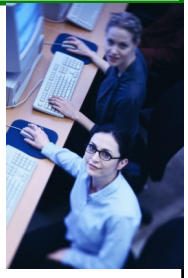
HIPE Data Users

With the increase in HIPE data users a training day is being held at the ESRI on Thursday, 17th October. This course has been held several times before and feedback from those attending has been very good. It is recommended that anyone using HIPE data in their work attend to ensure understanding of all aspects of these data. This course will be held at the ESRI, Whitaker Square, Sir John Rogerson's Quay, Dublin 2 from 9.45 to 5pm.

The main topics of the course are as follows.

- Introduction to HIPE
- Classification and Guidelines
- Interpretation of HIPE data
- Hands-on training using the HIPE Portal Reporter.

Please contact hipecodingquery@esri.ie for further information.



Upcoming Courses

Introduction to HIPE

WebEx Only

This is a general introduction to the variables collected by HIPE for new coders and others working in the HIPE system.

This course is delivered via WebEx and can be scheduled if you have a new coder joining the HIPE Dept at your hospital.

Coding Skills I

ESRI Only

This course is for new coders who have attended the Introduction to HIPE course.

Date: Tuesday 24th & Wednesday 25th September

Time: 10am – 5pm each day

Coding Skills II

ESRI Only

This course is for those who have previously attended Coding Skills I.

Date: Tues 26th – Thurs 28th November (3 days)

Time: 10am – 5pm each day.

Coding Skills III

ESRI Only

This course is for coders who have previously attended Coding Skills II. Experienced coders are welcome to attend this course for refresher training.

Date: Tues 22nd October—Thurs 24th October (3 days)

Time: 10am – 5pm each day.

To apply for any of the advertised courses, please complete the online training form at:
www.hipe.ie/training
If you would like to inform us of any training requirements, please send an email to hipetraining@esri.ie.

What would you like to see in Coding Notes?

If you have any ideas for future topics, please let us know.
Thanks and keep in touch: hipe@esri.ie

See the 'Find it Fast' section of the ESRI website for easy access.

www.esri.ie/health_information/find_it_fast/

Anatomy Physiology—Renal

This course will be delivered by a specialist speaker

Date: Tuesday, 5th November

Time: 11am – 1pm

Location: ESRI & WebEx

Anatomy Physiology—Infectious and Parasitic

This course will be delivered by a specialist speaker

Date: Tuesday, 5th November

Time: 2pm—4pm

Location: ESRI & WebEx

Coding Skills IV—Workshops

Topic: Same Day Endoscopy Coding

Date: Tuesday 8th October

Time: 11am – 1pm

Location: ESRI or WebEx

Topic: Data Quality Session

This course will include HCAT and Checker training. Please contact hipeit@esri.ie to install HCAT.

Date: Tuesday 19th November

Time: 10.30am – 1pm

Location: WebEx only

Further half day coding workshops will be held on 12th and 13th November. Topics to be confirmed.

Please contact us with any areas that you would like to see covered in future workshops.

Quote

"I have begun to think of life as a series of ripples widening out from an original centre."

Seamus Heaney RIP