Queries discussed by
WA Clinical Coding Advisory Group
Meeting on 30th March 2016


Apologies: Vana Savietto, Deb Yagmich.

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| 1         | External cause code for cultural circumcision What is the correct external cause code for a complication of male tribal circumcision? | **Recommendation:** Usually, the type of instrument used to perform the tribal circumcision will not be documented. In these cases it is appropriate to assign W26.9 *Contact with unspecified sharp object(s)* by following the Index pathway:  
Contact  
- with  
- - sharp object (cutting or piercing instrument) NEC W26.9  
In the event that that type of instrument is documented, a more specific code may be assigned.  

Please note that this decision replaces an earlier WACCAG decision from December 2014 as new codes were created in 9th edition.  

**Decision:** The correct external cause code for complication of male tribal circumcision is W26.9 *Contact with unspecified sharp object(s).* |

**[WA Clinical Coding Advisory Group Decision Date: 30.03.2016]**

| 2         | Postprocedural blisters due to friction What is the correct way to code blisters caused by friction between dressings and suture lines? This is often documented for patients post knee or hip operations. | **Recommendation:** There is no specific Index entry or code for postprocedural friction blisters in ICD-10-AM.  
Following the instructions in ACS 1904 *Procedural complications* leads to assignment of T81.8 *Other complications of procedures, NEC* by looking up  
Complication  
- postprocedural  
- - specified NEC T81.8.  

According to ACS 1904, an additional code from Chapters 1 to 19 should be assigned where it provides further specificity. In these cases, an S code for the blisters should also be assigned, such as S70.82 *Blisters of hip and thigh* or S80.82 |

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|           | **Blister of lower leg.**  
Decision: Postprocedural blisters due to friction between dressings and suture lines should be coded to T81.8 Other complications of procedures, NEC followed by an S code to reflect the site of the blisters. |          |
| 3         | **Bursectomy performed with SAD**  
Should a bursectomy performed with a subacromial decompression be coded separately, or is it inherent in the SAD procedure code? | **Recommendation:** Subacromial impingement syndrome (SAIS) is the most common disorder of the shoulder, accounting for 44-65% of all shoulder complaints.  
SAIS encompasses a spectrum of subacromial space pathologies including partial thickness rotator cuff tears, rotator cuff tendinosis, calcific tendinitis, and subacromial bursitis. The main consequences of SAIS are pain, weakness and reduced range of movement.  
The aetiology of subacromial impingement is controversial, with two main theories described: A degenerative (intrinsic) theory, where symptoms are thought to result from overload on degenerating rotator cuff tendons; and a mechanical (extrinsic) theory, where symptoms are caused by compression of the rotator cuff by the acromion.  
Conservative management is often successful but when it fails, current surgical treatment is generally arthroscopic subacromial decompression (SAD).  
The SAD procedure is based on the theory that primary acromial pathology (an extrinsic cause) is the initiating factor leading to the dysfunction and eventual tearing of the rotator cuff. SAD includes acromioplasty (removing the anterior inferior part of the acromion), and bursectomy (excision/debridement of the subacromial bursa). Other components are also performed as required such as division/resection of the coraco-acromial ligament and resection of any osteophytes from the acromio-clavicular joint that are thought to be contributing to impingement.  
Clinical advice indicates that a subacromial decompression procedure would normally include a bursectomy. The aim of an SAD is to decompress the sub-acromial space and any or all of the preceding component procedures would be inherent in doing so.  
**Decision:** Bursectomy is inherent in a subacromial decompression procedure and should not be coded separately when performed in the same operative episode. |          |
<p>| 4         | <strong>Open component separation</strong> | <strong>Recommendation:</strong> Repair of incisional hernia by component separation technique (CST) is a type of abdominal muscle |</p>
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| 3 | **Technique for repair of incisional hernia**  
What is the correct procedure code to assign for repair of incisional hernia by open component separation technique? | Advancement flap procedure.  
The rectus abdominus/internal oblique/transversus abdominus are separated from their aponeurotic sheaves and mobilised medially to cover the defect (with nerves and blood vessels intact). This is done to cover large midline abdominal defects. Advancement flaps require linear advancement of tissue in a single plane (e.g. sliding across the midline).  
Clinical advice is that the best code to assign for CST is 30405-00 [993] *Repair of incisional hernia with muscle transposition.*  
Mesh may also be inserted following CST to reduce the recurrence of incisional hernias treated by CST alone. Insertion of mesh is not inherent in the CST procedure code, it should be assigned an additional code of 30405-01 [993] *Repair of incisional hernia with prosthesis* by following the Index pathway:  
Repair  
- hernia  
- - incisional  
- - - with prosthesis (mesh).  
**Decision:** Repair of incisional hernia by component separation technique should be coded to 30405-00 [993] *Repair of incisional hernia with muscle transposition.* If mesh is also inserted, an additional code should be assigned: 30405-01 [993] *Repair of incisional hernia with prosthesis.* This query will be sent to the ACCD.  
[WA Clinical Coding Advisory Group Decision Date: 30.03.2016] |
| 5 | **Total lymphocyte irradiation**  
What procedure code should be assigned for total lymphocyte irradiation? | **Recommendation:** Total lymphocyte or lymphoid irradiation (TLI) is a method of inducing a strong immunosuppressive effect in patients undergoing bone marrow transplants, treatment of certain lymphomas or other therapies requiring immunosuppression. TLI involves exposing all lymph nodes, the thymus and the spleen to low dose radiation.  
Clinical advice suggests that the best procedure code to assign for total lymphocyte irradiation is 15600-03 [1789] *Total body irradiation.*  
**Decision:** The best procedure code to assign for total lymphocyte irradiation is 15600-03 [1789] *Total body irradiation.*  
[WA Clinical Coding Advisory Group Decision Date: 30.03.2016] |
| 6 | **RSA beads in total hip replacement** | **Recommendation:** Radiostereometric analysis (RSA) is an imaging technique which involves taking x-rays from two different directions at the same time, creating a ‘stereo’ image. RSA x-rays can be used to assess the components of a hip |

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| 1         | Should tantalum RSA beads inserted during a total hip replacement be coded? | **arthroplasty after implantation. Thus, the patient’s progress can be measured and the information can be used for research to improve implant design and technology for future patients.**

To precisely measure implant position on RSA images, beads are inserted into the bone surrounding the implant at the time of operation. The beads are about the size of a poppy seed and are made of tantalum, a metal that is used in prosthetic implants and is well tolerated by the body. These beads become stably integrated into the bone and can be used as references with which to detect any change in position of the implant components.

Clinical advice indicates that a procedure code is not necessary for the implantation of tantalum RSA beads. They are a component of the total hip replacement procedure.

**Decision:** Tantalum RSA beads inserted during a total hip replacement do not need to be coded separately. They are a component of the total hip replacement procedure.  

[WA Clinical Coding Advisory Group Decision Date: 30.03.2016]

| 7         | Obstructive sleep disorder  
 What should obstructive sleep disorder be coded to? Is it synonymous with obstructive sleep apnoea? | **Recommendation:** There is no Index entry in ICD-10-AM for ‘obstructive sleep disorder’. The classification indexing requires the terms ‘apnoea’ and ‘obstructive’ to be documented for a breathing related sleep disorder to be assigned to G47.32 Obstructive sleep apnoea syndrome. If these terms are not documented, G47.32 cannot be assigned.

Coders should obtain clarification from the treating clinician when encountering documentation of ‘obstructive sleep disorder’.

**Decision:** Coders should obtain clarification from the treating clinician when encountering documentation of ‘obstructive sleep disorder’. G47.32 Obstructive sleep apnoea syndrome should not be assigned.  

[WA Clinical Coding Advisory Group Decision Date: 30.03.2016]

| 8         | Viral induced wheeze  
 What code/s should be assigned for viral induced wheeze in an adult e.g. influenza and viral induced wheeze? Previous CCWA advice appears to only apply to children. | **Recommendation:** Clinical advice indicates that ‘viral induced wheeze’ is a specific diagnostic statement that refers to wheeze that has been triggered by a virus. The wheeze becomes a significant diagnosis in its own right and is usually the focus of treatment in the episode. The diagnosis ‘viral induced wheeze’ is most common in paediatric patients.

When the specific statement “viral induced wheeze” alone is documented as the principal diagnosis, coders should assign R06.2 Wheezing as the principal diagnosis and B34.9 Viral infection, unspecified as an additional diagnosis. If a specific virus has been documented, this should be coded instead of B34.9.

When ‘viral induced wheeze’ is documented with other diagnostic statements such as influenza, asthma or pneumonia, coders should be guided by ACS 0001 Principal diagnosis and ACS 0002 Additional diagnoses when assigning and...
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<td>The previous decision by CCWA published in September 2011 has been retired.</td>
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<td>Decision: ‘Viral induced wheeze’, when documented alone as the principal diagnosis should be coded to R06.2 <em>Wheezing</em> and B34.9 <em>Viral infection, unspecified</em> (unless the specific virus is known). When ‘viral induced wheeze’ is documented with other diagnoses, the code assignment and sequencing should be guided by ACS 0001 and ACS 0002.</td>
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| 9        | **Double balloon enteroscopy**  
What procedure code should be assigned for double balloon enteroscopy performed by colonoscopy approach? The patient had a previous resection and anastomosis and this DBE traversed the ileocaecal valve | **Recommendation:** A double balloon enteroscopy (DBE) is an endoscopic technique for visualisation of the small bowel. Two balloons are attached to the enteroscope and are then alternately inflated and deflated, which pleats the intestine over the enteroscope as it progresses step-wise through the small bowel.  
DBE is commonly performed similarly to a gastroscopy, by passing the enteroscope through the mouth and the upper digestive tract into the small bowel. However, DBE may also be performed in a retrograde fashion, through the lower digestive tract.  
Using ‘enteroscopy’ as the lead term, the ACHI Index directs coders to assign a double balloon enteroscopy a panendoscopy code. However, if the operation report documents that the scope is passed through the colon to the extent of the ileum, the following pathway may be used to arrive at a colonoscopy code:  
Illeoscopy  
- via  
- - colonoscopy – see Colonoscopy  
If the scope is passed to the extent of the jejunum, no such look up exists at ‘Jejunoscopy’, so the lead term ‘Enteroscopy’ must be used, leading to the assignment of a panendoscopy code.  
Decision: Coders must follow the ACHI Index and assign a procedure code for double balloon enteroscopy based on the documentation on the endoscopy report. Possible lead terms include ‘ileoscopy’ and ‘enteroscopy’, depending on documentation of the extent of the scope. A public submission will be made to the ACCD for updating of the Index in future editions. |

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| 1        | Traumatic neuroma due to surgery | **Q:** What is the correct diagnosis code to assign for a traumatic neuroma due to surgery? For example, a patient was admitted post brow lift with wound swelling. The wound was excised and the histopathology report found traumatic neuroma.  

**A:** The correct code to assign for traumatic neuroma due to surgery in the scenario cited is G97.8 Other postprocedural disorders of the nervous system following the index pathway:  

Complication  
- nervous system  
- - procedural  
- - - specified NEC G97.8  

ACS 1904 Procedural complications states 'An additional code from Chapters 1 to 19 should be assigned where it provides further specificity.' In the scenario cited, no additional code provides further specificity and thus no additional code is assigned.  

ACS 1904 Procedural complications is currently under review for ICD-10-AM Tenth Edition.  

[ACCD Coding Rules, March 2016] |
| 2        | Ptosis of eyebrow | **Q:** What code should be assigned for ptosis of the eyebrow?  

**A:** The index default at the lead term Ptosis is H02.4 Ptosis of eyelid and there is no subterm for 'eyebrow'. This default is not correct for 'ptosis of eyebrow'. Ptosis (also known as sagging) of the eyebrow is a condition separate to ptosis (or sagging) of the eyelid.  

The correct ICD-10-AM code to assign for ptosis of the eyebrow is L98.7 Excessive and redundant skin and subcutaneous tissue (which has an inclusion term for sagging skin).  

Follow the Alphabetic Index pathway:  

Excess, excessive, excessively |
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| 3        | Insertion, removal and exchange of silicone oil with repair of retinal detachment | Q: Should insertion, removal or exchange of silicone oil be coded separately when repair of retinal detachment is performed?  
A: The insertion of silicone oil, variously described as fluid exchange or replacement of vitreous, is a component of most retinal detachment repair procedures, and therefore is not to be assigned a separate ACHI code as per ACS 0016 General procedure guidelines/procedure components.  
Removal of the silicone oil is usually performed three to six months after retinal repair as an independent procedure and is classified to 42815-00 [205] Removal of silicone oil.  
Ophthalmic intervention codes are currently under revision for a future edition of ACHI.  
[ACCD Coding Rules, March 2016] |