Queries discussed by
WA Clinical Coding Advisory Group
Meeting on 21st September 2016

Attendees: Deb Yagmich, Brooke Holroyd, Rosi Katich, Elise White, Sharon Linton, Silvana Rossi, Robyn Graham, Emily Hookham, Jashan Johl.

Apologies: Lindy Burwood, Dragana Losic, Elke Blocher, Tanya Evdokimoff, Bill Pyper.

<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 1         | Pharmacy procedure codes  
When should a code for the allied health intervention of pharmacy be assigned?  
When is it appropriate to assign more specific procedure codes such as 96027-00 [1822]  
Prescribed/self-selected medication assessment or 96072-00 [1867]  
Prescribed/self-selected medication counselling or education? | Recommendation:  
95550-09 [1916] *Allied health intervention, pharmacy* should be assigned when there is sufficient evidence within the medical record that the pharmacist has provided a pharmacy intervention *to the patient*. This documentation may be recorded within the inpatient progress notes or on a specialised form.  

More specific procedure codes may be assigned when documentation indicates that they have been performed, as per ACS 0032 *Allied health interventions*.  

Decision: 95550-09 [1916] *Allied health intervention, pharmacy* should be assigned when there is documentation within the inpatient progress notes or on a specialised form that the pharmacist has provided a pharmacy intervention to the patient.  

More specific procedure codes may be assigned when documentation indicates that they have been performed, as per ACS 0032 *Allied health interventions*.  

[WA Clinical Coding Advisory Group Decision Date: 21.09.2016] |
| 2         | Bone graft with ORIF  
What procedure code should be assigned for a bone graft performed in conjunction with an ORIF? | Recommendation:  
In an open reduction with internal fixation (ORIF), fractured bones are ‘reduced’ into normal anatomical position, then internally fixed (with rods, pins, plates, screws, wires etc) to ensure the fracture stays reduced and heals in alignment.  

A bone graft may be performed in addition to the ORIF. The bone graft itself may or may not be held in place with internal fixation.  

ACHI bone graft with internal fixation codes, such as 48242-00 [1569] *Bone graft with internal fixation, not elsewhere* |
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>classified</em>, should only be assigned when the internal fixation is specifically for holding the bone graft in place. Some examples of procedure code assignment, depending on operation report documentation, are: ORIF code + 48239-00 [1569] <em>Bone graft, not elsewhere classified</em> or ORIF code + 48242-00 [1569] <em>Bone graft with internal fixation, not elsewhere classified</em> Decision: ACHI codes for bone graft with internal fixation should only be assigned when the internal fixation is specifically for holding the bone graft in place. They should not be assigned when a bone graft which is not held in place by internal fixation is performed in the same operative episode as an ORIF. [WA Clinical Coding Advisory Group Decision Date: 21.09.2016]</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>Goldilocks mastectomy</strong> What is the correct procedure code to assign for a Goldilocks mastectomy?</td>
<td><strong>Recommendation:</strong> A Goldilocks mastectomy is synonymous with a subcutaneous mastectomy which is a skin sparing mastectomy where the nipple is usually spared. The patient's glandular tissue is removed while preserving healthy tissue i.e. subcutaneous tissue, skin and nipple areolar complex (NAC). The patient is left with enough healthy tissue to create a smaller breast. This procedure is suited to larger breasts. Since the procedure is neither a complete amputation of the breast nor is it a full reconstruction (with flap, prosthesis etc) it is “something in the middle” thus called “Goldilocks” mastectomy. Using the Index pathway: Mastectomy - subcutaneous (unilateral) -- bilateral assign either 31524-00 [1747] <em>Subcutaneous mastectomy, unilateral</em> or 31524-01 [1747] <em>Subcutaneous mastectomy, bilateral</em> for documentation of Goldilocks mastectomy. Decision: Goldilocks mastectomy should be assigned to either 31524-00 [1747] <em>Subcutaneous mastectomy, unilateral</em> or 31524-01 [1747] <em>Subcutaneous mastectomy, bilateral.</em></td>
</tr>
<tr>
<td>Query no.</td>
<td>Query Description</td>
<td>Decision</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 4         | Failed lumbar puncture                                                            | **Recommendation:** A lumbar puncture is a procedure which involves insertion of thin, hollow needle into the spinal subarachnoid space to withdraw a sample of cerebrospinal fluid (CSF). The procedure may be diagnostic or therapeutic. Documentation of a failed lumbar puncture may mean a number of different things:  
- The subarachnoid space has been entered but insufficient CSF has been obtained for pathology  
- The subarachnoid space has been entered but no CSF has been obtained  
- The needle could not be passed into the subarachnoid space  
**Decision:** Documentation of failed lumbar puncture may refer to entry of the subarachnoid space which has failed to obtain sufficient or any CSF. As per ACS 0019 *Procedure not completed or interrupted*, the procedure should be coded to the extent performed. If documentation confirms that the subarachnoid space has been entered (i.e., insufficient fluid obtained), the correct code assignment is 39000-00 [30] *Lumbar puncture*. If documentation indicates that the subarachnoid space has not been entered or documentation is ambiguous, no procedure code should be assigned.                                                                                      |
| 5         | Ultrasound based endovascular carotid body ablation                               | **Recommendation:** Ultrasound based endovascular carotid body ablation is a new procedure which is currently undergoing study in a number of teaching hospitals. The procedure is being used to treat resistant hypertension. It is a catheter-based procedure which uses ultrasound to ablate the carotid body from inside the carotid artery. The carotid body is a chemoreceptor which is situated between the two carotid arteries.  
There is no ACHI code available for ultrasound based endovascular carotid body ablation. Clinical advice was sought on the best procedure code to assign. As some degree of nerve fibre destruction occurs during this procedure, a code for neurotomy may be assigned. Using the following Index pathway,  
Neurotomy  
- peripheral  
-- percutaneous by  
--- radiofrequency  
--- thermocoagulation – see Neurotomy/peripheral/percutaneous, by radiofrequency  
the ‘best fit’ code is 39323-00 [72] *Other percutaneous neurotomy by radiofrequency.*  |

[WA Clinical Coding Advisory Group Decision Date: 21.09.2016]
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 4        | **Non-small cell lung carcinoma vs adenocarcinoma**  
When a lung cancer is documented as non-small cell lung carcinoma (adenocarcinoma), which morphology should be coded? | **Recommendation:**  
Lung carcinomas can be divided into two main types: small cell lung carcinoma (SCLC) and non-small cell lung carcinoma (NSCLC). As the name suggests, NSCLC refers to a group of lung carcinomas which are not small cell. The most common types of NSCLC are squamous cell carcinoma, large cell carcinoma and adenocarcinoma. Clinically, adenocarcinoma is a more specific type of NSCLC.  
Additionally, ACS 0233 *Morphology* states “If a morphological diagnosis contains two histological terms which have different M codes, select the highest number as it is usually more specific”.  
M8140/3 *Adenocarcinoma NOS* is a higher number than M8046/3 *Non-small cell carcinoma*. It is also clinically a more specific diagnosis than NSCLC. Therefore, following the instruction in ACS 0233, M8140/3 *Adenocarcinoma NOS* should be assigned when ’non-small cell lung carcinoma (adenocarcinoma)’ is documented.  
**Decision:** Following the instruction in ACS 0233, M8140/3 *Adenocarcinoma NOS* should be assigned when both non-small cell lung carcinoma and adenocarcinoma are documented.  
[WA Clinical Coding Advisory Group Decision Date: 21.09.2016] |
| 6        | **Intranasal sedation**  
CCWA Decision *Sedation other than intravenous or inhalational* 17.11.2010 has now been retired due to the publication of ACCD National Coding Rule *Intramuscular sedation for anaesthesia* June 2016. However, the ACCD Coding Rule does not address intranasal sedation which was addressed in the CCWA decision. Should intranasal sedation be coded? | **Recommendation:**  
ACS 0031 *Anaesthesia* states:  
The distinction between sedation and general anaesthesia is often unclear from clinical documentation. For the purposes of classification in ACHI, 92515-XX [1910] *Sedation* may be assigned where the anaesthetic is administered as per general anaesthesia (i.e. intravenous or inhalational or both) and there is no documentation of the use of an artificial airway, such as an endotracheal tube, laryngeal mask, pharyngeal mask or Guedel airway.  
Therefore, according to ACS 0031 only inhalational or intravenous sedation should be coded.  
The ACCD Coding Rule is specific to intramuscular sedation and should not be applied to intranasal sedation.  
Intranasal sedation is not the same as inhalational sedation. In intranasal sedation, a mucosal atomiser device is used to deposit medication onto the highly vascular nasal mucosa and it is rapidly absorbed into the blood stream and cerebrospinal fluid. Inhalational sedation involves inhalation of the anaesthetic agent into the lungs through an |
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 5        | anaesthesia mask where it is then absorbed into the blood stream. | **Decision:** Current ACS and National Coding Advice do not allow for coding of intranasal sedation. A query will be sent to the ACCD to clarify whether intranasal sedation should be coded. In the interim, intranasal sedation should not be coded.  

[WA Clinical Coding Advisory Group Decision Date: 21.09.2016]                                                                                                                                                                                                                                                                 |
| 8        | Staging laparotomy                         | **Recommendation:**  

The intent of the lymph node excision is to determine whether the malignancy has metastasised to the lymph nodes, which is for staging of the malignancy. However, the term ‘staging’ is an essential modifier in the ACHI index:  

- **Excision**  

  - lymph node  

    -- intra-abdominal (simple)(total) NEC 90282-00 [811]  
    --- for staging of malignancy 35726-01 [985]  

Therefore ‘staging’ must be documented before assigning 35726-01 [985] Staging laparotomy. The intent of this code is for operations specifically performed for staging of a malignancy.  

For the scenario in this query, ‘staging’ was not documented and was not the sole intent of the procedure. The correct code to assign for lymph node excision is 90282-00 [811] Excision of lymph node of other site.  

**Decision:** Following the index, assign 90282-00 [811] Excision of lymph node of other site for excision of lymph nodes performed during a laparotomy. ‘Staging’ is an essential modifier which must be documented prior to assignment of 35726-01 [985] Staging laparotomy.  

[WA Clinical Coding Advisory Group Decision Date: 21.09.2016]                                                                                                                                                                                                                                     |
| 9        | Inflammation documented on histopathology report | **Recommendation:** When ‘inflammation’ meets ACS criteria for coding, carefully follow: the Index from lead term ‘Inflammation, inflamed, inflammatory’; and the Index and Tabular instructions to assign the correct code.  

Examples:  

‘Oesophageal biopsy: inflammation’  

Inflammation, inflamed, inflammatory → oesophagus → K20 Oesophagitis  

<p>|</p>
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>‘Biopsy stomach: chronic superficial inflammation’</td>
<td>Inflammation, inflamed, inflammatory → stomach (see Gastritis) → Gastritis → chronic → superficial → K29.30 Chronic superficial gastritis, without mention of haemorrhage</td>
</tr>
<tr>
<td></td>
<td>‘Bile duct: inflammation’</td>
<td>Inflammation, inflamed, inflammatory → bile duct or passage (see also Cholangitis) → K83.0 Cholangitis</td>
</tr>
<tr>
<td></td>
<td>‘Endometrium: chronic inflammation’</td>
<td>Inflammation, inflamed, inflammatory → uterus (see also Endometritis) → Endometritis → chronic → N71.1 Chronic inflammatory disease of uterus.</td>
</tr>
<tr>
<td></td>
<td>‘Bladder: inflammation’</td>
<td>Inflammation, inflamed, inflammatory → bladder (see also Cystitis) → N30.9 Cystitis, unspecified</td>
</tr>
<tr>
<td></td>
<td>When ‘inflammation’ meets ACS criteria for coding and there is no sub-term for the inflamed organ under ‘Inflammation, inflamed, inflammatory,’ follow the Index from ‘Disease’ to assign the correct code (as per Conventions used in the Tabular List of Diseases, Example 32).</td>
<td></td>
</tr>
</tbody>
</table>

**Decision:** When ‘inflammation’ of an organ meets ACS criteria for coding, carefully follow: the Index from lead term ‘Inflammation, inflamed, inflammatory,’ and the Index and Tabular instructions to assign the correct code. When there is no sub-term for the inflamed organ under ‘Inflammation, inflamed, inflammatory,’ follow the Index from ‘Disease’ to assign the correct code.

[WA Clinical Coding Advisory Group Decision Date: 21.09.2016]

---

10 Type 1 and Type 2 MI
Cardiologists are increasingly documenting myocardial infarctions as Type 1 or Type 2 rather than STEMI or NSTEMI. What code should be assigned for Type 1 and Type 2 MI?

**Recommendation:**
Traditionally, MIs have been classified based on electrocardiographic findings as ST elevation MI (STEMI) or non-ST elevation MI (NSTEMI) or anatomically as transmural or nontransmural.

In 2007, a consensus document was published by a joint task force of experts with a new universal definition of the term myocardial infarction. The criteria are based on cardiac biomarkers (such as troponin) and other signs and symptoms (symptoms of ischaemia, ECG changes and imaging evidence).

The document also provides clinical classification of myocardial infarctions as Type 1, 2, 3, 4a, 4b and 5.

When a myocardial infarction is documented as one of the types above, clinical coders should look for documentation which is indexed in the ICD-10-AM classification, such as STEMI, NSTEMI, transmural, nontransmural or the site of the MI. If such information is not available, I21.9 Acute myocardial infarction should be assigned.
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>[WA Clinical Coding Advisory Group Decision Date: 21.09.2016]</td>
<td>WA advice replaced by ACCD advice</td>
<td></td>
</tr>
</tbody>
</table>
| 1 | Revision arthroplasty of the knee | Q: Where ‘revision TKR’ (total knee replacement) is documented, and the operation report details replacement of a hemiarthroplasty with a total arthroplasty of the knee, is this classified as a revision procedure? 

A: In ACHI, replacement of a partial knee replacement with another partial knee replacement is classified as 49517-00 [1518] Hemiarthroplasty of knee by following the Alphabetic Index:

**Revision** (partial) (total)
- joint replacement (prosthesis)
  - knee, total (with removal of prosthesis)
    - - partial 49517-00 [1518]

(Nota: There is an inconsistency in the ACHI Alphabetic Index. The essential modifier for 'total' in the above indexing should be a nonessential modifier. As there are no further errata for Ninth Edition, the error will be amended for Tenth Edition).

Where documentation in the operation report indicates ‘revision TKR’, assign codes for revision of total knee replacement, even if the in situ device is a partial knee replacement. Assign codes for revision of total arthroplasty of knee by following the Alphabetic Index:

**Revision** (partial) (total)
- joint replacement (prosthesis)
  - knee, total (with removal of prosthesis) 49527-00 [1524]
    - - with
      - - - - anatomic specific allograft 49554-00 [1523]
      - - - - bone graft
      - - - - - - anatomic specific allograft 49554-00 [1523]
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 2        | Component separation technique for incisional hernia repair | Q: How do you classify component separation technique for repair of an incisional hernia?  
A:  
The component separation technique (CST) to repair an abdominal wall defect (usually an incisional hernia) is a type of rectus abdominis muscle advancement flap (Cone 2015).  
CST is performed by dissecting between and separating a number of intra-abdominal muscles to enable closure of a large or complex abdominal wall defect. The use of mesh reinforcement is a modification of CST that has been proven to reduce hernia recurrence (Heller, Chuma & Shengnan Xue 2012, Kim & Kim 2011).  
Component separation technique for repair of incisional hernia is classified to 30405-00 [993] Repair of incisional hernia with muscle transposition by following the Alphabetic Index:  
Repair  
...-hernia  
...-- incisional  
- - - with  
- - - - muscle transposition 30405-00 [993]  
If mesh is inserted, also assign 30405-01 [993] Repair of incisional hernia with prosthesis by following the Alphabetic Index:  
Repair  
...-hernia |
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Subcutaneous implantable cardiac defibrillator (S-ICD) electrodes</td>
<td>Q: What codes should be assigned for insertion, replacement, adjustment or removal of subcutaneous electrodes in a subcutaneous implantable cardiac defibrillator (S-ICD) system?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A: The subcutaneous implantable cardiac defibrillator (S-ICD) system consists of a pulse generator implanted under the skin of the chest at the mid axillary line. The pulse generator is connected to the electrode (lead) which is implanted under the skin tunnelled across the ribcage above the heart and is anchored in place under the skin. The defibrillator electrode remains outside the chest cavity. ACHI does not have specific codes for insertion, replacement, adjustment or removal of the subcutaneous defibrillator electrode. Clinical advice indicates these procedures are similar to transvenous endocardial electrode procedures in terms of purpose, associated implantation and connection to a generator box. Therefore as a best fit assign the following codes as appropriate:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38390-02 [648] Insertion of permanent transvenous electrode into other heart chamber(s) for cardiac defibrillator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>38350-03 [654] Replacement of permanent transvenous electrode of other heart chamber(s) for cardiac defibrillator</td>
</tr>
</tbody>
</table>

[ACCD Coding Rule September 2016]

References:


<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 90203-08 | Adjustment of transvenous electrode for cardiac defibrillator | 38350-04 [654] **Removal of permanent transvenous electrode of other heart chamber(s) for cardiac defibrillator**  
Improvements to ACHI will be considered for a future edition. |**[ACCD Coding Rule September 2016]** |
| 4        | Failed back syndrome               | Q: What is the correct code assignment for ‘failed back syndrome’?  
A: Failed back syndrome is a synonym for postlaminectomy syndrome. The correct code to assign for failed back syndrome is M96.1 Postlaminectomy syndrome, not elsewhere classified following the Alphabetic Index:  
Postlaminectomy syndrome NEC M96.1  
Updates to the classification have been made for ICD-10-AM Tenth Edition. |**[ACCD Coding Rule September 2016]** |
<table>
<thead>
<tr>
<th>Query no.</th>
<th>Query Description</th>
<th>Decision</th>
</tr>
</thead>
</table>
| 2        | Haemorrhoidal artery ligation and rectal anal repair (HAL RAR) | Q: What is the correct code for haemorrhoidal artery ligation and rectal anal repair (HAL RAR) procedure OR transanal haemorrhoidal dearterialisation (THD) with haemorrhoidopexy?  

A: 
Haemorrhoidal artery ligation and rectal anal repair (HAL RAR), also known as transanal haemorrhoidal dearterialisation (THD) with haemorrhoidopexy, is a minimally invasive procedure to treat haemorrhoids. The procedure usually consists of two components: haemorrhoid artery ligation (HAL) and transanal rectal repair (RAR). HAL involves the use of a Doppler proctoscope, through which the arteries feeding the haemorrhoid are identified and ligated by placing stitches around the artery. Once all the blood vessels supplying the haemorrhoid have been tied off, the haemorrhoid shrinks and falls off. The second part of the operation, known as RAR or haemorrhoidopexy, is performed to reduce the prolapse of the haemorrhoid and rectoanal mucosa by placing stitches to pull the haemorrhoid tissue back up into the upper anal canal. Currently there is no specific code in ACHI for this procedure. Assign 32135-00 [941] Rubber band ligation of haemorrhoids for Doppler guided haemorrhoidal artery ligation (HAL) or transanal haemorrhoidal dearterialisation (THD), following the index pathway:  
Ligation  
- haemorrhoids (rubber band) 32135-00 [941]  
If an adjunctive mucosal plication of rectal prolapse (RAR component of the procedure) or haemorrhoidopexy is performed, 32120-00 [929] Insertion of anal suture for anorectal prolapse should also be assigned, following the index pathway:  
Repair  
- prolapse, prolapsed  
-- anorectal  
--- by insertion of anal suture (Thiersch wire) 32120-00 [929]  
Improvements to ACHI will be considered for this procedure for a future edition.  

[ACCD Coding Rules December 2014] |