Coding queries & audit discussion cases

The July 2014 coding queries and audit discussion cases are now available to view on our website:


Coding queries
1. Gastric stimulation therapy
2. Passive smoking
3. Lynch syndrome, indication for colonoscopy
4. Debridement of burns at dressing change
5. Endoscopic dilation of duodenal stricture
6. Co-ablation of laryngotracheal papillomatosis
7. Repair of nasal septal perforation with cartilage graft
8. Sequencing of cancer codes in a palliative care episode

Audit discussion cases
1. Atrial myxoma, a benign connective tissue neoplasm
2. Pelvic abscess drained by laparotomy
3. Drainage of pyothorax

ACCD Education: Quarterly coding exercises

It is encouraged that coders complete the ACCD quarterly coding exercises. If any queries or discrepancies arise, please advise our team via the usual coding query process.

However, it should be noted that the answers from these exercises are not ratified coding advice, as they are not reviewed by the ICD Technical Group (ITG).
Clinical advice: Neoplasm of ectopic tissue

Rarely a neoplasm may arise in ectopic tissue. Ectopic is defined as a tissue or organ being located away from its normal position or arising in an abnormal site (Albert et al. 2012, 591). An ectopic tissue is a type of congenital abnormality, i.e. usually present from birth. It may manifest itself at any time during a person’s life.

Some examples of neoplasms in ectopic tissue include:

- Ectopic Thymoma
- Ectopic Phyllodes Tumour
- Ectopic Pancreatic Islet Tumour

**Ectopic Thymoma (thymus tissue) arising in pleura (usually arises in the thymus)**

The thymus gland is located in the anterior mediastinum (upper chest behind the sternum). It plays a role in the production of T-lymphocytes (white blood cells) in the immune system from infancy to adolescence. The thymus reaches its maximum size at puberty (40 grams) and then atrophies to fibrous fatty tissue in adulthood (Skoutelis et al. 2009).

Thymomas are tumours of the epithelial cells of the thymus. Ninety-six per cent of thymomas occur in the anterior mediastinum, but only 4% are ectopic tumours (Kitada et al. 2011). Ectopic thymomas have been described in the neck, base of the skull, pericardium, middle and posterior mediastinum, lung and pleura.

Thymomas are usually asymptomatic. However, thymomas arising from the pleura may produce symptoms such as cough, shortness of breath and chest pain, when the growing tumour compresses the surrounding tissues. Systemic symptoms can also occur due to the release of hormones or antibodies e.g. fever and chills.

Interestingly, 35% of thymoma patients also have Myasthenia Gravis or another autoimmune disease (Skoutelis et al. 2009).

**Ectopic Phyllodes Tumour (breast tissue) arising in labia majora (usually arises in the breast)**

The occurrence of ectopic breast tissue is 2-6% of the general population (Youn and Jung 2009). Ectopic breast tissue develops along the mammary ridges (milk lines) on both sides of the body. The ridges extend from the axilla to the external genitalia, inguinal regions and ending on the medial aspect of the thighs (Hao and Yang 2012).

Ectopic breast tissue has been found in the axilla, labia, and even in male patients. If there is a nipple and/or areola present then the ectopic tissue is called a supernumerary (or accessory) breast. Ninety-four per cent of ectopic breast tumours occur in undifferentiated breast tissue and only 6% in supernumerary breast tissue (Youn and Jung 2009).

The diagnosis of neoplasms of ectopic breast tissue is frequently delayed e.g. the rare Phyllodes tumour of ectopic breast tissue. This tumour has been found in the axillae and the labia of patients. It presented as a nodule in the axilla/labium an only after excisional biopsy and histopathology was the diagnosis revealed.
Phyllodes tumours can be benign, borderline or malignant. (Phyllodes Tumours 2014).

**Ectopic Pancreatic Islet Cell Tumour (pancreatic tissue) arising in the upper gastrointestinal tract e.g. stomach (these usually arise in the pancreas)**

Ectopic pancreatic tissue affects about 5% of the population (Goel et al. 2014). It can be found in any part of the abdominal cavity. However, more than 90% of cases are in the gastric antrum, proximal duodenum, Meckel's diverticulum, or jejunum. The ectopic tissue is usually in the submucosa, is less than 2cm in diameter and difficult to locate.

Patients are commonly asymptomatic or may rarely present with conditions of the pancreas such as; pancreatitis, carcinoid syndrome and pancreatic neoplasms. Ectopic pancreatic tissue and its diseases are usually diagnosed at laparotomy (Yuan et al. 2009).

**Treatment**

Treatment of ectopic tumours is treatment of the “site of origin” tissue. Thus, after local excision (if possible), treatment of an ectopic breast tumour (arising in the genitalia) would involve radiotherapy and chemotherapy as is appropriate for a neoplasm of breast tissue not that for a neoplasm of genital tissue.

**Classification**

In the ICD-10-AM Tabular List, there is a note at the beginning of Chapter 2, Neoplasms which states:

**6. Malignant neoplasms of ectopic tissue**

Malignant neoplasms of ectopic tissue are to be coded to the site mentioned, e.g. ectopic pancreatic malignant neoplasms are coded to pancreas, unspecified (C25.9).

The wording of this instructional note is ambiguous, but should be interpreted to mean that the tissue’s origin should be coded, rather than the site where the ectopic tissue has arisen. For example:

Ectopic thymoma (thymus tissue) arising in pleura, with excision of lesion of pleura performed.

In this case the thymus should be coded as the primary site, even though the ectopic thymoma has arisen in the pleura. This logic is reinforced because the alphabetic index provides a thymus site code for thymoma (D38.4 Neoplasm of unknown or uncertain behaviour of thymus), which cannot be ignored. The morphology code is as documented e.g. M8583/1 Thymoma, type B1 NOS. An additional diagnosis code should be added to show ectopic tissue (Q89.26 Congenital malformations of the thymus. Pathway: ectopic, organ or site, spell other site, thymus). The procedure coding will reflect the site of the ectopic tissue being excised. In this case, excision of lesion of pleura should be coded:

- **D38.4** Neoplasm of uncertain or unknown behaviour of thymus.
- **M8583/1** Thymoma, type B1, NOS
- **Q89.26** Congenital malformation of thymus
- **38424-00** Pleurectomy
Coding tip: Diabetic patient with hyperglycaemia

Some drugs (systemic glucocorticoids e.g. Dexamethasone, Hydrocortisone) may cause hyperglycaemia as an adverse drug effect. The ICD-10-AM classification links hyperglycaemia to diabetes, as per the index pathway:

Hyperglycaemia
- with diabetes (mellitus) – see Diabetes, diabetic

This is reinforced by the Excludes note at R73 Elevated blood glucose level.

Therefore, we need to code the adverse effect external cause codes with the diabetes mellitus code(s). The code list appears to read back that the adverse effect caused diabetes mellitus itself, however this is unavoidable and the only way to code this scenario. Drug-induced or chemical-induced diabetes are specifically indexed to block E13 Other specified diabetes mellitus so can be distinguished from these cases.

Example

A case of hyperglycaemia, secondary to IV administration of Hydrocortisone (for the treatment of intraoperative bronchospasm). The hyperglycaemia was treated with 4 units Novorapid. Patient has type 2 diabetes mellitus and morbid obesity.

Code assignment for hyperglycaemia secondary to Hydrocortisone:

E11.72 Type 2 diabetes mellitus with features of insulin resistance
Y42.0 Glucocorticoid and synthetic analogues causing adverse effects in therapeutic use
Y92.22 Health service area
U73.8 Injury or poisoning occurring while engaged in other specified activity
Back to basics: Working diagnosis/provisional diagnosis

When a patient is first admitted to hospital, the clinician may make a provisional/working diagnosis based on the patient’s condition at the time of admission. Following tests and observations in hospital, the clinician may change this diagnosis in light of the new information, or find the diagnosis has been disproved entirely.

Treatment may be started provisionally before a complete/final diagnosis is made. Part of the coder’s responsibility in the abstraction process is to review the documentation to determine the final diagnosis made, after study.

If a provisional/working diagnosis is later disproved and provisional treatment ceased, the provisional diagnosis should not be coded, as the patient has been found not to have that condition. Although resources were used for provisional treatment, this is considered precautionary treatment and the condition does not meet criteria for coding.

Example

Patient admitted with fever and rigors. Blood cultures performed, initial result showing Staphylococcus in one bottle, further cultures pending. Provisional diagnosis is Staphylococcal sepsis and IV Vancomycin is commenced. Subsequent blood culture result showed Staph epidermidis isolated – doctor confirmed it was likely a contaminant. The antibiotics are ceased. Final diagnosis was viral illness.

In this case, the provisional diagnosis which received precautionary treatment (staph sepsis) is not coded. Only the final diagnosis is coded: B34.9 Viral infection, unspecified.

Aspiration pneumonia external cause code

Recently published national advice (Coding Rules, June 2014) about external cause coding for aspiration pneumonia states:

Where aspiration pneumonia is documented and there is no indication of what was aspirated, do not assign an external cause code, as it will not provide any additional information.

When coding unspecified aspiration pneumonia (no documentation of what was aspirated), coders may find that they can’t follow the national advice because their PAS does not allow codes to be finalised unless J69.0 Pneumonitis due to food and vomit is accompanied by an external cause code.

In these cases, the external cause code W84 Unspecified threat to breathing should be used, even though it adds no further specificity, until the PAS edits are next updated when 9th edition is implemented.

ICD-10-AM Alphabetic disease index error (hard books)

The following index entry is missing from the 8th edition Alphabetic disease index in the hard books, due to a publishing error:

Endosalpingioma — see Endometriosis

The omission will be corrected in the 9th edition publication.
Coder spotlight

WA’s Clinical Coding Guru Retires

According to the Oxford Dictionary, a Guru is an influential teacher or popular expert. This description describes Suzanne (Sue) Stevens perfectly. For nearly two decades Sue Stevens was that person at the WA Department of Health who answered the phone, responded to emails and was the person everybody went to when they wanted to know anything about coding.

Turning seventy in February this year, Sue Stevens after nearly four decades of coding, finally closed her coding books and retired on the 10th May 2014.

Surprising Career Path

Sue, the daughter of a “Rat of Tobruk” was born in Kapunda, South Australia in 1944 when George VI was our King and John Curtin our Prime Minister. Moving to Perth at the age of two, Sue was educated at Perth College. Leaving school aged thirteen was not unusual for this time and Sue started her first job as an Insurance Clerk at National Mutual. At the sweet age of sixteen, Sue began her nursing training at Royal Perth Hospital.

On graduation, Sue worked on the Renal Dialysis Ward and the growing developments in renal medicine would see Sue’s interest take her to the United Kingdom to continue post graduate studies. Her cryptic crossword passion was founded here by completing the cryptic crossword from the London Age while on night shift.

On returning to Australia in 1967 for her brother’s wedding and unable to obtain work as a nurse, due to the lack of available positions, her career path went upwards. Sue became an air hostess for McRobertson Miller Airline Services (MMA), affectionately referred to by the Western Australian locals as ‘Mickey Mouse Airlines’. Sue was actually half an inch shorter than the height requirement but somehow convinced the Medical Officer to pass her. MMA serviced routes within Western Australia and was renamed Ansett WA. Sue was on the first plane to land in Darwin after the devastation of Cyclone Tracy in December 1974 and assisted in the evacuation.

Sue was one of Murdoch University’s first students attaining a Bachelor of Arts in History and awarded honours. In 1977, the year Elvis Presley died of a heart attack, Sue started work at Sir Charles Gairdner Hospital as an Insurance Clerk. It didn’t take her long to be discovered by the Medical Librarian and be taught to code.

WA Department of Health

In 1981, Sue accepted the Coding Supervisor’s position at the WA Department of Health. The vast majority of coding (excluding teaching hospitals) was completed centrally at the Department of Health using coding summaries (HA22s). The growing focus on inpatient case-mix data in Western Australian hospitals would see Sue Stevens play the most instrumental role in the devolvement and advancement of coding ever seen in our State.
The Coding Revolution

To improve the standard of the case-mix information across the State a mammoth transformation took place. The principle of coding from the entire medical record and not just the summary sheet was endorsed. All coding was to be undertaken by suitably qualified coders. Coding in all metropolitan hospitals was to be conducted at the hospital and there was a devolvement of coding to the country regions. This would require training programs to be conducted at the Department of Health. Computer systems would require morbidity modules to capture the data and edits implemented at data entry level.

Sue dealt with the concept of the requirements for the first version of the ANDRGs, between 50 to 60 coding queries a day and one of the most challenging assignments - the implementation of ICD-10 AM.

Winding Down

Sue took some long service leave and decided she just wanted to code. After working at a few hospitals she decided to stay at Joondalup Health Campus and wind down to retirement. Thirteen years later, Sue has decided she is too busy to work and needs more time to play lawn bowls and bridge. Sue thinks she will start swimming in summer and she wants to do a computer course.

Words of Wisdom

I asked Sue, what makes a good coder: “Paying attention to the detail, understanding what you don’t know and asking those who do.” Her favourite things about coding are: the piecing together of the medical history, reading about an aspect of a person’s life and using all of your acquired knowledge. Her biggest bug bear is the clinical documentation. “Clinician’s want to prove everything before making a diagnostic statement.” Sue thinks it is worse today and quotes Professor

D’Arcy Holman, “Medicine is an art-form not a science.”

Interview by Deb Yagmich.

We thank Sue for her contribution to Clinical Coding in WA and wish her a relaxing and happy retirement!