Coding Rules

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1. Debridement, antibiotic and implant retention
2. Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)
3. Lynch syndrome
4. Monoclonal antibodies for treatment of COVID-19
5. Testing for evidence of a previous SARS-CoV-2 infection
6. Traumatic subdural hygroma

National Coding Advice – Coding Rules and FAQs for Eleventh Edition current at 1 January 2022
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Debridement, antibiotic and implant retention

Q:

What code is assigned for debridement, antibiotic and implant retention (DAIR)?

A:

Debridement, antibiotic and implant retention (DAIR) is an intervention to treat prosthetic joint infection occurring after total joint replacement. The intervention consists of debridement, and removal of all infected tissues and synovial membrane, obtaining tissue specimens for microbiology testing and extensive irrigation with antibacterial solution. The prosthesis is retained while removable components such as polyethylene or acetabular liners are replaced (Barros et al. 2019; Qasim et al. 2017).

DAIR is considered as a revision of a total joint replacement and does not require separate codes for each component.

Where DAIR is performed following total hip replacement, assign 49324-00 **[1492]** *Revision of total arthroplasty of hip*.

Where DAIR is performed following total knee replacement, assign 49527-00 **[1524]** *Revision of total arthroplasty of knee*.

Follow the ACHI Alphabetic Index:

Revision

- joint replacement (prosthesis) (with removal of prosthesis)
- - hip (total) 49324-00 **[1492]**
- - knee (total) 49527-00 **[1524]**

Amendments will be considered for a future edition.

References:

Barros, L.H, Barbosa, T.A., Esteves, J., Abreu, M., Soares, D. & Sousa, R. 2019, 'Early debridement, antibiotics and implant retention (DAIR) in patients with suspected acute infection after hip or knee arthroplasty – safe, effective and without negative functional impact' *Journal of Bone and Joint Infection*, vol. 4, no. 6, pp. 300-305, viewed 15 September 2021, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6960028/>.

Qasim, S.N., Swann, A. & Ashford, R. 2017, 'The DAIR (debridement, antibiotics and implant retention) procedure for infected total knee replacement – a literature review', *SICOT-J*, vol. 3, no. 2, viewed 15 September 2021, <https://www.sicot-j.org/articles/sicotj/full_html/2017/01/sicotj150138/sicotj150138.html>.

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Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)

Q:

What codes are assigned for Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC)?

A:

Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) and AB-interno canaloplasty (ABiC) are both forms of minimally invasive glaucoma surgery (MIGS). They are performed for treatment of glaucoma in combination with procedures for the treatment of cataract.

GATT is performed via micro-incisions in the cornea, after which, the trabecular meshwork is cut. An advantage of the GATT approach is that there is less scar tissue and subsequent surgeries have a significantly higher rate of success (Glaucoma Associates of Texas 2021).

ABiC uses an illuminated microcatheter technology called iTrack to viscodilate the Schlemm channels of the eye in order to improve aqueous outflow without a stent or shunt. Instead of changing or bypassing the natural drainage pathways of aqueous humour, ABiC is designed to restore the natural outflow pathway by addressing all drainage channels (Webeyeclinic 2018).

Assign 90075-00 **[191]** *Other procedures for glaucoma* when GATT or ABiC is performed.

Follow the ACHI Alphabetic Index:

Procedure
- glaucoma NEC 90075-00 **[191]**

See also Coding Rule *Insertion of minimally invasive glaucoma surgery (MIGS) device without concurrent cataract extraction.*

Improvements to ACHI are proposed for Twelfth Edition.

References:

Glaucoma Associates of Texas 2021, *GATT procedure: Gonioscopy-Assisted Transluminal Trabeculotomy*, viewed 15 September 2021, <https://www.glaucomaassociates.com/gonioscopy-assisted-transluminal-trabeculotomy/>.

Webeyeclinic 2018, ABiC Glaucoma Procedure, viewed 15 September 2021, <https://www.webeyeclinic.com/glaucoma/abic-glaucoma-procedure>

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Lynch syndrome

Q:

What codes are assigned for same-day endoscopy for Lynch syndrome?

A:

Lynch syndrome is a genetic disorder that causes an increased risk of developing cancers. The most common cancer in people with Lynch syndrome is colorectal (large bowel) cancer. However, having Lynch syndrome does not necessarily result in developing cancer. The most common check-up is a colonoscopy to examine large intestinal tract (Cancer Australia n.d.; Centers for Disease Control and Prevention 2020).

Where Lynch syndrome is documented as the indication for same-day screening endoscopy apply the guidelines in ACS 0052 *Same-day endoscopy - Surveillance*:

- Assign Z12.1 *Special screening examination for neoplasm of intestinal tract* as principal diagnosis if no cancer is detected or has ever been detected. ACS 0052 states:

  Assign as principal diagnosis:

  - *an appropriate code from categories Z11, Z12 and Z13 Special screening examination for… if screening for a disease pre-cursor (risk factor) or other factor and no disease is detected or has ever been detected*

  Follow the ICD-10-AM Alphabetic Index:

  Screening
  - Lynch syndrome Z12.1

- Assign a code from category C18 *Malignant neoplasm of colon*, or C19 *Malignant neoplasm of rectosigmoid junction*, where a malignant neoplasm is detected.

Do not follow the ICD-10-AM Alphabetic Index at the lead terms *Lynch syndrome* or *Syndrome/Lynch* unless a malignant neoplasm has been detected.

Improvements to ICD-10-AM are proposed for Twelfth Edition.

References:
Cancer Australia, n.d, *Lynch Syndrome*, viewed 01 December 2021, <https://www.canceraustralia.gov.au/affected-cancer/lynch-syndrome>.

Centers for Disease Control and Prevention 2020, *Lynch Syndrome*, viewed 01 December 2021, <https://www.cdc.gov/genomics/disease/colorectal_cancer/lynch.htm>.

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Monoclonal antibodies for treatment of COVID-19

Q:

What codes are assigned when monoclonal antibodies are administered as treatment for COVID-19 in a same-day episode of care?

A:

Where treatment is provided for coronavirus disease 2019 (COVID-19), assign the relevant ICD-10-AM codes for COVID-19 in accordance with the published *National Coding Advice*.

Monoclonal antibodies (mAb) are developed in a laboratory and are designed to mimic or enhance the body's natural immune system response against an invader, such as cancer or an infection (Lloyd et al. 2021).

Sotrovimab is a type of mAb which has been developed for the treatment of mild to moderate COVID-19 (VTAG 2021).

Assign ACHI codes for administration of mAb in accordance with the guidelines in ACS 0042 *Procedures normally not coded.*

When mAb are administered for the treatment of COVID-19 as the principal reason for admission in a same-day episode of care, assign a code from block **[1920]** *Administration of pharmacotherapy* with extension -02 *Anti-infective agent* where antiviral agents are an inclusion term.

Follow the ACHI Alphabetic Index:

Administration

- type of agent

- - anti-infective — *code to block* **[1920]** *with extension -02*

References:
Lloyd, E. C., Gandhi, T. N., & Petty, L. A., 2021, 'Monoclonal Antibodies for COVID-19', *JAMA Network*, vol. 325, no. 10, pp.1015.
Victorian therapeutics advisory group (VTAG) 2021, *Use of Sotrovimab in adults with COVID-19*, viewed 01 December 2021, <https://www.victag.org.au/1.-PATIENT-INFORMATION_use-of-Sotrovimab_in-COVID-19_V1.1_9Sept21_pdf_.pdf>.

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Testing for evidence of a previous SARS-CoV-2 infection

Q:

What code should be assigned where a patient is tested for evidence of a previous SARS-CoV-2 infection?

A:

Coding Rule *Application of U06.0 Emergency use of U06.0 [COVID-19, ruled out]* confirms that health care facilities may test admitted patients for SARS-CoV-2 infection where COVID-19 is a differential diagnosis or there is a decision to rule out COVID-19 for other reasons.

Where a patient is tested with an intention to look for evidence of previous COVID-19 infection, rather than an acute/current COVID-19 infection, do not assign U06.0.

Assign an additional diagnosis of U07.3 *Emergency use of U07.3 [Personal history of COVID-19]* where clinical documentation indicates that the patient has previously confirmed COVID-19 that is no longer current, or U07.4 *Emergency use of U07.4 [Post COVID-19 condition]* where clinical documentation indicates a current condition is due to previous COVID-19.

See also Coding Rule *Classification of post COVID-19 conditions*.

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Traumatic subdural hygroma

Q:

What code is assigned for traumatic subdural hygroma?

A:

Traumatic subdural hygroma is a collection of cerebrospinal fluid (CSF) within the subdural space. Traumatic subdural haematoma is a collection of blood or blood products in the subdural space. Head injury can cause a separation of the dura-arachnoid interface resulting in subdural hygroma. While most subdural hygromas resolve, they can progress to become chronic subdural haematomas or both conditions can occur simultaneously with varying degrees of blood, bloody CSF or clear CSF present in the subdural space (Almenzalawy et al. 2019; Lee 2009).

Traumatic subdural hygroma is classified to S06.8 *Other intracranial injuries*.

Follow the ICD-10-AM Alphabetic Index:

Injury (traumatic)

- intracranial

- - specified NEC S06.8

Also assign external cause, place of occurrence and activity codes.

Amendments will be considered for a future edition.

References:

Almenzalawy, M.A., Essa, A.E.A., Ragab, M.H. 2019, 'Subdural hygroma: Different treatment modalities and clinical outcome.', *Open Journal of Modern Neurosurgery*, vol. 9, no. 3, pp. 208-220, viewed 9 September 2021, <https://www.scirp.org/journal/paperinformation.aspx?paperid=92269>.

Lee, K.S. 2009, 'The pathogenesis and clinical significance of traumatic subdural hygroma', *Brain Injury*, vol. 12, issue 7, pp. 595-603, viewed 9 September 2021, <https://doi.org/10.1080/026990598122359>.