Guidelines for writing a clinical coding query for VICC

Introduction

Queries to the Victorian ICD Coding Committee (VICC) are submitted via the online query form, by Victorian Clinical Coders and Health Information Managers (HIMs).

Queries relate to ICD-10-AM/ACHI/ACS and AR-DRG issues and are reviewed at the VICC meetings which take place 11 times per year. The VICC query response process is outlined in the flow chart on the HDSS website. Responses to queries take a minimum of two months due to the need for the committee to endorse its initial response at the subsequent meeting(s). The query and its response are then published in the VICC Query database. As the database is published quarterly this may further delay the query response being available to all coders, although the enquirer will receive a response immediately following the meeting at which the response is endorsed.

As queries, by their nature, are dealing with complex coding issues, it sometimes takes a lot of detailed discussion before committee members can agree on a response or a decision is made for referral to the ACCD. This discussion is often hindered and unnecessarily extended due to lack of clarity about the question being asked.

This document is being published to provide assistance for any clinical coders and HIMs considering sending a query to the committee.

Completing the online Query form

Query subject

The subject becomes the title of the query. It is important therefore that the subject clearly identifies the issue and immediately focuses the readers mind. Think about whether your query is about the principal diagnosis for a specific case, the interpretation of a standard, how to code a new procedure or whether is about the interpretation of a coding convention.

Example one:

A query with a subject heading of ‘underwarfarinisation’ and the issue involved a patient who was admitted with ‘underwarfarinisation’ as the principal diagnosis and no condition resulting from the underwarfarinisation.

The coding of underwarfarinisation is covered in ACS 0303 *Abnormal coagulation profile due to anticoagulants* but does not cover this scenario. An alternative subject heading could have been:
Principal diagnosis: Underwarfarinisation, no manifestation documented
This would have highlighted that the principal diagnosis is documented as Underwarfarinisation without further manifestation. Members would quickly realise that the standard does not provide direction in this circumstance

Example two:

A query with the subject heading of: “Inadvertent/intentional removal of devices requiring replacement” and the query related to whether inadvertent of intentional removal of devices could be coded as mechanical complications of the various devices. An alternative subject could have been:

Coding mechanical complications for inadvertent/intentional removal of devices requiring replacement

Query details

This is your opportunity to explain your issue in detail. It is important to stay on topic!

The query should include the following parts:

- Background information to give the query context:
    - Where in the record did you see the documentation pertaining to your query? i.e. operation report, discharge summary or outpatient notes
    - Reproduce the actual word(s) used in the record and refer to copies of the relevant forms if you have provided them
    - Is this a common issue at your health service, a new service or a 'one off' unusual case?
    - Has the scenario been discussed with peers? If opinions differ explain how or why.
- Detail the steps you have taken to answer question at a local level, for example:
    - Have you sought clinical advice or clarification of documentation
    - What code suggestions/alternatives have you considered?
    - What standards or ratified advice (e.g. VICC and ACCD) have you considered?
    - Internet searches
- Finalise your query with the specific question(s) you'd like answered:
    - If you have more than one question, clearly number each question
    - Keep the question short e.g. What is the correct code to assign? Can ACS xxx be used to justify this code assignment?

Attachments: Copies of documentation such as discharge summaries, clinical notes or operation reports which relate to the query should be provided.

Please note that whilst the online query form does not support attachments, de-identified scanned documents can be emailed directly to the HDSS helpdesk HDSS.Helpdesk@health.vic.gov.au with the subject heading 'Attachment to VICC query'.

Example one:

The committee received the following query under the subject of 'sloughing'.

> *We often get terms 'slough' or 'sloughy' documented in the medical record to describe wounds that are often debrided on the ward or in theatre.*
>
> *Could VICC advise if we can follow the index entry under Sloughing to assign R02 Gangrene in these cases?*
>
> *Sloughing (multiple) (phagedaena) (skin) (see also Gangrene) R02*
>
> *- abscess (see also Abscess) L02.9*
> *- appendix K38.8*
> *- fascia M79.8-*
> *- scrotum N50.8*
> *- ulcer (see also Ulcer/skin) L98.4*

Several issues were discussed with this query:

- Was the enquirer wondering whether the lead term 'sloughing' in the index could be followed? That is are the terms 'sloughy' and 'slough' interchangeable with 'sloughing'?
- Was the enquirer asking whether R02 Gangrene could be assigned for this case, as a default code regardless of the description of the wound?
- Was the enquirer asking whether R02 should be assigned alone?

- Was the enquirer aware that the default code can only be used when none of the essential modifiers applied to the case?
- Was the enquirer wondering whether R02 could be assigned in addition to one of the codes listed as essential modifiers, or in addition to another code that would describe the wound?

An alternative question could have been:

> *'Could VICC advise whether we can follow the index entry under Sloughing to:*
>
> 1. *assign R02 Gangrene in addition to the code for the wound?*
> 2. *as the only code when no code exists for the wound itself?*

This not only focuses the committee's deliberations on the specific questions but also saves the time spent trying to second guess the enquirer.

Search details

List all materials referenced such as Australian Coding Standards, published advice – State and National, clinical advice or advice from peers.

Episode identifier/Admission number

The inclusion of the episode identifier (where applicable) will assist the enquirer in retrieving the episode in order to provide VICC further information if required, and/or retrieving the episode for recoding if necessary once the query is resolved.

The perfect Query example!

Query title: Includes note for 'suture of wound' under Debridement codes

In Sixth edition there was an 'includes note' for suture of wound under code 30023-00 [1566] Excisional debridement of soft tissue. In Seventh edition this includes note has been removed.

1. Can you please confirm if the suture of the wound should be coded in addition to the debridement of soft tissue, or if the suture of wound is inherent in the debridement of soft tissue code?

2. If we need to assign an additional code for the suture in cases of excisional debridement of soft tissue, do we also need to assign an additional code for the suture of wound in cases where skin only is debrided?

This query title immediately tells the committee members that the query is about includes notes, specifically those associated with codes for debridement.

The enquirer has used clear sentences to describe the issue. The specific questions are then separated into paragraphs and are numbered. The committee can provide a yes/no answer to these questions in addition to the justification of the response.