Clinical Coding Advisory Group WA

Top Ten Coding Errors: Cases 6 -10

Teaching Hospitals 2007-2012

October 2013
Cases 1 – 5 were published in July 2013 and appear on the Clinical Coding in WA website, under ‘Education’.

Answers to Cases 6 – 10 (below) are provided here on pages 4 – 6.

Code the following scenarios:

6. An elderly woman is admitted following a fall. She is mildly confused on presentation, dehydrated and unsteady. IV fluids are given in ED. An x-ray reveals no injuries other than a Colles fracture, for which she requires closed reduction and pain relief. An MSU in ED comes back positive for E coli and she is started on IV antibiotics, which she completes over 3 days. Discharged well, back to Nursing Home, length of stay = 3 days.

Discharge Summary: 1. Fall

2. UTI, # distal radius

7. A 26 year old man is admitted for left axillary node clearance. A recent operation (2 weeks ago) to excise melanoma of the left anterior chest wall, had also revealed a metastatic node on sentinel LN biopsy.

The operation proceeds uneventfully under GA, ASA 3.

Pathology confirms metastatic melanoma in axillary lymph nodes.

Discharge Summary: chest wall melanoma
8. A 13 year old boy originally presented 2 months ago with a pelvic mass. Biopsy at the time revealed

“rhabdomyosarcoma (alveolar subtype)- pelvic”.

No mention of ‘metastases’ or ‘secondaries’ in the original histopathology. Later staging confirmed bone marrow and pelvic lymph node metastases.

At this episode he presents for IV chemotherapy as part of the initial cycle of chemo treatments. Chemo is administered by IV infusion, without incident or complication. He is attended by the physiotherapist and dietician and then discharged home the next morning. Length of stay: 1 day (overnight).

Discharge summary: metastatic alveolar rhabdomyosarcoma

9. A 44 year old man is admitted with a hot swollen knee joint, three days after an arthroscopy. He is treated with IV antibiotics over a further 3 days and then discharged home. Length of stay = 3 days

Discharge summary: septic arthritis of knee – arthroscopy knee (1/52 ago)

10. An 11 year old girl is admitted via ED with abdominal pain. She is taken to theatre on the same day for appendicectomy under GA, ASA 1E.

Operation Record:
- Procedure performed: laparoscopic appendicectomy
- Findings and Details of Operative Technique:
  - peritoneal adhesions noted, division of mesoappendix, base ligated with endoloops, normal-looking appendix to path.

- Histopath conclusion: normal appendix

She is discharged well the next day. Length of stay = 1 day (overnight).

Discharge Summary: mesenteric adenitis
Answers

6. N39.0 UTI
   B96.2 E. coli
   S52.51 fracture distal radius with dorsal angulation (Colles)
   W19 Fall
   Y92.9 place unknown
   U73.9 activity unknown
   E86 dehydration
   47363-00 closed reduction distal radius

- “Fall” is not a diagnosis.

- Patients who have had a fall may be admitted chiefly for:
  a) the injuries sustained
  b) the underlying condition(s) which precipitated their fall
  c) a tendency to fall repeatedly for which no cause is found (R29.6).

- In the case above the option c, is not applicable. This is a single fall. There is no mention of ‘repeated falls’, nor ‘tendency to fall’.

- UTI and fracture are both present on admission and both are treated. Both are potentially related to the fall, one as the cause (UTI) and one as the outcome (fracture).

- Apply the ‘Two or more diagnoses that equally meet the definition for principal diagnosis’ rule (ACS 0001) - ask the clinician to nominate the principal diagnosis clearly, or assign the first mentioned. Removing ‘fall’ (as a non-diagnosis), the first mentioned diagnosis is “UTI”. This is the default position then. To overturn it in favour of radius # would require the clinician to be consulted and confirm that choice.

- Additional notes:
  Coders often think that in a presentation with fall, the principal diagnosis will always be an injury. This has led to the sequencing of trivial abrasions over and above very serious infections (such as sepsis), where the infection caused the fall and was the main focus of treatment. There is potential for error whenever doctors list an event (MVA, assault, fall) as the principal diagnosis, instead of an actual diagnosis.
7. C77.3 metastatic malignancy, axilla
   M8720/6 metastatic melanoma
   C43.5 melanoma, skin, trunk
   M8720/3 melanoma, primary site
   30336-00 radical excision, lymph nodes, axilla
   92514-39 GA ASA 3

The discharge summary gives the primary site - chest wall.
(melanoma - site classification - chest wall - C43.5)

There are also metastases: (histopathology and history): metastatic nodes, axilla: therefore: neoplasm; lymphatic gland, axilla, secondary: C77.3

Both must be coded. If a primary site is coded, whether as principal or additional diagnosis, all metastatic sites must also be coded (ACS 0236).

Sequencing is determined by focus of treatment at this episode (ACS 0236). The primary site has already been excised and this episode is for resection of known axillary lymph node metastases, already established by sentinel lymph node biopsy.

8. C49.5 neoplasm, connective tissue, pelvis, malignant, primary
   M8920/3 rhabdomyosarcoma, alveolar subtype
   C79.5 neoplasm, bone, (marrow), malignant, secondary
   C77.5 neoplasm, lymphatic (nodes), pelvic, malignant, secondary
   M8920/6 rhabdomyosarcoma, alveolar subtype, metastatic
   96199-00 IV pharmacotherapy antineoplastic (cytotoxic chemo)
   95550-03 physio
   95550-00 dietician

The index pathway for rhabdomyosarcoma is:

- neoplasm, connective tissue, site (pelvis), malignant:

A common error is to go straight to the site: e.g. neoplasm, pelvis, malignant.

Code all secondaries as well as the primary site (ACS 0236)

Sequencing is determined by focus of treatment this episode (ACS 0236) - this is the initial treatment phase of the primary (C49.5).

Clinical coders who have trouble classifying rhabdomyosarcoma, will also have problems with similar neoplasms of connective tissue:
sarcoma, leiomyosarcoma, fibrosarcoma
9. **M96.8** other specified postprocedural, – musculoskeletal
   **M00.96** septic arthritis- knee joint
   **Y83.8** complications of other surgical procedures
   **Y92.22** place of occurrence – hospital or health service area
   **U73.8** activity - other

ACS 1904 requires that the problem (septic arthritis) be coded as a postprocedural complication, only where documented as being ‘directly related to the procedure’. The discharge summary final diagnosis could reasonably be interpreted as meeting that criterion. It relates the problem (septic arthritis) directly to the procedure.

The look up is: complications, musculoskeletal, postprocedural, specified: M96.8

Add a chapter code to show the nature: M00.96

The most common error is to assign ALL post-op infections to T81.41 without going through the step by step logic of ACS 1904.

See also ACS 1904, example 11, endophthalmitis from cataract surgery:

- H59.89, H44.0 (not T81.41, H44.0).

A brief summary of the steps in ACS 1904 is appended (page 7).

10. **I88.0** mesenteric adenitis
    **30572-00** laparoscopic appendicectomy
    **92514-10** GA, ASA 1E

Clinical coders generally understand that appendicectomy does not always mean the final diagnosis is appendicitis.

The more common error occurs when there are adhesions (K66.0).

'Division of mesoappendix' in the presence of adhesions, is sometimes mistakenly interpreted as 'division of adhesions' (30393-00).

Division of mesoappendix is part of appendicectomy and does not require separate coding. It is not adhesiolysis (no 30393-00). Since the adhesions are noted but not divided, they, also, are not coded (no K66.0).
Appendix 1

Summary of ACS 1904 steps:
These are applicable to ANY procedures, including dialysis, infusion, injection, but EXCLUDING Radiotherapy (see ACS 1902).

MAIN TERM (NOUN), POSTPROCEDURAL
1) focus on the main term (noun) e.g. nausea, headache, fistula, etc
2) look for postprocedural: e.g. headache postprocedural.
3) look also for the term (noun) related directly to the specific procedure e.g. headache – lumbar puncture.
4) if both look-ups are found, choose the more specific:
   Headache, postprocedural: G97.8
   headache, lumbar puncture: G97.1
   (choose the latter).

COMPLICATIONS POSTPROCEDURAL
5) Having focussed only on the main term (noun), but without success, ONLY then, look up complications of the body system (e.g. for hip pain M25.55 look up complications musculoskeletal, postprocedural: M96.8, M25.55).
6) At the same time, try complications of the specific procedure, if there is such a look up (for example: complications, dialysis… complications, anaesthesia…)
7) If both pathways are found, choose again the more specific.
   e.g. dehydration due to dialysis: E89.8, E86 is more specific than T80.8, E86.
   The external cause codes will show the dialysis specifically.

DEFAULT
8) If there is still no indexed pathway use T81.8 as the final default (e.g. for R codes which cannot confidently be assigned to a specific body system or specific procedure) [or for non-R codes where the chapter has no postprocedural range (e.g. L codes, D codes, F codes)].

IMPLANTED DEVICES/ GRAFTS / PROSTHESES
Remember: overriding exceptions to all of this are:
- complications specifically related to* an implanted device, graft, or prosthesis (T82 – T85).

(*where the clinician makes the relationship)