Welcome
We are pleased to announce a new Coding Educator has joined our team – welcome Brooke Holroyd. Brooke is working part-time (Wednesday to Friday).

We hope you all had a happy and safe Easter holiday.

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


Coding queries
1. Detorsion of ovaries
2. Botox injections in cerebral palsy patients
3. Osteitis pubis
4. Follow-up and symptom in same-day scope

Audit discussion cases
1. Booked chemotherapy day case with complication (hypotension) arising during episode
2. Admission for fall (no injury)
3. Lower respiratory tract infection vs pneumonia
4. Booked colonoscopy day case for tattooing of malignant polyp
Website A-Z coding query index

All WA coding queries published on our website are accessible via the A-Z index: http://www.clinicalcoding.health.wa.gov.au/news/coding_index.cfm

With the accumulation of queries over time, the alphabetic index list has grown. For ease of searching, we recommend using the ‘Find’ function in your internet browser. In Internet Explorer, there are two ways to perform a ‘Find’ search: in the Edit menu, select ‘Find on this page’, or press CTRL+F on your keyboard.

A box will appear in which you can type a word or letters, and as you type, the relevant matches on the page are automatically highlighted in yellow. Once you have finished typing, the total number of matches for your search appears, and you can navigate through these matches with the “Next” and “Previous” buttons.

Clinical review: Heart failure

Heart failure occurs when the heart is unable to pump blood around the body effectively. Congestive heart failure (CHF), also known as congestive cardiac failure (CCF), is heart failure that is accompanied by congestion of body tissues (Porth 2005, 608). Common causes of heart failure include:

- ischaemic heart disease / coronary artery disease
- myocardial infarction
- cardiomyopathy
- valvular heart disease
- hypertension
  (Harris, Nagy and Vardaxis 2010, 421)

Left and right sided heart failure

Heart failure can be classified according to the side of the heart (left ventricle or right ventricle) that is affected. Although the initial heart failure may affect only one side, long-term heart failure usually involves both sides (Porth 2005, 609).

Left ventricular failure (LVF) causes pulmonary congestion. Right ventricular failure (RVF) causes systemic venous congestion and peripheral oedema (Harris, Nagy and Vardaxis 2010, 421). CHF is diagnosed when RVF with systemic venous congestion has occurred.

The manifestations differ depending on the extent to which each ventricle is involved:

<table>
<thead>
<tr>
<th>Left ventricular failure</th>
<th>Right ventricular failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased cardiac output and pulmonary congestion</td>
<td>Congestion of peripheral tissues</td>
</tr>
<tr>
<td>Activity intolerance</td>
<td>• Dependent oedema: lower extremities if patient ambulatory, sacral area if supine</td>
</tr>
<tr>
<td>Impaired gas exchange</td>
<td>• GI tract congestion, ascites</td>
</tr>
<tr>
<td>Pulmonary oedema</td>
<td>• Liver congestion</td>
</tr>
</tbody>
</table>

(Porth 2005, 609)

RVF is usually caused by LVF. Therefore CHF in many cases is a chronic progression from LVF. However, this is not true in all cases as other causes can be responsible for RVF, such as right ventricle infarction (inferior myocardial infarction). In such cases there is no LVF or pulmonary congestion.

Signs and symptoms

The common signs and symptoms of CHF reflect the impaired tissue perfusion and volume (fluid) overload around the body.

Symptoms include: fatigue, shortness of breath and decreased exercise tolerance. Signs include: dyspnoea; cyanosis; tachycardia; pitting oedema of subcutaneous tissues in feet, ankles and legs; peripheral vasoconstriction (cold and
pale extremities); moist rales at the base of
the lungs; ascites; liver enlargement,
splenomegaly and raised jugular venous
pressure (JVP). Weight may be monitored
to assess accumulation of fluid. On CXR
there may be cardiac enlargement
(cardiomegaly), hilar congestion, pulmonary
oedema and pleural effusions.

ICD-10-AM codes

I50.0 Congestive heart failure
Congestive heart disease
Right ventricular failure (secondary to left heart failure)

I50.1 Left ventricular failure ▼0920
Cardiac asthma
Left heart failure
Oedema of lung with mention of heart disease or heart failure
Pulmonary oedema with mention of heart disease or heart failure

I50.9 Heart failure, unspecified
Cardiac, heart or myocardial failure NOS

Coding tips

- LVF is captured in code I50.0
  *Congestive heart failure* and does not need to be coded separately
- Coding Matters volume 7 number 3,
  December 2000 provides some coding instructions:
  o As per ACS 1802 *Signs and symptoms* it is unnecessary to code symptoms and signs such as oedema if they are part of the patient’s heart failure. However, if pleural effusion requires specific intervention e.g. drainage, it should be coded
  o If it is documented that the patient has acute pulmonary oedema and CHF, assign only I50.0 *Congestive heart failure.*
- As per ACS 0920 *Acute pulmonary oedema,* when ‘acute pulmonary oedema’ is documented without further qualification about the underlying cause, assign code I50.1 *Left ventricular failure.*
- If a clear connection between hypertension and CHF is documented e.g. “CHF secondary to hypertension”, assign I11.0 *Hypertensive heart disease with (congestive) heart failure* as per ACS 0925 *Hypertension and related conditions*
- If ‘LVF’ is consistently documented in an episode, yet there is mention of CHF in past medical history, it should not be assumed that the CHF is current and related to the LVF. The documentation should be checked carefully as it’s possible that the past history of CHF has resolved and was due to a cause other than LVF.
- Oedema of the feet, ankles and legs (R60.0) is excess fluid in the subcutaneous tissues and is not usually of musculoskeletal origin. In cases where this symptom meets criteria for coding (e.g. ankle swelling – cardiac investigations NAD), documentation of “swelling” instead of “oedema” in the context of suspected heart failure is poor documentation and is indexed to a musculoskeletal chapter ‘M’ code which is incorrect. If swelling meets criteria for coding, and confirmation of ‘oedema’ with the doctor is not possible, assign R22.- *Localised swelling, mass and lump* rather than an M code.

References

Harris, Peter, Nagy Sue and Vardaxis Nicholas. eds. 2010 *Mosby’s Dictionary of Medicine, Nursing & Health Professions.* 2nd ed. Sydney: Mosby Elsevier

**Coding tip: Tobacco use disorders**

ACS 0503 *Drug, alcohol and tobacco use disorders* advises that tobacco use must always be coded where appropriate documentation is provided, using one of the following codes:

- **Z86.43 Personal history of tobacco use disorder**
- **Z72.0 Tobacco use, current**
- **F17.1 Harmful use of tobacco**  
  Assign this code if the clinician has clearly documented a relationship between a particular condition(s) and smoking (even if patient has quit). **This code should not be assigned if tobacco dependence syndrome is documented.**
- **F17.2 Tobacco dependence syndrome**

**Example**

“*COPD due to smoking*” documented in past medical history, COPD does **not** meet criteria for coding in the current episode.

**Tobacco use code assignment:**

F17.1 *Mental and behavioural disorders due to use of tobacco, harmful use (not Z72.0 Tobacco use, current)*

This is in accordance with examples 6 and 7 in ACS 0503.

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**Back to basics: Low birth weight**

ACS 1618 *Low birth weight and gestational age* directs coders that the codes:

P07.0 - *Extremely low birth weight* and P07.1 - *Other low birth weight*  
refer to baby weight at time of birth, not weight at subsequent episodes of care.

These codes are intended for use where low birth weight occurs in a premature infant, and are sequenced following the appropriate prematurity code from P07.2- or P07.3-, as per the tabular instruction.

Coding Q&A, December 2012, advised that low birth weight codes are predominantly coded in the birth episode and should not be routinely coded in subsequent episodes. If low birth weight meets criteria for coding in subsequent episodes, the low birth weight P code should correspond to the birth weight, therefore the admission weight entered by the coder for the current episode obviously may not match the weight range described in the P code.

If admission weight is not routinely documented, this issue needs to be addressed with the clinical staff.
Coder spotlight

This issue we interviewed Miriam Johnson from Swan Districts Hospital...

How long have you been coding?
2 years

At which hospital did you commence your coding career?
Swan Districts Hospital

What made you decide to become a clinical coder?
My sister was studying Health Information Management at Curtin University. When I finished work after my second baby was born, I was looking for some flexible work. She suggested working for PIMS in a hospital and from there we discussed coding. I worked at Sir Charles Gairdner Hospital in Emergency weekend shift and studied coding part time.

What do you like most about clinical coding?
Definitely the flexibility. My life is full of logistics (as any mother can testify), so being able to attend assemblies, sports days, orthodontic appointments etc. is fantastic.

What do you like least about clinical coding?
Documentation issues, such as lack of discharge summaries.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
I have just completed Intermediate ICD-10-AM, ACHI and ACS course through HIMAA. This was quite a challenge and as usual I underestimated the time it takes to study and prioritising it in my weekly schedule. It was a huge relief to sit the exam and finish.

What casemix/specialties do you find most challenging in your current role?
Mental Health episodes with long length of stay. Reading through these files can be very time consuming. There is a lot of documentation, with little coding.

Describe the coding service at your hospital
We have two campuses with Swans and Kalamunda coming under the same umbrella. We currently have two full time and four part time coders, located across both sites. Our casemix is quite broad and includes emergency, obstetrics, special care nursery, mental health, rehabilitation, general medicine, paediatrics, and day surgery. I am based at Swans which is located in Midland. It is like a country hospital with lots of free parking for staff and visitors (particularly if you start early). It has fewer staff than the tertiary hospitals and people get to know each other quite well. Everyone says hello in the corridors, etc.

The hospital is set to close late 2015 with a new hospital being built closer to the train line in Midland. The new hospital will be managed by SJOG. Swans will stay operational until the new hospital opens. The plan is for all patients to be transferred over two days. There will be lots of interesting challenges with the logistics of the changeover.