Coding Education Newsletter

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Coding queries & audit discussion cases

The coding queries and audit discussion cases are available to view on our website. These are published after each WACCAG meeting.

September 2016

Coding queries

1. Pharmacy procedure codes
2. Bone graft with ORIF
3. Goldilocks mastectomy
4. Failed lumbar puncture
5. Ultrasound based endovascular carotid body ablation
6. Non-small cell lung carcinoma vs adenocarcinoma
7. Intranasal sedation
8. Staging laparotomy
9. Inflammation documented on histopathology report
10. Type 1 and Type 2 myocardial infarction

Audit discussion cases

1. Situational crisis with alcohol intoxication
2. Diabetes with foot ulcer
3. ACS 0001 - Problems and underlying conditions

Contacts

Coding Education Team website

www.clinicalcoding.health.wa.gov.au

Editorial queries

vedrana.savietto@health.wa.gov.au

Delivering a Healthy WA
a. Sepsis due to aspiration pneumonia
b. 1. ICH due to
2. high IRN
4. Stoma education and allied health rehabilitation (ACS 2103 Admission for post acute care)

ACCD query responses
1. Revision arthroplasty of the knee
2. Component separation technique for incisional hernia repair
3. Subcutaneous implantable cardiac defibrillator (S-ICD) electrodes
4. Failed back syndrome
5. Haemorrhoidal artery ligation and rectal anal repair (HAL RAR)

November 2016

Coding queries
1. Anaemia with iron deficiency
2. Thrombocytosis
3. R45.81 Suicidal ideation
4. Drug and alcohol use at the time of injury
5. Immunisation in obstetrics
6. Grafting in ACL/PCL reconstruction

Audit discussion cases
1. Post operative complications
   a. Post op delirium
   b. Failed TOV
2. Cellulitis post steroid injection
3. Spontaneous abortion with endometritis

ACCD query responses
1. Eosinophilic oesophagitis

ACCD update

The ACCD Classification Information Portal (CLIP) is a web-based information system where coders can search and view national Coding Rules.

If you are not already registered, you should be using CLIP regularly to ensure your coding meets national Coding Rules.

Coders can register here:
https://www.accd.net.au/account/AccountDetails.aspx?action=Register

If you recall a Coding Rule but are unable to find it via the CLIP search functionality, you can check the following ACCD documents:

- Coding Rules - Retired
- Coding Rules – Superseded

These are available for download as PDF documents:

It may be that a Coding Rule you recall has been retired or superseded. Keep in mind that the content of retired decisions may still be current, just that they have been incorporated into the ICD-10-AM classification or ACS and therefore the Coding Rule itself has become redundant.
HIMAA-NCCH Conference 2016

The HIMAA NCCH National Conference was recently held in Melbourne.

All presentations, including those in the coding and classification stream of the conference, may be viewed on the website:


Back to basics

Trial of void (TOV)

A trial of void assesses the ability of the bladder to empty after removal of an indwelling catheter (IDC).

ACS 1436 Admission for trial of void provides classification guidelines for episodes where the patient is specifically admitted to perform a trial of void. The standard instructs to assign principal diagnosis Z46.6 Fitting and adjustment of urinary device, along with various additional diagnosis and ACHI codes as per the criteria set out in the standard.

Z46.6 Fitting and adjustment of urinary device is only assignable for TOV in accordance with ACS 1436, and would not be assigned for TOV in other admitted episodes (e.g. surgical, obstetric) as TOV is routine following IDC removal.

Similarly, IDC insertion and removal ACHI codes are not normally coded as per ACS 0042 Procedures normally not coded, however in an admission specifically for trial of void, these ACHI codes need to be assigned in accordance with ACS 1436.

Coding of urine retention (R33) or urine retention due to surgical procedure (N99.8, R33, external cause codes) is not governed by ACS 1436 and should be assigned in any episode where the condition meets criteria for coding.

The WA CCAG interpret that ACS 1436 equates “failed trial of void” to urine retention (R33), but that other aspects of ACS 1436 should only be applied when coding episodes where patient is admitted specifically for TOV.

Relevant Audit Discussion Cases involving trial of void can be viewed on our website: http://www.clinicalcoding.health.wa.gov.au/news/

- September 2015 Audit Discussion Cases
- November 2016 Audit Discussion Cases

Epidural anaesthesia
A form of regional anaesthesia where local anaesthetic and/or opioid are administered into the epidural space via a catheter. Analgesia is maintained by either intermittent dosing or a titrated infusion (Harris, Nagy and Vardaxis 2010, 615).

Epidurals are most commonly performed in the lumbar spine, but may be performed in the cervical or thoracic areas depending on the area of the body requiring analgesia. Epidurals are often used in labour/birth and postoperative pain management.

Spinal anaesthesia
A form of regional anaesthesia where local anaesthetic and/or opioid is injected into the subarachnoid space. Also known as ‘spinal block’ or ‘neuraxial block’.

In spinal anaesthesia the needle passes through the dura mater and into the subarachnoid space. It is faster acting than epidural anaesthesia as the drugs spread more easily in the cerebrospinal fluid (Australian and New Zealand College of Anaesthetists 2016).

Spinal anaesthesia is commonly used for caesarean sections and other surgical procedures where the surgical site is located below the waist e.g. hip arthroplasty.

Lumbar puncture
A lumbar puncture (also known as ‘spinal tap’) is a medical procedure to collect cerebrospinal fluid (CSF) from the subarachnoid space. The needle is usually inserted at L3/L4.

Failed lumbar puncture is defined as insufficient or no CSF obtained for a variety of reasons including:

- patient characteristics e.g. anatomy, obesity
- incorrect positioning of patient
- practitioner inexperience
Post-dural-puncture headache
Post-dural-puncture headache is a common complication of spinal anaesthesia and lumbar puncture. It is caused by CSF leakage from the puncture of the dura mater.

Epidural anaesthesia involves the epidural space which is not as deep as the subarachnoid space. However, if there is inadvertent puncture of the dura during an epidural, then a post-dural-puncture headache may occur.

Classification
There are two relevant WA CCAG coding decisions:

- Failed epidural, re-sited

- Failed lumbar puncture

References

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

Maggie Boros
North Metropolitan Health Service (NMHS) – Sir Charles Gairdner Hospital

How long have you been coding?
I have been coding for eight years.

At which hospital did you commence your coding career?
I began my coding career as a trainee at Sir Charles Gairdner Hospital in Nedlands, Perth after completing the Medical Terminology and the Introductory ICD-10-AM coding course through HIMAA and have progressed to becoming a proud full time member of our large professional coding team.

What made you decide to become a clinical coder?
My first career was as a Cartographer, compiling and drawing civilian, military and mining maps by hand. As the field became increasingly computerised, I decided to further my interest in the medical sphere by studying to become a clinical coder.

What do you like most about clinical coding?
I love the constant challenge and the analytical skills that coders require to complete their job to a high standard. There isn’t any room for mistakes, so a keen eye for detail and precision come in handy.

What do you like least about clinical coding?
The lack of sufficient documentation and difficulty in reading some handwriting can be daunting.

Have you recently undertaken coding workshops, conferences etc.? Or plan to in the future?
The life of a coder is one of keeping continually up to date. After finishing the Clinical Indication for Coders course through Curtin University, I completed the Advanced Coding Course through HIMAA with a scholarship from the Department of Health. I also spend my own time researching particular diseases/procedures to stay abreast of current practices.

**What casemix/specialties do you find most challenging in your current role?**

We have a great variety of casemix which is quite complex at SCGH. There are many challenging specialties, but I find coding Ophthalmology and ENT quite tough with the complexity that we see at SCGH.

**Describe the coding service at your hospital.**

Sir Charles Gairdner Hospital’s Clinical Coding Department is now part of the North Metro Health Services (NMHS) Finance and Business Department. Our team comprises of an Area Coding Manager, a Clinical Coding Co-ordinator, two Educators and around 22 full- time and part-time level 4 & 5 Clinical Coders. We are situated on the first floor of the E-block with five offices and are able to enjoy views of the internal courtyards.

Many of us work across NMHS sites and I have worked at OPH as well as SCGH.

SCGH coders now meet regularly with doctors of different specialties which is beneficial to both parties. I meet with General Surgery clinicians and find it to be very rewarding as we are able to learn the various details of the diseases and procedures from their discussions.

We are very fortunate to be supported in our roles as coders including the educational sessions in our monthly meetings.