Coding Education Newsletter

Issue 4, June 2013

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Coding queries & audit discussion cases

Coding queries
The June 2013 coding queries are now available to view on our website:

1. Same day admission for insulin pump
2. Skin rolling
3. Constipation with overflow diarrhoea
4. Delirium on a background of dementia
5. Use of Z53.- Procedure not carried out codes
6. Multiple primary tumours in the same organ
7. Encrusted JJ stent
8. Intraperitoneal infusion of ADEPT

Audit discussion cases
Five of the most common coding errors will be presented in the format of a coding test with accompanying answers/explanations, to be provided to clinical coding managers as an opportunity for coder education. The test will not be published on our website until August 2013, allowing managers time to undertake this activity.

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Delivering a Healthy WA
NCCC

ICD-10-AM/ACHI/ACS 8th edition education

The NCCC is compiling Eighth Edition FAQs for queries arising from the Eighth Edition Workshop material.

A reminder that if you were unable to attend a workshop, the education material will be posted on the NCCC website as a tutorial video from mid-June 2013. NIP registrants will be notified when the tutorial video becomes available.

Data Quality

8th edition change - dagger and asterisk convention

In Eighth Edition there is a change to the dagger and asterisk convention in ACS 0001 Principal diagnosis. Dagger and asterisk codes are now sequenced according to the principal diagnosis definition, rather than automatically sequencing the dagger code first in the combination.

The PAS data reporting method for a dagger and asterisk codes remains unchanged i.e. when a dagger and asterisk code combination is the principal diagnosis, the second code must be recorded as a co-diagnosis (‘Code Also’ or ‘CA’ in TOPAS).

Rehabilitation in the Home (RITH)

As per Operational Directive 0436/13 Recording non-admitted outpatient activity for RITH using an approved PAS, as of 1 July 2013 RITH services will be reclassified as non-admitted outpatient activity.

This means use of RITH virtual wards should be ceased as RITH will instead be reported as outpatient activity.
Data Quality (cont.)

The HMDS Data Quality Team have identified that some facilities are having difficulty reporting Unqualified and Qualified newborns. We hope the following information will be useful. Please contact (08) 9222 4290 or (08) 9222 2339 with any questions.

Newborn flowchart

Example 1: 9 days of age or less
A healthy infant with a date of birth of 13 October 2011 who accompanies their mother and is admitted to the hospital on the 19th October 2011 will have:

*Care Type: Newborn
Patient Type: Unqualified

Example 2: Admitted from birth to > 10 days
An infant with a date of birth of 13 October 2011 who stays in hospital until 25th October 2011 and requires ongoing acute care from day 4 until discharge, will have the following classifications:

Day 1-3 *Care Type: Newborn
Patient Type: Unqualified Newborn

Day 4 – 12 *Care Type: Newborn
Patient Type: Qualified Newborn

Example 3: Admitted at 10 days of age or greater
An infant admitted for ongoing acute care at 11 days of age (transferred from another hospital) will have the following classification:

*Care Type: Acute
Patient Type: Admitted Client

*NB: HCARe Care Type = Epi of Care
### Data Quality (cont.)

#### Permissible Care Type/Patient Type combinations for newborns

<table>
<thead>
<tr>
<th><em>Care Type</em></th>
<th>Patient Type</th>
<th>Example</th>
</tr>
</thead>
</table>
| Newborn     | Qualified Newborn | A newborn that meets at least one of the following criteria:  
- Newborn 9 days of age or less admitted to a Neonatal Intensive Care Unit or Special Care Nursery;  
- the second or subsequent live born infant of a multiple birth;  
- newborn admitted or remaining in hospital without their mother or mother a boarder. |
| Newborn     | Unqualified Newborn | Newborn 9 days of age or less and does not meet any of the above criteria. Unqualified newborns that are still in the hospital at 10 days of age and not receiving acute care should be re-classified to Boarder status (statistical discharge to Boarder) |
| Acute Care  | Admitted Client   | Newborn admitted at age 10 days admitted from home or transferred from another hospital and requiring ongoing acute care as per admission criteria.                                                                                                                                   |
| Boarder     | Boarder           | Newborn older than 9 days accompanying its mother and not receiving acute care.                                                                                                                                                                                                                                                             |

### When to reclassify a newborn

<table>
<thead>
<tr>
<th>Example</th>
<th>Change Required?</th>
<th>Statistical Discharge required?</th>
</tr>
</thead>
</table>
| Unqualified newborn post day 9 remains in hospital with its mother – not receiving acute care | Care Type *changed* to Boarder   
Patient Type *changed* to Boarder | Yes                                                                                           |
| Unqualified newborn goes to L2N on day 5                                | Patient Type *changed* to Qualified   | No                                                                                              |
| Qualified newborn (2\textsuperscript{nd} liveborn twin) goes from L2N to ward with mother | Care Type stays as Newborn   
Patient Type stays as Qualified | No – being twin 2 does not change throughout the admission so the patient is classified as Qualified for entire admission regardless of their location or care received. |
| Qualified newborn by virtue of admission to NICU from birth to day 6, is transferred from the NICU to the Obstetric ward with mother. | Care Type stays as Newborn   
Patient Type *changed* to Unqualified | No                                                                                              |
3M Codefinder™ tip

With 8th Edition just around the corner now is a good time to review any Coding Notes you have entered at a hospital level into Codefinder™. To do this you can:

1. Click on the Note Editor icon in the top tool bar

![Note Editor icon](image)

2. Select the Note Type e.g. Diagnosis. All the codes of that Note Type with a Note will appear in the drop down box to the right. You can click on these in turn to review and change the content. Change to the next Note Type and review that Note Type etc.

![Note Editor interface](image)

3. OR You can click on the Note Editor as above and choose ‘Print All’. This button is located near the bottom on the right hand side of the frame. If you ‘Print All’ you can select to print Multifacility, Facility and/or Current User Notes. It is best to select all categories. This will then print out all the notes and you can review them on paper and make the necessary changes.
Coding tip: Pain following trauma

When a patient suffers pain due to trauma but no injury is diagnosed, the following advice from 10AM Commandments (Coding Matters December 2006, volume 13 number 6) should be followed:

Pain versus injury post trauma

Patients involved in trauma accidents such as motor vehicle accidents, fall from height, sports injury, etc may present at the emergency department with pain in certain areas of the body without any obvious injury. The NCCH received a query asking whether the principal diagnosis in these cases should be pain or injury as it could be argued that pain signifies an underlying injury.

Example

Patient admitted to accident and emergency (A&E) post motor vehicle accident (MVA) complaining of neck and back pain. Investigations to exclude injuries reveal no abnormal findings and analgesics were given. The patient is discharged with a final diagnosis of neck and back pain.

Codes:  

- S19.9 Unspecified injury of neck  
- S39.9 Unspecified injury of abdomen, lower back and pelvis

Appropriate external cause, place of occurrence and activity codes

The above advice is only to be followed when the pain meets ACS 0002, and no specific injury (e.g. contusion, fracture, laceration) is present.

Back to basics: similar terms in the index

When searching the index or Codefinder™ it is important to read carefully as similar-looking terms may be present.

An example of an identified error is inadvertent selection of thrombocythaemia instead of thrombocytopenia.

Index:

- Thrombocythaemia (essential) (haemorrhagic) (idiopathic) (primary) (M9962/3) D47.3
- Thrombocytopenia, thrombocytopenic D69.6
  - with absent radius (TAR) Q87.26
  - congenital D69.4
  - dilutional D69.5
  - due to
    - drugs D69.5
    - extracorporeal circulation of blood D69.5
    - massive blood transfusion D69.5
    - platelet alloimmunisation D69.5
    - essential D69.3
    - hereditary D69.4
    - idiopathic D69.3
    - neonatal, transitory P61.0
  - due to
    - exchange transfusion P61.0
    - idiopathic maternal thrombocytopenia P61.0
    - isoimmunisation P61.0
    - primary NEC D69.4
    - puerperal, postpartum O72.3
    - secondary D69.5
    - transient neonatal P61.0

Thrombocythaemia

Essential Thrombocythaemia is a myeloproliferative disease in which the bone marrow produces too many platelets (thrombocytes). This affects the normal blood clotting process, and can result in thrombosis and haemorrhage (MPN Research Foundation 2012). The correct code assignment is:

- D47.3 Essential (haemorrhagic) thrombocythaemia
- M9962/3 Essential thrombocythaemia

Thrombocytopenia

Thrombocytopenia is a reduction in the number of platelets in the blood, which can result in haemorrhage. There are various types, most of which are classified to block D69 Purpura and other haemorrhagic conditions.

Reference:

Coder spotlight

This issue we interviewed Sue Leeves from Hollywood Private Hospital...

How long have you been coding?
About 18 years

At which hospital did you commence your coding career?
I commenced and was trained by HDWA/Curtin for 1 month.

What made you decide to become a clinical coder?
I needed work and a friend told me about clinical coders, so I rang the HDWA just at the right time. Barbara Campbell and Sue Stevens employed me on contract. I stayed for 8 months and was then employed by Hollywood Private Hospital.

What do you like most about clinical coding?
The challenge of coding accurately and constantly learning about disease and procedures.

What do you like least about clinical coding?
Incorrect discharge summaries, and the subjectivity versus objectivity in abstracting.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
Yes, the NCCC eighth edition workshop for changes effective 1 July 2013. I’ll attend anything the hospital wants to send me to.

What casemix/specialties do you find most challenging in your current role?
ENT and Orthopaedics.
April quiz winner & answers

Congratulations to clinical coder Jashan Johl from Swan Kalamunda Health Service, who won the April 2013 quiz competition with the following answers:

1. According to the HMDS Reference Manual (July 2012), what is the maximum length of digits for the data element Infant Weight?
   **4 digits**

2. Which of the following is NOT in the hepatobiliary system:
   a. Kupffer cells
   b. Wharton’s duct
   c. Bile canaliculi
   d. Disse’s space

3. “Code also” and “Use additional code” instructions take precedence over criteria in ACS 0002 Additional diagnoses. True or False?
   **True**

4. The primary malignancy is coded as a current condition if a subsequent admission for wider excision shows there is no residual malignancy on histopathology. True or False?
   **True**

5. The official group responsible for reviewing and endorsing coding queries in Western Australia:
   a. WA Coding Advisory Panel
   b. WA Coding Committee
   c. WA Clinical Coding Advisory Group

6. How many thoracic vertebrae are there in the human body?
   **12 thoracic vertebrae**

7. Codes in categories P00–P04 Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery can be assigned for adult patients. True or False?
   **True**

8. Name the condition where there is acute inflammation and infection of the alveoli, which fill with pus and fluids. **Pneumonia**

9. According to NCCC national coding advice, what is the correct diagnosis code assignment for Levator Ani Syndrome?
   **K59.4 Anal spasm**

10. Name the two newly created Australian Coding Standards in 8th edition, as detailed in the NCCC Eighth Edition Forecast.
    **ACS 0742 Orbital and periorbital cellulitis**
    **ACS 2114 Prophylactic surgery**
June quiz competition

The first entrant to submit correct answers for all 10 quiz questions via email to: vedrana.savietto@health.wa.gov.au will win a double pass for Hoyts or Greater Union cinemas.

The quiz answers and winner will be announced next issue. Previous winners are not eligible to enter again. Good luck!

1. Bowman’s capsule is part of which body system?
   a. Musculoskeletal system
   b. Digestive system
   c. Urinary system

2. Name the two Australian Coding Standards relating to sequelae

3. What procedures should be coded for the following example: EUA and fistulectomy for anal fistula
   a. Fistulectomy, EUA, anaesthesia
   b. Fistulectomy, anaesthesia
   c. EUA, fistulectomy, anaesthesia

4. Oxygen therapy is routinely coded for all patients. True or False?

5. Name the disorder of the exocrine glands characterised by production of abnormally thick mucus secretions

6. What does each letter in the abbreviation TNM represent in the TNM Classification of Malignant Tumours?

7. Name the bacteria that pregnant patients are screened for in pregnancy, and if found to be carriers require antibiotics during labour to prevent transmission to the baby?

8. Cutting away damaged tissue or slough from skin using scalpel and scissors is known as e________ d_________

9. Which of the following is classified as malignant in ICD-10-AM?
   a. Prolactinoma
   b. Paget disease, mammary
   c. Thecoma NOS

10. __________d fracture is where bone is splintered or crushed into several pieces.