Coding Education Newsletter

Issue 16, June 2015

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Coding queries and audit discussion cases

The April to June 2015 coding queries and audit discussion cases are now available to view on our website. They are published after each WACCAG meeting. The Coding Education Newsletter is published quarterly.


April 2015

Coding queries
1. Alcohol or drug withdrawal scale
2. Diagnosis for same day removal of cervical suture
3. Os acromiale
4. Hypertension in acute post-streptococcal glomerulonephritis (APSGN)
5. Cellulitis/abscess due to self-injecting

ACCD query responses
1. Cellulitis of an infected blister
2. Skin rollering
3. VAC dressings
4. Laceration with debridement
5. High metal ions and metallosis due to THR

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Delivering a Healthy WA
Audit discussion cases

1. Admission for convalescence/aftercare, hospital in the home (HITH) transfer, post total knee replacement
2. Principal diagnosis selection, in post-operative transfer for pelvic inflammatory disease
3. Suspected conditions, chest infection in an asthmatic

May 2015

Coding queries

1. Adverse effect of Champix
2. Ventilation in organ procurement
3. Limbal stem cell deficiency causing conjunctivalisation

ACCD query responses

1. Endoscopic dilation of duodenal stricture
2. Repair of nasal septal perforation with cartilage graft
3. Plugging of perianal fistula
4. Replacement of stent in an ileal conduit
5. Vaginal mesh erosion

Audit discussion cases

1. Multiple coding in secondary hyperparathyroidism of renal origin
2. Anal ulcer, with scar (cicatrix) due to Bowen Disease
3. Suspected conditions, “? febrile neutropenia”

June 2015

Coding queries

1. Mucinous cystadenoma
2. Blastocystis hominis
3. Eosinophilic oesophagitis
4. Mucus plug with bronchiectasis
5. Erosive oesophagitis
6. Weaning and counting of noninvasive ventilation
7. Anticoagulation therapy pre-surgery

ACCD query responses

1. Interpretation of ACS 0020 Bilateral/multiple procedures for bilateral insertion of ureteric stents
2. Drug induced anaemia

Audit discussion cases

1. Manifestations of an overdose
2. Suspected sepsis, symptomatic premature newborn
3. Urosepsis with septic shock
Data Quality:

Mental Health Care Type
The Data Integrity Directorate have been working closely with stakeholders from across the state in planning the implementation of the upcoming Mental Health Care Type. The introduction of the new care type will allow for better identification of how we deliver mental health care both locally and nationally. WA Health has decided to take a phased approach to the introduction of the new care type that will come into effect from the 1st July 2015. Initially, clients admitted to specialised mental health wards will have the care type assigned to their care in line with the national definition.

To support hospitals and health services implement the new care type, the Data Integrity Directorate have worked with stakeholders to develop two eLearning packages. The first has been customised for health professionals and presents background information, requirements and a series of scenarios designed to demonstrate the application of the care type throughout a client’s admission to hospital. The second eLearning package has been designed with administrative staff, ward clerks and clinical coders in mind. Whilst there are no scenarios for clinical coding staff to interact with, you are most welcome to review the administrative examples for familiarity. Likewise, if you would like a more in-depth clinical awareness of the care type’s application, you are welcome to peruse the health professionals module at your leisure. You can view the eLearning modules as often as you like.

Updated Clinical Edits
The Data Quality Team have tailored the clinical edits to meet the needs of ICD-10-AM Ninth Edition. We would like to encourage sites to start working on clearing edits as we approach the end of the financial year.

Non-Formal Edit Process
Over the next 12 months, the Data Quality Team will be undertaking a non-formal edit process to identify data errors. Submitted data will be reviewed to identify trends and the findings shared with sites to review. As an example of a non-formal edit, the team may check for babies with qualified patient types that do not meet the qualified criteria.

The ICD-10-AM/ACHI/ACS Ninth Edition will be implemented on 1st July 2015. Online education material has been available since May 2015 from the Australian Consortium for Classification Development (ACCD) website at no cost. All clinical coders are encouraged to access and complete this online education. Questions regarding the Ninth Edition updates can be submitted online and will be used to inform the frequently asked questions to be published in Coding Rules. Individual responses will not be provided.

https://www.accd.net.au/Education.aspx

The Coding Education Team will be providing a summary document of the significant ICD-10-AM/ACHI/ACS Ninth Edition changes and that document will be available on the Clinical Coding in Western Australia Website Education page, by mid-July.

Some of the significant changes to note include:

**Rehabilitation and Palliation**

The assignment of codes for rehabilitation and palliation, Z50.9 *Care involving the use of rehabilitation procedure, unspecified* and Z51.5 *Palliative care* will be possible outside the episode of care type rehabilitation and palliation respectively. Both codes are never to be assigned as the principal diagnosis (see ICD-10-AM Tabular, Appendix C). The current edits will be lifted accordingly. The criteria for reporting the appropriate episode of care types: rehabilitation and palliation remain the same. For more information on care type criteria please refer to the Admission, Readmission, Discharge and Transfer Policy (ARDT).

**Cancelled Procedures**

*Z53 Persons encountering health services for specific procedures, not carried out* is never to be assigned as a principal diagnosis. This means it is no longer possible to report patients who progress beyond the administrative process and who may consume clinical time, yet are cancelled before arrival in theatre, or commencement of procedure, by the code Z53.- as principal diagnosis (with no other codes required). These admissions from 1st July 2015 are to be cancelled and no episode of care reported. A non-admitted patient service event is not to be reported. The ARDT will be updated to reflect this change in policy.

**ACS 0003 Supplementary Codes for Chronic Conditions**

A new Australian Coding Standard (ACS) has been introduced to instruct on the coding of a discrete list of chronic conditions represented in the code range U78.- to U88.- when documented but do not meet the criteria for coding (as instructed in ACS 0002 Additional diagnoses and other general and specialty coding standards, coding conventions and coding rules).

These supplementary codes for chronic conditions are listed in the ICD-10-AM Alphabetic Index under the pathway:

Supplementary
- codes for chronic conditions.

The codes are mapped so as not to be included in the grouping for Diagnosis Related Group (DRG) allocation.

**WA Coding Standards Update**

The WA Coding Standards (WACS) 02 *Cancelled elective procedures*, (with Appendix 1 Flowchart) and WACS 04 *Psychiatric diagnosis with overdose or injury* will be updated to reflect the changes in coding Z53 and the introduction of the Mental Health Care Type.
Clinical review

Malignant neoplasms of the breast (C50) and quadrants of the breast

Note (not shown above): C50.6 Axillary tail of breast is the primary site code for the axillary tail or tail of breast (SEER Training Modules 2015).

C50 Malignant neoplasm of breast includes connective tissue of breast. It excludes skin of breast (coded to C43.5 or C44.5).

The above clock diagram shows the right and left breasts as if the clinician was looking at the patient face-on. Each breast is divided into horizontal halves - upper and lower and vertical halves - inner and outer. If the primary site is described as upper, lower, inner or outer, the ICD-10-AM primary site code is C50.8 Overlapping lesion of breast because a more specific C50.x code cannot be determined with that description alone.

The breast halves are divided into quarters or quadrants:
- upper-inner quadrant (UIQ) - C50.2
- lower-inner quadrant (LIQ) - C50.3
- upper-outer quadrant (UOQ) - C50.4
- lower-outer quadrant (LOQ) - C50.5.
The code for nipple and areola is C50.0 Nipple and areola. If the primary site is the central portion of the breast, sub-areolar, or beneath the areola (i.e. usually within 1 cm of the areolar complex), use primary site code C50.1 Central portion of breast.

Clinicians sometimes describe the location of a breast tumour using clock positions. Again, the clinician is looking at the patient and assigns the clock times from that view. So, the upper inner quadrant of the right breast is between 12 and 3 o’clock; the lower inner quadrant is between 3 and 6 o’clock; the lower outer quadrant is between 6 and 9 o’clock; and the upper outer quadrant is between 9 and 12 o’clock.

When looking at the left breast, the upper outer quadrant is between 12 and 3 o’clock; the lower outer quadrant is between 3 and 6 o’clock; the lower inner quadrant is between 6 and 9 o’clock; and the upper inner quadrant is between 9 and 12 o’clock.

**Examples**

1. Malignant tumour at 2 o’clock in the left breast. Assign:

   **C50.4 Upper-outer quadrant of breast**

   On the breast clock diagram, 2 o’clock on the left breast is the upper-outer quadrant and the site code is C50.4.

2. Malignant tumour at 3 o’clock in the right breast. Assign:

   **C50.8 Overlapping lesion of breast**

   On the breast clock diagram, 3 o’clock on the right breast is at the horizontal midline of the breast. 3 o’clock overlaps the upper and lower quadrants. Tumours such as this, on the midline (horizontally or vertically) overlap two subcategories within the three character category (C50) and are assigned the fourth digit subcategory ‘8’ i.e. C50.8 Overlapping lesion of the breast if it cannot be determined in which quadrant the tumour originated. (Centers for Disease Control and Prevention 2015)

**See also:**

- ICD-10-AM Alphabetic Index - Table of Neoplasms
- ICD-10-AM Tabular List - Chapter 2, Note 5
- ACS 0234 Contiguous Sites

**Multifocality, multicentricity and the timing of occurrence**

These terms are often used to describe the extent of disease in breast cancer. e.g. used to describe multiple tumours diagnosed clinically, on physical examination, breast imaging (mammogram, US, MRI) or biopsy.

**Multifocal** (MF) disease: presence of two or more breast tumours diagnosed at the same time within the same quadrant.

**Multicentric** (MC) disease: presence of two or more breast tumours in different quadrants of the same/other breast.

If multiple tumours are present in the breast(s) check documentation carefully to determine whether tumours are considered to be multiple separate primaries or are a primary tumour with metastatic spread. If unsure check with the clinician. If multiple separate primaries are confirmed from the documentation or by the clinician, each site should be coded separately.

**Synchronous** breast tumours are two or more tumours that occur in either breast at the same time (up to 10% of breast tumours found on MRI).
Metachronous breast tumours are two or more breast tumours that occur in either breast in two different time periods (Oh 2008 583-587, Coding Education Team 2013).

The survival rate of women with synchronous and metachronous breast cancers is worse than those with unilateral disease (Knipe 2015).

Oncoplastic surgery (OPS) is the third option between standard breast conservation surgery (BCS) and mastectomy. OPS integrates wide excision for breast cancer with plastic surgery techniques for immediate reshaping of the breast (Pillarisetti and della Rovera 2012).

References


Coding tip - Birth weight and gestational age

**P07 Disorders related to short gestation and low birth weight, not elsewhere classified**

**P05 Slow fetal growth and fetal malnutrition**

**Premature infants**

Premature infants (born before 37 completed weeks gestation) can be assigned:

1. A code from P07.2x *Extreme immaturity* to P07.3x *Other preterm infants.*
   Refers to how long the gestation period is for the baby, not how old the baby is.

2. A code from P07.0x *Extremely low birth weight* to P07.1x *Other low birth weight.*
   Refers to what the baby weighed at the time of birth.

**Note:**
- When using codes from block P07 for episodes subsequent to the birth episode, the fifth character must correspond to the birth weight and gestational age of the birth episode.
- When gestational age (P07.2x – P07.3x) and birth weight (P07.0x – P07.1x) are available, priority of assignment (sequencing) should be given to gestational age.

3. A code from P05.x *Slow fetal growth and fetal malnutrition, only when* assignment is supported by:
   - documentation
   - index pathways

**Term infants**

Term infants (born from 37 completed weeks gestation) can be assigned:

A code from P05.x *Slow fetal growth and fetal malnutrition, only when* assignment is supported by:

- documentation
- index pathways
- and meets principal or additional diagnosis criteria.

**Note:**
- P05.0 *Light for gestational age* or P05.1 *Small for gestational age* should not be routinely assigned for all babies less than 2500g at term.

**Example:**

A term infant diagnosed as small for gestational age (SGA) receives intense monitoring for feeds and weight.

**Code assignment:**

P05.1 *Small for gestational age*

- and is required in addition to P07 codes to fully translate the diagnostic statement.

**Example:**

A premature infant (born at 33 weeks; birth weight 1300g) was sent to the special care nursery with intrauterine growth retardation (IUGR).

**Code assignment:**

P07.32 *Other preterm infant, 32 or more completed weeks but less than 37 completed weeks*
P07.12 *Other low birth weight 1250–1499g*
P05.9 *Slow fetal growth, unspecified*
Coding at Fiona Stanley Hospital

With thanks to Brian Stanley, Coordinator Clinical Coding.

It has been an interesting start for the South Metropolitan Health Service (SMHS) Coding Service at Fiona Stanley Hospital (FSH). The Project Officer/Coordinator Clinical Coding commenced on September 1\textsuperscript{st} 2014 with the addition of two clinical coders one from Fremantle Hospital and the other from Royal Perth Hospital. This small team set about working on getting things organised for preparation of our first patients in October 2014. Ensuring the computer systems were working for coding requirements, writing up work processes and education material for future staff and learning the new programs at FSH.

In October 2014, the State Rehabilitation Service opened at FSH with the transfer of 120 patients from Royal Perth – Shenton Park Rehabilitation Hospital. It was with excitement we coded our first cases, locating the information and documentation in the digital medical record and completing the coding.

Since then we have had the opening of the Obstetrics and Neonatology units with some Medical and Surgical admissions in December 2014; then in February 2015 the opening of the Emergency Department and transfer of other services from Royal Perth and Fremantle Hospitals.

We are now fully operational and have most of our coding staff on board. Our coding staff are from various hospitals including Fremantle, Royal Perth, Armadale, Sir Charles Gairdner and St John of God Murdoch. Our two Coding Educator/Auditors have been very busy helping staff settle into the new department, providing education and answering questions from the new staff. We have also commenced four new trainee/junior coders, who have been very enthusiastic in their learning and eager to get into the thick of coding.

Digital Medical Record

Our digital medical record (DMR) also known as ‘BOSSnet’ is a hybrid electronic medical record with computerised notes and electronic forms as well as scanned paper medical record forms. The DMR looks similar to the physical record in most hospitals, with tabs for the file dividers and folders to make easy navigation around the medical record. Most notes can be viewed as a PDF document to make it easier to read and navigation between documents is usually a mouse click away.

It takes a little while to get used to the digital medical record, although most coders are quite comfortable moving around the different screens and programs.
in their normal coding processes after a short period. There are always new things to learn about the programs, with the different short cuts to make life easier. It does take a little while to get used to not having any physical medical records in the coding department.

Each coder’s workstation has three computer monitors – one for BOSSnet, one for WebPAS (the patient administration system) and one for 3M Codefinder/iSoft Clinical Manager or other programs required during the coding process.

Similar to other hospitals that have implemented a scanned/digital health record system, we have found the coding process slower than we are used to with the paper record; however, most hospitals say they have attained similar outputs to paper based medical records within a 12 month period and may even become a little faster.

Hospital staff at FSH are very friendly and the clinicians are enthusiastic and willing to engage with the coding department to ensure the coding is accurate and the hospital is funded appropriately for the care provided. We will continue efforts with clinician engagement to improve documentation quality, and with education of clinicians and clinical coders to produce a high standard of data and information for reporting and decision making.

We will continue our efforts to develop and grow as a coding team at FSH so that all coders can develop to their highest potential in a friendly and supportive environment.

(Education with Bill Pyper March 2015 – FSH Clinical Coding Department)

**Coder spotlight**

**Anupam Johl, Fiona Stanley Hospital**

**How long have you been coding?**

I have been in this profession for the last three years.

**At which hospital did you commence your coding career?**

I started my career as a clinical coder in a private hospital in the beginning of 2012 and a few weeks later I joined the Cancer Registry at Sir Charles Gairdner Hospital as Clinical Coder.

**What made you decide to become a clinical coder?**

I worked as Research Project Officer with CSIRO and with young kids it was hard to balance family and work. I was looking to change my career and at the same time wanted to utilise my experience of data analysis and my education in the sciences. The job description of clinical coder caught my interest. The flexible working conditions were definitely an important consideration.
What do you like most about clinical coding?

I enjoy the data abstraction and analysis of a mixed casemix. Every case brings a new challenge and opportunity to learn new things about the human body.

What do you like least about clinical coding?

Missing documentation and difficulty with reading doctors’ handwriting is the most annoying part of clinical coding.

Have you recently undertaken a coding workshop, conference or course? Or do you plan to in the future?

I have completed Intermediate ICD-10-AM, ACHI and ACS from Health Information Management Association Australia (HIMAA). Currently I am also doing a Masters in Public Health (part time) from Charles Darwin University.

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

Sometimes I find mental health coding challenging, especially when there are a number of differential diagnoses and especially when the discharge summary states an imprecise principal diagnosis such as situational crisis.

Describe the coding services at your Hospital?

I am part of the clinical coding team at Fiona Stanley Hospital. We work in a paperless environment with digital records. There are 15 clinical coders, four trainees, one coding clerk and two educators working under the Clinical Coding Coordinator. Our office is situated on the ground floor in the main building. We are fortunate to have a nice big office with wall sized windows. We have a lecture room which is currently used for training purposes and our own kitchen area.

HIMAA Senior Associate Membership

Are you a clinical coder who has graduated from a Health Information Management Association of Australia (HIMAA) coding course? Or do you have five years of senior level experience? This means you are eligible for Senior Associate Membership with HIMAA. Senior Associate Membership gives you the opportunity to network with other professionals, keep up to date with the health information profession and receive discounts at events including the 2015 HIMAA NCCH National Conference.

For more information contact the HIMAA Membership Officer by email: membership@himaa.org.au or call: (02) 9887 5002.