Welcome
Welcome to the second issue, and thank you to all those who provided feedback for our first newsletter. Our team wish you a safe and happy Easter break.

Coding queries & audit discussion cases
The 6 March 2013 CCAG meeting was cancelled due to insufficient coding queries.

Audit discussion cases
The March audit discussion cases will soon be published on our website. The cases this month are based on a review of episodes grouped to DRG 801: Operating Room Procedure Unrelated to Principal Diagnosis.

Grouping to DRG 801 is correct in some cases, however it is important to have a quality assurance process in place to review coding of episodes grouped to DRG 801A, 801B and 801C to identify possible coding errors.

NCCC
ICD-10-AM/ACHI/ACS 8th edition
The NCCC have released the eighth edition forecast which provides an overview of what changes we can expect with the new edition:

Eighth edition hard books and electronic version (CodeXpert) are now available to order from the NCCC: https://nccc.internetrix.net/

Registration has opened for the one day education workshops to be held at Crown Club, Burswood:
Data Quality

Data Quality analysis of Mental Health Legal Status (MHLS)

The Data Quality Team is currently reviewing the completion and accuracy of MHLS reporting to the HMDS. This process involves cross-referencing MHLS data against patient Mental Health Legal forms (e.g. Form 1, Form 6, Form 9 etc) (sourced from the Mental Health Information System).

To assist us in our analysis, we will be issuing a brief, informal questionnaire to applicable public hospitals to better understand site specific practices on how MHLS is determined from the medical record and subsequently entered into the patient administration systems. We know that in many instances, the clinical coder is often required to enter the MHLS but we do not fully understand the documentation requirements sites might have in place to prompt a clinical coder to capture a patient as "Involuntary".

Given that MHLS is an important data element that supports DRG allocation and subsequent funding, it is important that we have consistent and accurate data collection practices in place across sites. We hope that by providing us with insight into how you or your site assigns MHLS, we can enhance data standards and business rules that govern its collection.

We will be sending the questionnaire to health information managers and clinical coding coordinators/managers who may in turn circulate to you for completion. It is an informal questionnaire, with no right or wrong answers and will be used for information gathering purposes only. You can remain anonymous however it would be helpful to our analysis to know the region or establishment you work in. We hope that receivers of the questionnaire are eager to participate and we look forward to receiving your feedback.

Call for feedback: HMDS Reference Manual 2013

The HMDS Reference Manual will be undergoing its yearly review and update in the coming months. As we are trying to progressively enhance the Manual's clarity and comprehensiveness we welcome any feedback, comments or requests for inclusion that you might have. Please forward your feedback to: hmds.edits@health.wa.gov.au

Activity Based Funding

ABF/ABM staff forum – 9 April 2013

The ABF/ABM Program team are holding a staff forum on Tuesday 9 April in the Theatrette at Royal Street. This event is aimed at clinical and corporate managers who are actively involved in supporting their health services to transition to the ABF/ABM environment.

More details, including how to register for this free event, are on the ABF/ABM intranet site at http://activity/post/2013/03/05/Managing-in-an-ABFABM-world---staff-forum-Tuesday-9-April-2013.aspx

Clinical Documentation Improvement Program 2013

Building on the success of the first wave of this program in 2012, the Clinical Documentation Improvement Program 2013 has commenced. Over 50 staff participated in the first of three Lean training sessions this month. Participants come from a range of roles including doctors, nurses, allied health, clinical coders and health information staff. They are leading a range of initiatives aimed at reducing waste and improving processes and quality of clinical documentation.

For more information about any these activities, or any aspect of the ABF/ABM program, please contact the team at activity@health.wa.gov.au or call 9222 2337.
Coding tip: ACS 1006 Ventilatory support

Definition
ACS 1006 defines ventilatory support as the “process by which gases are moved into the lungs by a device that assists respiration by augmenting or replacing the patient's own respiratory effort”.

Invasive ventilatory support
Mechanical ventilation via an invasive artificial airway – either an endotracheal tube or a tracheostomy tube.

Non-invasive ventilatory support
Mechanical ventilation via a non-invasive device such as face mask, mouthpiece, nasal mask, nasal pillows, nasal prongs, nasal tubes nasopharyngeal tubes and nasal cannula.

It is important to note that documented use of devices such as face mask or nasal prongs may relate to oxygen therapy. Administration of oxygen is not a form of ventilatory support and is not routinely coded, except in neonates as per guidelines in ACS 1615 Specific Interventions for the Sick Neonate.

High flow nasal cannula (HFNC)
HFNC refers to delivery of heated, humidified and blended oxygen/air at high flow rates via nasal cannulae (Wilkinson, Andersen and Holberton 2008, 1). It is commonly referred to as ‘high flow therapy’. HFNC has been widely adopted in paediatrics as an alternative to nasal CPAP.

After clinical consultation the NCCC decided HFNC should be coded the same way as CPAP, by assigning an appropriate code from block 570 Noninvasive ventilatory support (see December 2011 Coding Q & A).

Eighth edition ACHI will include index amendments for high flow nasal cannula and high flow therapy, and an amendment to ACS 1006 Ventilatory Support to include HFNC.

Reporting ventilation hours
Only completed (whole) hours should be coded. For example:
- Ventilation duration less than 60 minutes is not a complete hour and is not coded or reported
- 2 hours 50 minutes – coded as 2 completed hours

Subsequent periods of the same type (invasive or noninvasive) of ventilation, should be added together and assigned one ACHI code only (excludes weaning – see below).

Non-invasive ventilation hours
Total duration is calculated to enable selection of the appropriate ACHI code, however it is not reported to the HMDS (excludes weaning – see below).

Invasive ventilation (continuous ventilatory support) hours
Total duration is calculated to enable selection of the appropriate ACHI code, and must be reported to the HMDS via the following PAS data fields:

- TOPAS: Mech Vent Time
- HCARe: Mech. Vent
- webPAS: Hours of mechanical ventilation

Weaning
Calculation of invasive ventilation hours should include any non-invasive weaning time (as per point 1d in ACS 1006).

Reference:
http://www.neonatologytoday.net/newsletters/nt-aug08.pdf
Back to basics: using the disease index and ACHI index

Lead terms and modifiers
In the disease index and ACHI index, the terms indented beneath a lead term are referred to as modifiers and can be either essential or non-essential modifiers.

Essential modifiers: it is essential for the term to be present in clinical documentation for the index pathway to be followed.

Non-essential modifiers (terms inside parentheses): these terms do not necessarily affect coding – it is not essential for the term to be present in clinical documentation for the pathway to be followed.

Examples
Retained placenta
Retention
- placenta (total) (with haemorrhage) O72.0
- - without haemorrhage O73.0

The term ‘with haemorrhage’ is inside parentheses and is therefore a non-essential modifier, and does not need to be documented for O72.0 Third stage haemorrhage to be assigned.

The term ‘without haemorrhage’ is an essential modifier and must be documented for O73.0 Retained placenta without haemorrhage to be assigned.

Perforated appendicitis
Appendicitis K37
- with
- - peritoneal abscess K35.3
- - peritonitis (localised) (perforation) (rupture) K35.3
- - - generalised K35.2

We cannot follow the pathway which includes ‘perforation’ in parentheses, because the essential modifier ‘peritonitis’ is not documented. The correct code assignment for “perforated appendicitis” is therefore K37.
Coder spotlight

Thanks to Ausma Kenzig at Bunbury Regional Hospital for agreeing to be our first interview participant...

How long have you been coding?
15 years

Which hospital did you commence your coding career?
At Bunbury Regional Hospital

What made you decide to become a clinical coder?
I first came across clinical coding in Port Macquarie Hospital, NSW, where I was working as an Enrolled Nurse. Years later I injured my back and was looking for a career change and an expression of interest had been advertised for a part-time relief coder at Bunbury Hospital, so I applied and was successful.

What do you like most about clinical coding?
From the time I commenced coding I have loved the position. Some of the main things I like about coding:

- Being able to use my nursing knowledge without the physical workload required in nursing (due to ongoing injury).
- The challenges of reading handwritten documentation and solving problems
- Training new coders
- Meeting new people when helping with coding backlogs at other health services
- Education sessions, as all the coders get together to exchange ideas and friendship

What do you like least about clinical coding?
Nothing, I enjoy my job role.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
I completed HIMAA coder accreditation certification in 2006 and continue to do currency certification every 2 years, due again in 2014. I also recently participated in the WACHS clinical coding workshop.

What casemix/specialties do you find most challenging in your current role?
Obstetrics has always been most challenging but with time it is getting better.

Describe the coding service at your hospital?
I believe Bunbury Regional Hospital has a wonderful coding service from the management down to the coders. We are very fortunate to have a spacious office and an outlook onto a beautiful garden. We have good storage space for outstanding records.

There are four resident coders at present – two full-time; two job share; and one relief. At present we have one part-time trainee coder.

The coders at Bunbury Regional Hospital get opportunities to go to other health services when needed, but we would love to have more education sessions.

We are in the fortunate position to be able to liaise with the clinicians at any point in time and have education sessions once a week with interns.
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. Good luck!

1) Which of the following is not listed in the ICD-10-AM external cause of injury index?
   a) Bitten by millipede
   b) Contact with bat fish
   c) Crushed by lizard
   d) Contact with parrot

2) According to the HMDS Reference Manual (July 2012), how many separations were added to the HMDS collection in 2011/2012?

3) What is the name of the smallest bone in the human body?

4) Which organ is affected in Gull’s disease?

5) What are the four major blood types?

6) A newborn is assigned “Qualified” status if they have a serious medical condition. True or False?

7) The spot on the back of the elbow where the ulnar nerve rests against the humerus bone is commonly referred to as the ____y bone.

8) In which organ is the oblique fissure located?

9) When a patient requires transfer to another hospital for management of a condition, the code Z75.3 Unavailability and incompleteness of health-care facilities should be assigned. True or False?

10) Who shared the Nobel Prize in 1945 with Sir Alexander Fleming, for the discovery of penicillin and its curative effect in various infectious diseases?
Clinical coding Auditing Course 2013

CLINICAL CODING AUDITING SHORT COURSE

Are you a competent clinical coder? Do you want to gain certification in auditing that will allow you to work within your health service or provide auditing services to external agencies? With the implementation of Activity Based Funding (ABF) by the Commonwealth government, the emphasis on funding accountability continues to increase in all aspects of health service management and the need for quality auditing of coded data also increases.

This course is designed to develop skills in auditing coded data, analysing and reporting on the audit outcomes, and developing strategies for dealing with the audit outcomes.

By undertaking this course, or by sponsoring your health information manager or clinical coder to undertake it, you will be ensuring that your organisation has the skills needed to maintain the quality of data necessary for efficient and accurate financial management.

The course consists of four modules:

Module one: Principles of Casemix and Casemix Funding models
Module two: Theory and Principles of Auditing
Module three: Statistical Analysis and Methodology
Module four: Audit Outcomes – reporting and strategic development

Entry to this course is open to anyone who holds a qualification in clinical coding, obtained as part of a degree in Health Information Management or via one of several short courses available.

The course will be run as an online distance education course over a period of five months commencing in April 2013. Students will be required to work through the material in a systematic manner and in a time-frame provided as part of the course material.

Applications close on April 4, 2013.

For further information, go to our website: http://www.latrobe.edu.au/courses/health-information-management/short-courses