Coding queries & audit discussion cases

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


Coding queries
1. Retained placenta following missed abortion
2. Borderline diabetes

Audit discussion cases
1. Discrepancy between clinical diagnosis at gastroscopy and histopathology findings
2. Deep wound repair with layered suturing technique
3. Adverse effect (osteitis pubis) of radiotherapy
**Australian Consortium for Classification Development (ACCD)**

A reminder for all coders to ensure they are registered on the ACCD Classification Information Portal (CLIP) to receive notification when national coding decisions are published. Some recent decisions are being finalised for publication in the near future.

To register on the ACCD CLIP, visit:


**Data Quality**

The Coding Education Team is currently undertaking a quality review of coded data in three areas:

- Inappropriate use of diagnosis code R69 *Unknown and unspecified causes of morbidity*
- Acute admissions with principal diagnoses Z60.2 *Living alone* and Z63.0 *Problems in relationship with spouse or partner*
- Additional diagnosis codes assigned with principal diagnosis of Z38.0 *Singleton, born in hospital*

Coders may be contacted via their manager to provide feedback on documentation and coding of the above scenarios. The information obtained will assist our team to develop coding guidelines on these topics.

**Clinical review: Generalised Anxiety Disorder (GAD)**

Generalised Anxiety Disorder (F41.1) is a mental health condition in which a person is often worried or anxious about many things and finds it hard to control this anxiety.

The cause of GAD is unknown. Genes may play a role, and stress may also contribute. It is a common condition, affecting about 3% of people. Anyone can develop this disorder, even children.

The main symptom is frequent worry or tension for at least six months, even when there is little or no clear cause. Worries seem to float from one problem to another. Even when aware that worries or fears are excessive for the situation, a person with GAD still has difficulty controlling them.

Other symptoms of GAD include: problems concentrating; fatigue; irritability; problems falling or staying asleep, or sleep that is restless; and restlessness when awake. Physical symptoms may also be present. These can include muscle tension, upset stomach, sweating, or difficulty breathing.

**Classification**

Anxiety disorders are predominantly classified in the following code blocks:

- F40 Phobic anxiety disorders
- F41 Other anxiety disorders

Anxiety symptoms and signs can be present in a wide variety of anxiety disorders, of which GAD is just one type.

Medical record documentation such as “anxious” patient is not necessarily evidence of a specific anxiety disorder. Many patients are anxious when faced with illness and hospitalisation. This is a normal reaction to a stressful situation, not necessarily an anxiety disorder with specific diagnostic criteria.
Clinical review:
Generalised Anxiety Disorder (continued)

Classification
Anxiety symptoms need to be excessive, persistent and maladaptive for a disorder to be diagnosed. When a patient’s emotional state seems extreme, the patient may be referred to an appropriate clinician for assessment. The clinician then documents the findings on physical examination and/or mental state examination and arrives at a diagnosis.

For coding purposes, anxiety disorders need to be diagnosed and documented by the appropriate clinician (doctor, psychiatrist, or clinical psychologist).

If after assessment no disorder is found but anxiety symptoms meet ACS 0002 Additional diagnoses, then an appropriate R code, such as R45.89 Other symptoms and signs involving emotional state should be assigned.

Coding tip: Incontinence

ACS 1808 Incontinence instructs coders when R32 Unspecified urinary incontinence and R15 Faecal incontinence should be coded. There was clarification of these guidelines in 10AM Commandments (vol 16 no 1, June 2009).

Classification guidelines
The coder should first determine whether R32 and/or R15 meet criteria in ACS 0001 Principal diagnosis or ACS 0002 Additional diagnoses. If yes, the coder next needs to determine whether the criteria in ACS 1808 Incontinence are met.

For it to be coded, incontinence needs to be confirmed to be a persistent problem, which includes any of the following ACS 1808 criteria being met:

- Persistent prior to admission
- Present at discharge
- Persists for at least seven days during the admission

N.B. the criterion “present at discharge” does not include transient incontinence present on the discharge date – only persistent incontinence should be coded.
Back to basics: Multiple drug use

Principal diagnoses such as “polysubstance abuse” or “drug induced psychosis”, with involvement of multiple psychoactive substances where the substance which has mostly caused/contributed to the presentation is not specified, should be queried with the doctor. If this is not possible, assign a code from F19.- as per the tabular note at block F19:

This category should be used when two or more psychoactive substances are known to be involved, but it is impossible to assess which substance is contributing most to the disorders. It should also be used when the exact identity of some or even all the psychoactive substances being used is uncertain or unknown, since many multiple drug users themselves often do not know the details of what they are taking.

F codes to describe the known substances involved should also be assigned (sequenced directly after F19.-).

Example
Principal diagnosis: Drug induced psychosis
Progress notes: patient admits to use of methylamphetamines and cannabis
Assign:
F19.5 Mental and behavioural disorders due to multiple drug use and use of psychoactive substances, psychotic disorder
F15.51 Mental and behavioural disorders due to use of other stimulants, including caffeine, psychotic disorder, methylamphetamine
F12.5 Mental and behavioural disorders due to use of cannabinoids, psychotic disorder
Coder spotlight

This issue we interviewed
Susanne Forbes from Mount Hospital

How long have you been coding?
4 Years

At which hospital did you commence your coding career?
The Mount Hospital

What made you decide to become a clinical coder?
I had to retrain from a Clinical Nurse working in Cardiothoracics. After a fall, I could no longer nurse as the injuries I sustained meant I could not perform CPR again without permanent damage to my neck. I asked if I could do clinical coding as I had done a lot of research work before, and enjoy the art of finding information. The hospital was very happy to do this, so I worked in Medical Records clerically for a year as I studied at night at home.

What do you like most about clinical coding?
The challenge of finding the correct code when no appropriate lead term is given by the doctor, or there is no code available for the surgery performed. Also the discussions that occur between the team of coders to help find the correct / best code.

What do you like least about clinical coding?
The continued difficulty of reading doctors’ handwriting; and the need to send off query letters when there is no diagnosis documented to accompany the operation note.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
I have attended all the “New Edition” coding courses, and recently represented the Mount Hospital at Hollywood’s first Coding Workshop day, which I found to be very informative and enjoyable. It was also a relief to hear the questions asked by the other hospital representatives, as they often included things that I wonder about as well.

What casemix/specialties do you find most challenging in your current role?
I find complex orthopaedics and injuries a challenge as I have not worked in a coding area that deals with them very often, unlike some of the other coders in my team. But I do have them as back up to provide advice and ensure my accuracy.

Describe the coding service at your hospital
We have six coders, two of these have the challenge of managing the department so their coding time is limited and one of them is also still training. Two of the other coders have been coding 12 years or more, one full time and the other part time. The part time coder also trains our new coding staff, one of whom has just finished her first year.

I work two days per week but it has been increased to include a Sunday where I come in on my own and code as many as possible to cover the gap of excess files left by Friday. On a Sunday I can code as many as 100 but during the week I usually code the high income ones, so only get 30-40 done per day.

I have also adopted the role of Coding Educator where I choose a topic for our monthly coding meeting which includes a discussion followed by coders answering the relevant questions. I personally enjoy it very much, and get feedback that the questions are often a challenge.

Our office is tucked off to the side of the Hospital, (many years ago it was the Laundry for the hospital). As many people had trouble finding us we asked could we paint our front door to make it stand out more and so now everyone just looks for the bright red door!! It is a small but great office combination of people to come to work with. I feel very lucky to be able to come to work here each day.