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WA Coding Rules & Audit Discussion Cases

The latest WA Coding Rules and Audit Discussion Cases are now available. These are usually published on our website after each WACCAG meeting, however we are currently unable to publish any content. All publications will be emailed until our website has transitioned to a new server.

In the past the WACCAG published queries were known as ‘WA Coding Queries’. They have been renamed ‘WA Coding Rules’, in line with national terminology ‘ACCD Coding Rules’. Both WA and ACCD Coding Rules are official ratified advice.

Other sources of coding advice (including newsletters, education documents, Audit Discussion Cases, Codefinder™ shared notes) are based on Australian Coding Standards and state and national ratified advice, however should be used with caution as classification rules are continually evolving.

February 2017

WA Coding Rules

1. Clarification of Dec 2015 ACCD Coding Rule Coding from findings on medical imaging (radiological) reports

2. Clarification of Dec 2016 ACCD Coding Rule Sameday admissions for chemotherapy/pharmacotherapy for neoplasm(s) and neoplasm related conditions
ACCD Coding Rules replacing WA advice
1. External cause of injury for tattoo complication
2. Goldilocks mastectomy

Audit discussion cases
1. Thrombosis, intracranial/cerebral venous
2. Histopathology result failing to confirm documented diagnosis or procedure
3. Alcohol intoxication

April 2017

WA Coding Rules
1. Hepatitis B immunoglobulin (HBIG) administration in newborn
2. TNM stage documentation
3. Endoscopy with insertion of flatus tube

Audit discussion cases
1. Documentation of lesion vs tumour vs growth in clinically diagnosed neoplasm
2. Principal diagnosis of “cancer” in same-day endoscopy cases
   a. Cystoscopy post prostatectomy
   b. Follow up check cystoscopy with no recurrence found
3. Parotid primary cancer with skin metastasis

ACCD Coding Rules replacing WA advice
1. Hut Lung
2. Hyperplastic rectosigmoid polyp
3. Intranasal and oral sedation
4. Iliac artery stenosis with Type 2 diabetes mellitus and peripheral vascular disease
5. Type 1 and type 2 myocardial infarction
6. Decompressive laminectomy of thoracic and lumbar spine by posterior approach
7. Lords plication of hydrocele
8. Complications of prosthetic devices, implants and grafts/haematoma following cardiac catheterisation
9. Selection of morphology codes from pathology reports
Department of Health coding team

Background
The Department’s coding team was established in 2009. The newly established positions enabled dedicated management of clinical coding as a separate entity to Data Quality (‘edits’). The increased resources also enabled training and validation of trainee clinical coders at metropolitan and rural hospitals.

With restructuring of health services in 2011 and establishment of new Coding Educator positions at various hospitals, the team’s focus shifted from training coders to supporting Coding Educators.

The coding team has always worked closely with the Department’s Data Quality team and the Clinical Information Audit Program. As our profile has increased over the years, our service provision has expanded to other departments including Data Analysis, Data Linkage and Epidemiology.

System Manager
On 1 July 2016 the Health Services Act 2016 commenced and established the Director General as the System Manager in the WA Health System. The Director General, supported by departmental officers, sets system-wide direction, guidance and policy with mechanisms to ascertain compliance with the stated direction and monies provided for health service delivery.

In line with the System Manager functions, one of the key responsibilities of our team is **oversight of coding data quality** submitted to the Hospital Morbidity Data Collection (HMDC). Compliance monitoring in the form of coding data quality audits is required to monitor compliance with Australian Coding Standards, clinical coding conventions and other national and state reporting requirements. The coding team have historically conducted ad-hoc coding data quality reviews but there is need for expansion to a more formalised audit program, which is planned to commence in 2017.

Coding queries
Another key responsibility is provision of **coding consultancy** to all WA hospitals via our coding query process. Details about the process can be viewed on our website: [www.clinicalcoding.health.wa.gov.au/news](http://www.clinicalcoding.health.wa.gov.au/news) (N.B. this web address is current at time of publication but will soon be changing with our website moving to a new server).

We are eager to assist and will do our best to answer queries within seven days. Some queries may need to be presented to WACCAG or ACCD and will obviously take longer to resolve, but we’ll provide interim advice in these situations.

Rebranding of the coding team – WA Clinical Coding Authority (WACCA)
With the evolving nature of the coding team’s role and the establishment of the new governance model for WA Health with the Health Services Act 2016, the Coding Education Team has been renamed to better reflect the service we provide as the State Authority for clinical coding, with the new name: **WA Clinical Coding Authority (WACCA)**.

In addition, our position titles have changed from Coding Trainer to Coding Consultant. The team has undergone recent personnel changes with Elise White going on parental leave. Julia Stone will be replacing Elise while she is away – we welcome Julia back to our team.
Department of Health coding team (cont.)

Clinical Coding Policy

WA Coding Standards (Operational Directive 0620/15) has been reviewed in relation to the update of the ARDT policy which is currently underway, and also relevant Tenth edition changes.

A new Clinical Coding policy has been developed in order to align with the Health Services Act 2016 and the Department’s role as System Manager. To comply with requirements for mandatory policies, the WA Coding Standards have been attached as an appendix and this new policy will supersede OD 0620/15.

The policy has recently undergone stakeholder consultation and is due to take effect 1 July 2017.

Tenth Edition update

ACCD will again deliver online education for the upcoming Edition change. The education material is free of charge and was recently released with instructions emailed to all CLIP registrants.

Coders should ensure they are registered on CLIP. If you need to register please visit the ACCD website: https://www.accd.net.au/account/AccountDetails.aspx?action=Register

WACCA plans to work closely with Coding Educators/Team Leaders to provide support in the transition to Tenth Edition. We propose to hold a forum(s) for gathering ideas and addressing Tenth Edition issues. This will enable information sharing and a combined effort to submit Tenth Edition FAQs to ACCD, avoiding duplication. The forum will be held once all Educators have completed the online education. More information will be sent out in the near future.
Back to basics

Test results and ACS 0010 General abstraction guidelines – a summary

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Example</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings that provide specificity about a documented condition</td>
<td>Breast lumpectomy, histopathology pending when discharge summary written. Histopathology finding: breast carcinoma.</td>
<td>The histopathology finding adds specificity to the documented condition ‘breast lump’. Carcinoma is coded rather than breast lump. (ACCD Coding Rule Principal/additional diagnoses (1 of 3), Sept 2008)</td>
</tr>
<tr>
<td>'Dermal cyst’ documented on operation report and discharge summary, however the histopathology later showed the lesion to be an angiomyoma.</td>
<td>Where there is discrepancy between the clinical diagnosis and histology, clinical verification should be sought prior to code assignment. (ACCD Coding Rule Clinical diagnosis versus histology, Dec 2011)</td>
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<tr>
<td>Patient admitted with menorrhagia for vaginal hysterectomy. Histopathology finding: leiomyoma of the uterus. There is no documented association.</td>
<td>When there is uncertainty, coders should verify with the clinician whether the leiomyoma is significant to determine whether it should be coded. (ACCD Coding Rule Coding of findings on pathology results, Dec 2009)</td>
<td></td>
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<tr>
<td>Same-day endoscopy to investigate abdominal pain. No findings noted on endoscopy report but multiple stomach biopsies taken. Histopathology finding: chronic gastritis.</td>
<td>'Findings’ as referred to in ACS 0046 Diagnosis selection for same-day endoscopy includes any diagnoses on the endoscopy report or the histopathology report. The instructions in ACS 0010 General abstraction guidelines should not be followed, as this standard is overridden by ACS 0046 for coding of same-day investigative endoscopies. (WA Coding Rule Findings on same day endoscopy, Jan 2015)</td>
<td></td>
</tr>
<tr>
<td>Initial admission with multiple trauma. X-ray finding: fractured nose. The fracture is not documented elsewhere in the medical record.</td>
<td>ACS 1907 Multiple injuries guidelines must be applied in conjunction with ACS 0010 General abstraction guidelines. Therefore do not code test result findings not documented in the medical record or confirmed by the clinician. In this case fracture cannot be coded unless confirmed with the clinician. (ACCD Coding Rule Coding from findings on medical imaging (radiological reports), Dec 2015)</td>
<td></td>
</tr>
<tr>
<td>Ureteric calculus documented in medical record. Radiology report finding: hydronephrosis.</td>
<td>Although the classification links ureteric calculus and hydronephrosis, each condition must be documented or confirmed by the clinician to be coded. Therefore the finding of ‘hydronephrosis’ on radiology report cannot be coded unless documented elsewhere in the medical record or confirmed by the clinician. (ACCD Coding Rule Coding from findings on medical imaging (radiological reports), Dec 2015)</td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy for cholelithiasis. Histopathology finding: cholelithiasis with cholecystitis. Cholecystitis is not documented elsewhere in medical record.</td>
<td>As cholecystitis is not documented, it cannot be coded unless confirmed with the clinician. (WA Coding Rule Clarification of ACCD Coding Rule ‘Coding from findings on medical imaging (radiological reports)’ Feb 2017)</td>
<td></td>
</tr>
</tbody>
</table>
Back to basics (cont.)

ACS 0010 General abstraction guidelines – electronic discharge summaries with ‘cut and pasted’ content

With widespread use of electronic discharge summaries in WA, ‘cutting and pasting’ is an expected and normal use of system functionality.

Often investigation results are cut and pasted into the discharge summary and any pasted diagnostic statements should be considered equivalent to those typed by the author of the discharge summary.

ACS 0010 still applies – all diagnoses in the discharge summary must be verified by reviewing pertinent documents in the body of the clinical record before they can be coded.

What does debridement by a Podiatrist usually involve?

- Instruments: sterile single-use carbon steel surgical blade, sterile autoclavable scalpel handle.
- Infection control: one blade per handle per wound.
- Removal of non-vital skin tissue. For example:
  - removal of callus developed on peri-wound site
  - removal of macerated skin surrounding the wound
  - removal of slough on top of wound
- Depth of debridement is down to a healthy granulating wound bed.

Another form of wound debridement performed at some hospitals is low frequency ultrasonic wound debridement, using an ultrasonic wound debridement machine and sterile saline to remove slough on top of a wound, down to a healthy granulating wound bed.

Coding Tip: Debridement and other Podiatry procedures

Debridement

Podiatrists provide care to “high risk” patients with foot ulcer(s) which often involves regular debridement of wounds. All Podiatrists are qualified to perform non-surgical wound debridement. Regular “high risk” foot wound debridement by Podiatrists is recommended by International Diabetic Foot Ulceration Guidelines.

Due to the nature of chronic diabetic foot ulcers, some wounds have tendon and/or bone on view. Podiatrists do not perform debridement of tendon or bone. However, bone chips may fall out from the wound by themselves if there is presence of osteomyelitis.

Classification of debridement in Podiatry

ACS 0032 Allied health interventions advises: “For inpatient coding it is only necessary to assign the general code(s) in block [1916] for allied health intervention(s). However, clinical coders are encouraged to use the more specific codes for allied health interventions to better represent the interventions performed”.

ACCD Coding Rule Debridement of burn performed with change of dressing, March 2015 provided the following advice:

“ACCD considers the statement in Australian Coding Standard 1203 ‘most debridements are excisional’ refers to
debridements performed in an operating room as per the reference to ‘surgeon’. Clinical advice confirms that debridement, de-roofing of blisters and trimming of skin during a change of burn dressing performed on the ward with no anaesthesia is non-excisional debridement."

Classification conventions do not always align with clinical practice. Although Podiatrists and other health professionals may describe debridement as ‘excisional’ in that there is excision of non-vital skin tissue, for classification purposes it is coded as non-excisional debridement as per the above ACCD Coding Rule. Therefore documentation of ‘debridement’ of ulcer or other skin condition by a Podiatrist should be coded: 90686-01 [1628] Non-excisional debridement of skin and subcutaneous tissue.

Other common Podiatry procedures

Callus

- **Debridement of callus**
  Assign 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue

- **Callus reduction** involves progressively reducing the thickness of a callus using either lateral cutting strokes from a scalpel blade, or the abrasive action of a diamond electro-deposition file. As there is no specific ACHI code for callus reduction, assign 95550-04 [1916] Allied health intervention, podiatry as per ACCD Coding Rule Callus reduction performed by Podiatrist, March 2017.

Corn

Hard corn is a callus with a deep hard centre. Once the callus part has been removed, the hard centre needs to be removed (enucleated).

- **Debridement of corn**
  Assign 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue.

- **Corn enucleation**
  As there is no specific ACHI code for corn enucleation, assign 95550-04 [1916] Allied health intervention, podiatry as per ACCD Coding Rule Callus reduction performed by Podiatrist, March 2017.

Verruca

- **Debridement of verruca** involves removal of callus on top of the verruca down to ‘pin-point bleeding’. Debridement then performed using sterile single-use surgical blade. Assign 90686-01 [1628] Nonexcisional debridement of skin and subcutaneous tissue.

Ingrown toenail procedures

Classification instruction regarding ACHI code assignment for ingrown toenail procedures performed by Podiatrists has been intentionally omitted from this publication awaiting further advice from ACCD.

Acknowledgements

WACCA acknowledges Bingyan Pang – Senior Podiatrist from East Metropolitan Health Service, for provision of clinical advice.