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Coding queries & audit discussion cases

The October 2013 coding queries cases are now available to view on our website:


Coding queries

1. Fetal distress
2. Superficial papillary TCC
3. SMART syndrome
4. Repositioning of gastric band
5. Bakri balloon catheter for management of post abortion haemorrhage
6. Sequencing Z38 Liveborn infant as principal diagnosis
7. Capsular contracture of breast

Audit discussion cases

Top 10 Coding Errors, Tertiary Hospitals 2007-2012 (part 2 Cases 6-10) are now available to view on our website:

Eleventh edition education FAQs

Following the ICD-10-AM/ACHI/ACS Eleventh Edition workshops, the NCCH has published Part 1 of the FAQs on CLIP.

The Coding Education Team submitted a query about imaging procedure coding which has been answered in the FAQs. The response was in keeping with a past WA CCAG decision (Jan 2013).

To read the FAQs, log into CLIP:


NCCH are awaiting clinical advice to clarify the responses for the remainder of the FAQs. These will be published as Part 2 as soon as possible.

3M Codefinder™ tip

Copy code

With the 8th edition change to the coding of multiple skin lesions, coders are now required to code the total number of lesions excised. In light of this it is time to revisit the Copy Code feature in Codefinder™. This feature allows you to copy a code which is listed on the Patient Summary screen.

This feature can be used whenever a code needs to be assigned more than once.

Enter the number of times you wish to copy the code.

Tick the Copy Attributes box if you wish to copy the Clinician/Date or any Edit Text changes that you have added to the code you are copying.

The ‘Group copied codes together’ feature will activate if you are copying more than one code. The default will ensure the multiple codes you are copying are copied as a set of codes and the sets will appear under each other. If you untick this box the codes will appear on the screen with the same codes listed together.

Please contact Kathy Wilton at 3M, kwwilton@mmm.com if you require further information.
Coding tip: Lithotripsy of urinary tract

Lithotripsy refers to calculus fragmentation to facilitate extraction or expulsion of calculus from the body.

Endoscopic or percutaneous approach

Fragmentation can be performed endoscopically (e.g. ureteroscopy, pyeloscopy) or percutaneously (e.g. nephroscopy). Radiological imaging guidance is used. The main modes of fragmentation include:

- Laser
- Ultrasonic – a probe emitting high frequency sound waves (Anderson et al. 2012, 1066)

Extraction may be performed immediately after fragmentation (e.g. basket extraction). A stent may also be inserted for drainage.

Extracorporeal shock wave lithotripsy (ESWL)

A non invasive procedure where shock waves generated by a Lithotripter machine are administered externally. The device is pointed at the exact position of the calculus (determined by radiological imaging). The patient is either immersed in a water bath or placed in contact with a water cushion. Water is used as a medium to minimise dissipation of energy (Grasso and Green 2012). The ideal result is small calculus fragments (less than 1mm) which can pass through the urinary system and be expelled from the body (Grasso and Green 2012).

Classification

In the ACHI index, the term “lithotripsy” is only listed for extracorporeal shock wave lithotripsy (ESWL). If “lithotripsy” is documented and methods other than ESWL are performed, look up the term “fragmentation”.

For example: Ureteroscopy and lithotripsy performed for ureteric calculus.

Although the term lithotripsy is documented, this is an endoscopic procedure rather than ESWL. The correct pathway:

Ureteroscopy - with -- fragmentation of calculus
36809-01 [1074] Endoscopic destruction of ureteric lesion

OR

Fragmentation - calculus
-- ureter (closed) (endoscopic)
36809-01 [1074] Endoscopic destruction of ureteric lesion

References:

Back to basics: Dagger and asterisk convention

In ICD-10-AM, codes for aetiology (underlying cause) are annotated by a dagger (†), and manifestation codes by an asterisk (*) symbol.

Occasionally the index may lead to a dagger and asterisk pair that only partly reflects the condition being coded.

Example 1: Dementia due to secondary parkinsonism

Index:
Parkinsonism
- with
- - dementia G20† F02.3*

This dagger and asterisk pair fails to capture the specific type of Parkinson’s disease (G21.- Secondary parkinsonism).

Coding Matters (vol 14 no 2) advised in this instance that the dagger and asterisk pair G20† F02.3* should not be assigned. Instead, code the aetiology (G21.-) and manifestation (F03) separately, and then sequence as per ACS 0001 Principal diagnosis.

Example 2: Graves’ cardiomyopathy

Index:
Cardiomyopathy
- thyrotoxic E05.9† I43.8*

This index pathway forces the assignment of E05.9 Thyrotoxicosis, unspecified and fails to capture the specific type of thyrotoxicosis – Graves’ disease (E05.0).

Both codes are from the same rubric (E05 Thyrotoxicosis), unlike the above Coding Matters scenario where the codes were in different rubrics (G20 and G21).

In this scenario, the dagger and asterisk pair E05.9† I43.8* cannot be ignored. We must follow the index and assign E05.9† I43.8* along with the code for Graves’ disease (E05.0 Thyrotoxicosis with diffuse goitre) to fully translate the medical statement.

A query will be sent to ACCD asking for the index to be reviewed to consider changing thyrotoxic cardiomyopathy to E05.-† I43.8*.
Coder spotlight

This issue we interviewed Christine Moore from Osborne Park Hospital …

How long have you been coding?
I have been coding since December 2009, so 3 years and 10 months now.

At which hospital did you commence your coding career?
I commenced my coding career at Fremantle Hospital.

What made you decide to become a clinical coder?
I have always been interested in medical issues, primarily disease processes and procedures. My work background before coding was Records Management in various state government departments. I quite accidently found out about clinical coding doing some research on the internet.

What do you like most about clinical coding?
Coding really develops your medical knowledge. I love the challenge of coding each individual case, particularly the more involved cases where you sometimes need to do extra research.

What do you like least about clinical coding?
The process issues such as when discharge summaries aren’t provided; or when discharge summaries contradict procedure reports or integrated progress notes; or bad handwriting which cannot be deciphered.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
I haven’t attended anything very recently, but do keep up to date with coding education material on the W.A Coding website. I read and re-read the standards, particularly the standards on diabetes, CRF, Hepatitis etc. In the near future I would like to apply for a scholarship to do the advanced clinical coding course through HIMAA which I believe will be beneficial for my coding knowledge and skills.

What casemix/specialties do you find most challenging in your current role?
Geriatrics; Psych Geriatrics; Obstetrics and Neonatal; and complex Surgical.

Describe the coding service at your hospital
The total number of coding staff is four. There is one full time coder – myself; one coder who works four days per week; one half-time coder and another coder who works one day per week. We will be hiring another full time coder in the future. The Department of Health have been providing training assistance and are currently training two of our coders. With regards to education, we attend relevant workshops and ensure we have copies or access to all the latest relevant material. We liaise with clinicians regularly regarding obtaining relevant information about cases and our HIM and coders have provided education to them at times.

Editor’s note
We have been advised that the ABF/ABM Program is unfortunately unable to offer any new scholarships in 2014.