Coding queries & audit discussion cases

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


August Coding Queries
1. Gastric band removal.
2. Gastric band port resiting.
3. Repair of tegmen tympani defect and PORP repositioning.
4. Bilateral ureteric stent insertion.

August Audit Discussion Cases
1. Carcinomatosis peritonei (peritoneal carcinomatosis) and malignant ascites.
2. Obstetric coding.
3. Sequencing arterial and nerve injuries.

October Coding Queries
1. Replacement of Memokath urinary stent in ileal conduit
2. Follow-up infected shoulder joint prosthesis by arthroscopic biopsy
3. Diabetes with iliac artery stenosis
4. Calculating ventilation hours
5. Drug induced anaemia

October Audit Discussion Cases
1. Charcot’s joint disease and peripheral sensory neuropathy
2. Index pathway for DVT of leg
3. Ischaemic stroke with facial palsy and dysphasia
Manual removal of placenta in a single vaginal delivery

The following edit, *Invalid combination of (O80-O84) / Z37.x / procedure*, has been updated in line with a recent coding rule published by the NCCH.

When a spontaneous vertex delivery (90467-00 [1345]) is coded with manual removal of placenta (90482-00 [1345]), the principal diagnosis to be assigned is O83 Other assisted single delivery, not O80 Single spontaneous delivery.

In the following example:

**PDx:** O80 Single spontaneous delivery

O73.1 Retained portions of placenta and membranes, without haemorrhage

Z37.0 Single live birth

**PPx:** 90467-00 [1336] Spontaneous vertex delivery


The warning edit *Invalid combination of (O80-O84) / Z37.x / procedure* will be raised and the site will need to review the current coding and amend if appropriate.

(Coding Rules: Manual removal of placenta in a single vaginal delivery-published 15 June 2014)

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Rehabilitation

A rehabilitation care type can only be reported to the Hospital Morbidity Data Collection (HMDC) when the rehabilitation care is:

- Delivered under the management of (or informed by) a clinician with specialised expertise in rehabilitation; and
- Evidenced by an individualised multidisciplinary management plan, which is documented in the patient’s medical record. The plan must include negotiated goals within indicative time frames and a formal assessment of functional ability.

Currently the Code Z50.9 *Care involving rehabilitation procedure, unspecified* should not be assigned in an episode of care which does not have a care-type: Rehabilitation.

The clinical coder should refer cases for clarification when there is no evidence in the medical record to support a Rehabilitation care type, even if there is clinical documentation such as ‘for rehabilitation’
Data quality: Duplicate edits

*Edit number 20 – ‘This case has potential duplicate cases identified’* is a very common edit that occurs across most sites at one time or other. It is basically alerting sites that the Hospital Morbidity Data Collection (HMDC) has received data that shows two admissions for the one patient for the same time period. Obviously because it is impossible for a person to be in two places at once, an error in the data needs to be corrected. The duplicate may have occurred at the one site or across two or more different sites.

**WHAT PROCESS SHOULD YOU FOLLOW?**

The following steps are just a suggestion to help speed up the process of investigating and finding where the error has occurred. If all sites follow something like this, then it should make the investigation and location of duplicate errors much easier and timely to correct:

**Step 1:**

I. Read comments on Edits spreadsheet – note details particularly if another site is mentioned as having the duplicate case.

II. If you don’t have enough information, contact HMDC (see contact details below) to ask for more details about the duplicate cases. *Perhaps ask the following questions:*

   - Is the duplicate admission at your site?
   - Is the duplicate admission at another site and what site is it?
   - What dates are potentially overlapping for the two admissions?

**Step 2:**

Retrieve the **physical medical record** for the patient containing the admission in question.

**Step 3:**

I. Read the medical record documentation.

II. Ascertain the admission, transfer, leave and discharge movements of the patient.

III. Review both the physical medical record and the PAS separately to gain the whole picture. Note: these may not necessarily match.

**Step 4:**

I. Print or copy a screen shot from your PAS of the whole admission showing all the patient movements and ensure they correctly match the medical record documentation.

II. If there is any discrepancy, begin to investigate where possible, with the staff involved at ward level. (assuming the case is not an old case)

**Step 5:**

I. Contact the other site (if another sites is involved) if everything matches between the documentation in the medical record and your PAS.

II. Email the other person at the other site a screen shot of each other’s PAS patient movements to clarify where the discrepancy may lie.

**Step 6:**

I. Ensure both sites have done a medical record and PAS search.

II. If necessary and you can’t agree on where the error lies, further questioning of staff may be required.
III. Try looking at other modules in your PAS e.g. emergency module, outpatients etc.

IV. It may even be necessary to speak with the doctor who treated the patient or if the patient arrived by ambulance, reviewing documentation from the ambulance service about arrival date and times.

WHAT NEXT ONCE YOU FIND THE ERROR?

1. For public health sites, please update your PAS accordingly and resubmit the case. Then update your edit spreadsheet with what the error was and note the date the update was made on your PAS. Send to HMDS when complete.

2. For private health sites, please update your PAS and advise HMDS accordingly with explicit instructions how to correct the error in the edit spreadsheet.

EXAMPLES OF WHAT YOU MIGHT DOCUMENT ON YOUR EDIT SPREADSHEET TO RETURN TO HMDC

**Private Establishments**: (Corrects error in own PAS; notify HMDS Edits how to specifically correct edit in data already submitted)

<table>
<thead>
<tr>
<th>Hosp</th>
<th>Batch</th>
<th>Case</th>
<th>Error Desc</th>
<th>UMRN</th>
<th>Account</th>
<th>Adm Date</th>
<th>Sep Date</th>
<th>HDWA comment</th>
<th>Site Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>24892</td>
<td>341</td>
<td>This case has potential duplicate cases identified</td>
<td>XXX258</td>
<td>XXXX1587</td>
<td>03/05/2014</td>
<td>04/05/2014</td>
<td>Pls review sep date as patient was admitted to XXXX on the 3/5/2014</td>
<td>Admission date was entered incorrectly in our PAS. The correct admission date should be 4/4/2014 @ 1245 hrs and discharge date 5/5/2014 @ 1000 hrs.</td>
</tr>
</tbody>
</table>
Public Establishments: (Corrects error in own PAS and resubmits case; Advises HMDS Edits of correction made and resubmitted)

<table>
<thead>
<tr>
<th>Hosp</th>
<th>Batch</th>
<th>Case</th>
<th>Error Desc</th>
<th>UMRN</th>
<th>Account</th>
<th>Adm Date</th>
<th>Sep Date</th>
<th>HDWA comment</th>
<th>Site Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX</td>
<td>24892</td>
<td>341</td>
<td>This case has potential duplicate cases identified</td>
<td>XXX2565</td>
<td>XXXX1587</td>
<td>03/05/2014</td>
<td>04/05/2014</td>
<td>Pls review sep date as patient was admitted to XXXX on the 3/5/2014</td>
<td>Error made here at X Hospital with recorded date of admission. We have updated case on 05/05/14 to reflect correct admission date of 4/4/2014 @ 1245 hrs and discharge date of 5/5/2014 @ 1000 hrs.</td>
</tr>
</tbody>
</table>

After investigation the error is discovered to have been made at the external hospital:

<table>
<thead>
<tr>
<th>Hosp</th>
<th>Batch</th>
<th>Case</th>
<th>Error Desc</th>
<th>UMRN</th>
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<tr>
<td>XXX</td>
<td>24892</td>
<td>341</td>
<td>This case has potential duplicate cases identified</td>
<td>XXX2565</td>
<td>XXXX1587</td>
<td>03/05/2014</td>
<td>04/05/2014</td>
<td>Pls review sep date as patient was admitted to XXXX on the 3/5/2014</td>
<td>Liaised with site contact (xxx name) at XX hospital where duplicate admission identified. Both sites agree error in XX hospital data and they will advise and correct accordingly.</td>
</tr>
</tbody>
</table>

NOTE: Often there are more than just the duplicate admission errors for the particular patient admission. There may be several other edits attached to this admission that require correction.

If once you have notified us of the correction or updated the duplicate case, you still see the case on your edit report; the other edits attached to it will need to be corrected before it disappears from your report.

Hospital Morbidity Data Collection Contacts:

Data Review Officer
Mon, Thu & Fri: Samantha Rickert
☎ 9222 4290
Email: Samantha.Rickert@health.wa.gov.au

Quality Assurance Officer
Jeremy Wood
☎ 9222 2339
Email: Jeremy.Wood@health.wa.gov.au

Acting Data Quality Coordinator
Denise McMahon
☎ 9222 2472
Email: Denise.McMahon@health.wa.gov.au
Clinical review: Urinary Diversion and Reconstruction

A urinary (tract) diversion procedure reroutes the normal flow of urine out of the body. The first urinary diversion was performed in 1852, an ureteroproctostomy (Costa 2013).

The flow of urine may be blocked (at the level of kidney/ureter/bladder/urethra); or the bladder may not store urine adequately due to:

| Malignancy                                      | • Primary cancers of bladder and genitourinary tract.  
|                                               | • Secondary involvement from cancers of adjacent pelvic organs and tissues. |
| Neurogenic bladder conditions                  | • Traumatic spinal cord injury (e.g. paraplegia, quadriplegia).  
|                                               | • Congenital malformations of the spinal cord (e.g. spina bifida, other myelodysplasias).  
|                                               | • Multiple sclerosis.  |
| Other                                          | • Chronic pelvic pain.  
|                                               | • Renal/ureteric/bladder stones, prostatomegaly, chronic urinary retention.  
|                                               | • Chronic bladder infection, interstitial cystitis.  
|                                               | • Radiation injury to the bladder, injury to the urethra.  
|                                               | • Chronic incontinence. |

(Costa 2013)

A urinary diversion may be temporary or permanent, and; incontinent or continent.

Temporary urinary diversion
In temporary procedures the urine is diverted for a period of days or weeks until the condition necessitating it is treated. These are incontinent procedures since urine flows continuously into an external drainage bag.

1. Urinary catheterisation

*Urethral catheter*: a catheter is passed through the urethra into the bladder, e.g. Foley’s catheter.

*Suprapubic catheter*: a catheter is passed directly into the bladder, e.g. percutaneously or laparoscopically via a cystotomy.

2. Nephrostomy

A *nephrostomy tube* is inserted directly into the kidney. Urine drains to an external drainage bag, e.g. percutaneous nephrostomy (Cleveland Clinic 2009).

Permanent urinary diversion

Surgery is usually required to divert urine flow permanently.

1. Incontinent urinary diversion

A *urostomy* is the diversion of urine such that it drains continuously through an opening in the abdominal wall (stoma). Urine is collected in an external drainage pouch (ostomy pouch). There are two main types:

Cutaneous Ureterostomy. This is the only form of diversion procedure that does not require the use of a segment of resected gastrointestinal tract. One or both ureters are attached directly to a stoma on the
anterior abdominal wall. This type of urostomy is uncommon in adults. It may be necessary when intestine cannot be used (e.g. inflammatory bowel disease, high dose radiation damage) or after palliative cystectomy in frail patients. Ureterostomy may be performed in children prior to a more definitive diversion procedure (Costa 2013).

**Ileal Conduit.** A segment of intestine (usually 15-25cm of ileum, but can be jejunum, caecum or colon) is resected from the gastrointestinal tract. The segment of intestine is mobilised on its vascular pedicle and becomes the conduit (passageway) for urine from the ureters. The ureters are attached at the proximal (oversewn) end of the conduit and the distal end of the conduit attaches to the abdominal wall (stoma). Urine drains continuously into an ostomy pouch. Diversion of urine by an incontinent ileal conduit is the most common surgical diversion procedure as it has fewer postoperative complications.

**Urinary Pouching Systems**

Pouching systems are one or two-piece systems. Two piece systems have a skin barrier/wafer/faceplate which remains attached to the skin while allowing for the changing of the pouch. They may also contain a valve/spout attachable to a leg bag or night drain (connected to a larger drainable bag or bottle) (UOAA 2014).

2. **Continent urinary diversion**

In a continent urinary diversion urine is drained *intermittently by the patient* from an internal reservoir (pouch). A segment of intestine is used to create a reservoir in the abdomen. The intestinal segment is opened and a spherical shaped pouch is created. This shape increases the segment’s capacity for urine storage. The ureters are attached to the reservoir. There are two main types:

**Continent Cutaneous Reservoir.** This reservoir has a one-way (continent) valve at its outlet to hold the urine until a catheter is inserted. The valve can be made from the ileal-caecal valve as in the Indiana Pouch. Alternatively, a nipple valve is made from small intestine as in the Kock Pouch. The stoma is often hidden in the umbilicus. The patient catheterises the stoma intermittently throughout the day (Cleveland Clinic 2009), (UOAA 2014).

**The Bladder Substitute (syn: Neobladder, Orthotopic Diversion Orthotopic Neobladder).** The internal intestinal reservoir (the new bladder or neobladder) is anastomosed to the ureters at one end and to the urethra at the lower end. Thus the neobladder is in its correct (orthotopic) position and urine is voided through the normal channel (urethra). Continence is provided by the external urethral sphincter. Sometimes catheterisation is still needed to completely empty the reservoir. There is a high incidence of urinary incontinence (up to 20%) with this procedure, so specific patient selection is essential (Cleveland Clinic 2009).

Another type of continent urinary diversion is: **Ureteroenterostomy (e.g. Ureterosigmoidostomy):** Ureters are anastomosed to the (sigmoid colon or rectum). The anal sphincter provides continence. This diversion is rarely performed due to a high complication rate.
Classification

The ACHI procedural blocks have been refined so that codes assigned for urinary diversion now include concepts previously requiring multiple codes (Douglas 2000, 14-17).

[1129] Other procedures on urinary system

36600-02 Formation of incontinent intestinal urinary reservoir

- Formation of ileal or colon conduit

Includes:
- formation of cutaneous abdominal stoma
- isolation of intestinal segment (resection and anastomosis)
- reimplantation of ureters

36606-00 Formation of continent intestinal urinary reservoir

Includes:
- formation of:
  - cutaneous abdominal stoma
  - nonreturn valve
  - isolation of intestinal segment (resection and anastomosis)
  - reimplantation of ureters

36606-03 Formation of continent intestinal urinary reservoir with attachment of reservoir to urethra

- Formation of neobladder

Includes:
- isolation of intestinal segment (resection and anastomosis)
- re-implantation of ureters

References:


United Ostomy Associations of America, Inc. (UOAA). 2014 “What is an Ostomy?”
Follow the Index carefully to assign the correct code:

**Step 1**
Check the Index under the main term which best describes the complication, *then* for sub-terms of:
- procedural
- postprocedural or
- the procedure involved

**Example:**
*Failure, failed*
- kidney
  -- postprocedural N99.0

*Leak, leakage*
- cerebrospinal fluid G96.0
  -- from spinal (lumbar) puncture G97.0

 *(Assign an additional code from Chapters 1-19 where it provides further specificity.)*

**Example:**
G97.0 Cerebrospinal fluid leak from spinal puncture

**R51 Headache**

**Step 2**
If there are no sub-terms of procedural, postprocedural etc. under the main term, check the Index under:
- Complication(s) *then*
  o the body system to which the complication pertains *then*
    ▪ postprocedural

**Example:**
*Complications* (from) (of)
- eye
  -- postprocedural
  ---specified NEC H59.89

**OR**
• Complication(s) then  
  o the type/nature of complication

Example:
Complications (from) (of)  
- accidental puncture or laceration during procedure T81.2

OR

Where the procedural complication relates to a prosthetic device, implant or graft, check the Index under:
• Complication(s) then  
  o the device (if known/ listed) or  
  o prosthetic device, implant or graft

Example:
Complications (from) (of)  
- breast implant (prosthetic)  
  -- mechanical T85.4

Step 3
When a symptom (classifiable to Chapter 18) meets the definition of a procedural complication, assign:
• the chapter specific postprocedural disorder code and  
• the symptom code

Example:
Complications (from) (of)  
- digestive K92.9  
  -- postprocedural (see also...) K91.9  
  ---specified NEC K91.8

K91.8 Other postprocedural disorders of digestive system, NEC  
R13 Dysphagia

If no link can be made to a chapter specific postprocedural disorder code,* assign:
• T81.8 Other complications of procedures, not elsewhere classified, and  
• the symptom code

*the relevant chapter may not have a postprocedural category or the symptom overlaps several body system chapters.

Haemorrhage due to or associated with prosthetic devices, implants and grafts.

The excludes note at T81.0 Haemorrhage and haematoma complicating a procedure, NEC states when a haemorrhage is due to or associated with prosthetic devices, implants and grafts code T82.8, T83.8, T84.8, T85.8-.  

It is important to note the haemorrhage does not need to have a cause and effect relationship documented with the device. However the haemorrhage does need to be associated with or related to the prosthetic device, implant or graft. The haemorrhage or haematoma needs to be in the proximity of the device, implant or graft, i.e. around the device, above the device, under the device, over the device or from the device.

Example:
A suture haematoma post a TKR. There is no association with the device. Assign T81.0 Haemorrhage and haematoma complicating a procedure, NEC.
The coding query process: submitting a coding query

**Coding Query Process Document**

Thank you for the many and varied queries received. To answer queries accurately and in the shortest time period attention is drawn to the above document.

It has been noted that some coding queries being sent to the Coding Query email address are not structured in an appropriate manner. It is important that coders where possible approach the treating clinician as this may provide further details that may in fact answer the query.

Queries should be about actual cases, not in scenario form. Documentation applicable to the case should be supplied. The Coding in WA Website, (under the WACCAG section) contains the Coding Query Process document which provides details on how a query should be submitted.

The education team asks that all coders please follow this process. If a query has been generated at a particular site, coding contractors need to follow the same coding query process as other coders at the site and submit queries via the agreed representative.

WA Clinical Coding Advisory Group: database

If coders become aware that a response in the database contradicts advice published in another jurisdiction, e.g. VICC, coders are encouraged to submit a query (via their agreed representative) to that jurisdiction so that the jurisdiction can take steps to obtain national clarification.

3M™ Codefinder™ Notes

WA public hospitals have agreed to have one repository for the 3M™ Codefinder™ Notes. This means all the public coders will be able to view the same notes.

A ‘clean up’ process is under-way to ensure the notes are valid. You may find many notes are repeated, obsolete and perhaps incorrect. Until the review is completed please apply the advice found in these notes with caution, especially if it is old or not WA Clinical Coding Advisory Group (WACCAG) advice.

Once the review is complete, only selected representatives from each area health service will be able to edit the notes. Thank you to all who are participating in the Notes review process. We appreciate everyone’s patience, while the One Note Shared Repository is refurbished.
Coder spotlight

This issue we interviewed Josephine Ciputra from Graylands Hospital...

How long have you been coding?
Just over a year. I started my coding career in May 2013.

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

What made you decide to become a clinical coder?
I was ready for a career change when I came across a newspaper booklet released by WA Health about which career pathways are available under the Department of Health. The description of what clinical coders do caught my interest as it seemed to combine data analysis with my previous education in medical and health sciences.

What do you like most about clinical coding?
I like the challenge of constantly learning new things. I also enjoy the analytical aspect of the abstraction process.

What do you like least about clinical coding?
For me it’s a toss-up between the ambiguity of some coding rules/standards, and the lack of accurate documentation by clinicians.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?
I finished my coding validation/audit process through the Department of Health approximately two months ago. I have also been fortunate to receive input from the Coding Educators at Sir Charles Gairdner Hospital, as I also code Mental Health cases there.

What casemix/specialties do you find most challenging in your current role?
Graylands Hospital is a psychiatric hospital with no acute medical ward, therefore I struggle with cases that involve multiple specialty team input, such as some of the cases I code at Sir Charles Gairdner Hospital.

Describe the coding service at your hospital
We have two full-time coders at Graylands, who cover: Graylands Hospital, State Forensic Mental Health Service and Selby Lodge (for psychogeriatric cases). We also code mental health cases at Sir Charles Gairdner Hospital. Therefore we move around, sometimes on a daily basis.

Congratulations
We would like to congratulate Vedrana, Andrew and Oliver Savietto on the August arrival of their beautiful baby girl Scarlett Ava. Vana will return to her role as Senior Coding Trainer and Newsletter Editor in 2015. All our best wishes until then…