Government of **Western Australia**
Department of **Health**

Coding Education Newsletter

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Coding queries & audit discussion cases

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

http://www.clinicalcoding.health.wa.gov.au/news/

Coding queries

1. Causal link in same day endoscopy coding
2. Infra-orbital bruise
3. Palacos bone cement

Audit discussion cases

1. Post-partum complications following caesarean twin delivery
2. Cancelled elective procedure
3. Debridement of plantar wound

Delivering a **Healthy WA**

Australian Consortium for Classification Development (ACCD)

Several publications have recently been released and are available to all CLIP users:

- Errata 2, December 2013

- December 2013 Coding Rules (equivalent of former 10-AM Commandments and Q & A)

- FAQs from eighth edition education – Part 2

- Code-it! ACCD Newsletter

HIMAA Certification Currency

Clinical coder Certification 8th edition Currency applications open on 1 February and close 28 February 2014. The application form will be available on 1 February.

http://himaa2.org.au/education/?q=node/162

WA Cancer Registry

A reminder for clinical coders that coding queries relating to neoplasms or histopathology reports should be directed via the normal coding query process, rather than direct to Dr Tim Threlfall at the WA Cancer Registry.

In answering our queries, our team will liaise with WA Cancer Registry staff whenever necessary.

La Trobe University coding courses

Enrolments are currently open for the following La Trobe University online short courses:

- Clinical Coding Auditing course 2014 (applications close Friday April 4, 2014)

- Comprehensive Clinical Coding Refresher Short Course 2014 (application close Monday February 17, 2014).

For further information, including the application form, visit:

http://www.latrobe.edu.au/courses/health-information-management/short-courses

Coding tip: Conditions complicating pregnancy

ACS 1521 Conditions complicating pregnancy directs coders that a condition should be classified as a pregnancy related complication in the following situations:

- If the condition complicates pregnancy; or

- If the condition is aggravated by the pregnancy; or

- If the condition is the main reason for obstetric care.

It can be difficult for coders to determine if any of the above criteria are met, particularly when there is scant or poor documentation.

For non-obstetric conditions, the coder should check the documentation carefully to determine whether **any obstetric observation or care is given**. Some examples include CTG monitoring; ultrasound; being seen by a midwife or obstetrician etc. If any obstetric observation or care is given, the condition should be coded as a pregnancy related complication (with the appropriate 'O' code).

'Incidental pregnant state' means the care received is essentially indistinguishable when compared with a non-pregnant patient with the same condition. The fact that the patient is pregnant is noted, but does not affect the admission in any way, and there is nil obstetric care or observation.

Example

8/40 pregnant patient admitted from antenatal clinic for BSL monitoring, diabetic education and commencement of insulin due to poorly controlled Type 2 diabetes mellitus. The patient is not seen by a midwife or obstetrician. No CTG or ultrasound. However the doctor documents the following:

"Discussed with patient need to control diabetes to prevent complications like IUGR"

"Aim for discharge home in 2-3 days. Patient not keen to stay in hospital – reinforced that it is necessary for fetal wellbeing".

The above documentation indicates obstetric care, therefore pregnancy is not considered 'incidental'. The following diagnosis codes would be assigned:

O24.12   *Pre-existing diabetes mellitus, Type 2, in pregnancy, insulin treated*
E11.65   *Type 2 diabetes mellitus with poor control*

Back to basics: Sequelae

There are three types of sequelae in the ICD-10-AM classification:

- Sequelae of disease (ACS 0008)

- Sequelae of injuries, poisoning, toxic effects and other external causes (ACS 1912)

- Sequelae of procedural complications (ACS 1904)

There is no time limit for sequelae i.e. it may be apparent almost immediately, or may occur months or years later.

Sequelae of disease

A sequela of a disease is a **current condition** directly caused by a **previous condition**.

As the previously occurring condition is no longer current, an acute code for the condition is not assigned. Rather, an appropriate sequelae code is used.

Sequelae of disease (continued)

Two codes are required and are sequenced as follows:

1. The residual condition (**current condition**)

2. The cause of the sequela (**previous condition** no longer receiving acute treatment) using the appropriate sequela code.

Example
Bilateral neural deafness (current condition) resulting from previous measles infection (previous condition).

H90.3 *Sensorineural hearing loss, bilateral*
B94.8 *Sequelae of other specified infectious and parasitic diseases*

Sequelae of injuries, poisoning, toxic effects and other external causes

A sequela of an injury is a **current condition** directly caused by a **previous injury, poisoning, toxic effect or other external cause.**

As the underlying cause is no longer current, an acute code for injury, poisoning, toxic effect or other external cause is not assigned. Rather, the appropriate sequelae code is assigned from the code range T90 – T98.

Three codes are required and sequenced as follows:

1. The residual condition (current condition)

2. The cause of the sequela (previous injury, poisoning etc.) using a code from T90 - T98.

3. The external cause of the injury, poisoning etc. using a code from Y85 - Y89, plus place of occurrence and activity codes.

Example
Organic personality disorder (current condition) resulting from brain injury (previous injury) from MVA 3 years ago.

F07.0 *Organic personality disorder*
T90.5 *Sequelae of intracranial injury*
Y85.0 *Sequelae of motor-vehicle accident*
Y92.49 *Unspecified public highway, street or road*
U73.9 *Injury or poisoning occurring while engaged in unspecified activity*

Sequelae of a procedural complication

A sequela of a complication is a **current condition** that is the result of a **previously occurring procedural complication or misadventure**.
Two codes are required and are sequenced as follows:

1. The residual condition (current condition)

2. T98.3 *Sequelae of complications of surgical and medical care, NEC*

Example

Ureterovaginal fistula (current condition) resulting from previous ureteral injury (previous misadventure) during laparoscopic hysterectomy.

N82.1 *Other female urinary-genital tract fistulae*
T98.3 *Sequelae of complications of surgical and medical care, NEC*

Sequelae often occur as a late effect, and therefore some coders incorrectly think if a procedural complication occurs a long time after a procedure, it is considered a sequelae. Time is not the factor that defines sequelae – it is the presence of a **current condition** caused by a **previous condition**. For example, displacement of a hip prosthesis two years after the original surgery is not classified as a sequela because the displacement is not caused by a previous condition. This is instead classified as a procedural complication.

Coder spotlight

This issue we interviewed Jo Fitzgerald from the WA Country Health Service - Wheatbelt…

How long have you been coding?

5 years

At which hospital did you commence your coding career?

I commenced my traineeship at Northam Hospital, and am now coding for 14 hospital sites in the Wheatbelt.

What made you decide to become a clinical coder?

In the early 90's I heard about Morbidity Officers and asked what they did. When I was told about the job, I liked the sound of it as it sounded very interesting, especially if I could no longer nurse.

What do you like most about clinical coding?

I enjoy the challenge of finding codes and interesting diagnoses.

What do you like least about clinical coding?

Clinical and clerical staff can lack understanding about the importance of clinical documentation, data integrity and accuracy of the patient administration system. As the Wheatbelt has only been under ABF for the last few years, there is still a lack of understanding amongst many of the doctors about the need for a comprehensive and complete discharge summary.

Have you recently undertaken coding workshops, conferences, courses etc? Or plan to in the future?

Since commencing as a coder I have attended all the WACHS coding workshops and workshops for edition updates. I also attend extra training and information sessions to enhance my knowledge and understanding. I recently had a diabetes training session with the DoH Coding Education Team and have signed up for the HIMAA Intermediate Challenge Exam coming up in March.

What casemix/specialties do you find most challenging in your current role?

For me the most challenging are Diabetes and Orthopaedics.

Describe the coding service at your hospital

The Wheatbelt has 24 hospital sites and 20 Residential Aged Care Facilities. Currently there are two coders – myself based at Northam Hospital, and Thea Smith based at Narrogin Hospital. Amy Collins is the Manager of Corporate and Health Information and is based in Wheatbelt Regional Office in Northam (separate to the hospital). Both Thea and I have introductory Certificates and are looking to complete the Intermediate Certificate this year. We liaise with each other and other coders throughout the WA Country Health Service. We have also worked with Amy to organise training sessions with the DoH and coding sessions in the Metro area to further improve our knowledge and skills in casemix that is not common to the Wheatbelt, or that with which we struggle. As a team we have started working with clinical staff to tackle several issues with coding, including recent presentations and clinical information audit reviews with the doctors, with a focus on documentation and discharge summary completion. This is still a work in progress, but we are optimistic that we will see an improvement in documentation in the near future.

Santa's story

Last issue we asked for a story to accompany the code list, describing Santa's bad luck whilst delivering presents. The most creative entry was from Evans Obaga from Kalgoorlie Hospital, well done Evans:

Code list:

S06.02 Loss of consciousness of brief duration [less than 30 minutes]

S43.02 Posterior dislocation of humerus

W17.8   Other specified fall from one level to another

Y92.09 Other and unspecified place in home

U73.1   Injury or poisoning occurring while engaged in other types of work

S80.0   Contusion of knee

W55.8   Bitten or struck by other specified mammal

Y92.86 Other specified place of occurrence, other specified countryside

U73.1   Injury or poisoning occurring while engaged in other types of work

T17.4   Foreign body in trachea

W44   Foreign body entering into or through eye or natural orifice

Y92.07 Indoor living areas, not elsewhere classified

U73.1   Injury or poisoning occurring while engaged in other types of work

F10.0   Mental and behavioural disorders due to use of alcohol, acute intoxication

E66.9   Obesity, unspecified

Santa's Story, by Evans Obaga

History of presenting complaint
At about 1am on Boxing Day, Santa was on his last delivery route at an outback roadhouse when instead of drinking the glass of milk and Anzac cookies that were left out for him, he went into the roadhouse's wine cellar and helped himself to a bottle of rum. He hurriedly drank the bottle of rum together with the cookies at which point he began to choke on the cookies. Realising that he could get caught, he tried to make a quick getaway up the roadhouse chimney but he slid down the chimney shaft onto the fire place landing heavily on his right shoulder. The roadhouse occupants, startled by the commotion, woke up to find a sooty looking Santa who had lost consciousness for approximately 10 minutes.

He roused to complain of excruciating pain on his shoulder. The roadhouse owner noticed Santa slurring his words with what looked like a bottle of rum tucked in his apron area.
The roadhouse owner drove Santa to the nursing post where the RFDS team were dispatched to transport Santa to a health facility.

PMHx
Obese (trying to lose weight through Jenny Craig and Wii)

Meds
Nil
NKDA

Social Hx
Admits to drinking alcohol, at least 500ml a day, every day.

Examination – subjective
- Main complaint is that of right shoulder pain sustained from fall, with a choking sensation in his throat.
- Pain to knee sustained from a dingo bite while trying to fend off wild dingoes when washing his sleigh and giving his reindeer water at an outback waterhole prior to his last delivery route.

Examination – objective
- Shoulder deformity. X-ray reveals posterior dislocation of humerus
- Swallowing deformity noted on barium swallow study
- Knee bruise from dingo bite
- Intoxicated (bal of 0.42)
- Covered in soot
- Neuro observations not done due to intoxication

Plan
- Dislocation reduction in ED under ketamine sedation
- Admit to ward until sobered up
- Review with surgeons for possible oesophagoscopy under GA for removal of Anzac cookie
- Thiamine
- AWS
- Neuro observation once sobers up
- Dietitian review re: obesity