Government of Western Australia
Department of Health

Coding Education Newsletter

Issue 6, August 2013

Inside this issue:

Contacts

Coding Education Team website

www.clinicalcoding.health.wa.gov.au

Editorial queries:

vedrana.savietto@health.wa.gov.au

Delivering a **Healthy WA**

Coding queries & audit discussion cases

Coding queries

The August 2013 coding queries and audit discussion cases are now available to view on our website: http://www.clinicalcoding.health.wa.gov.au/news/

1. Karydakis procedure
2. Type 2 diabetes with fatty liver
3. Tycron sutures
4. Blood alcohol level
5. Symphisitis pubis in pregnancy

Audit discussion cases

1. Neonates
2. Same day chemotherapy

Australian Consortium for Classification Development (ACCD)

There was recent announcement of the newly formed Australian Consortium for Classification Development (ACCD). The ACCD will be led by the NCCH (University of Sydney), in collaboration with the University of Western Sydney and KPMG.

They are responsible for the ongoing development of the AR-DRG Classification System (which includes ICD-10-AM/ACHI/ACS and AR-DRGs). Check out their new website: http://www.accd.net.au/

ACCD Classification Information Portal (CLIP)

The information portal previously known as NIP has been replaced by the ACCD Classification Information Portal (CLIP). CLIP includes all previous national coding advice (NCCC *Coding Q&A*). There is also mention on the new ACCD website that they propose to re-introduce the quarterly newsletter *Coding Matters* as an additional method of communication.

NCCC NIP registrants were asked to consent to their account details being shared. If you voted yes, you can go to the new website and verify your registration and access CLIP: http://accd.net.au/Clip/account/Login.aspx

If you did not agree to share your account details, your NIP username and password are still valid but your personal details are hidden, and it is important that you log in to CLIP and verify and update your details: http://accd.net.au/Clip/account/Login.aspx

If you don't have an account, you can register here: http://accd.net.au/Clip/account/AccountDetails.aspx?action=Register

Data Quality

2012/13 financial year data

Hospital Morbidity Data System 2012/13 financial year data submission is now due!!

The Data Quality Team are currently reviewing the 12/13 financial year data to ensure that complete data has been received from all sites in readiness for the annual Department of Health Commonwealth submissions.

Data is submitted annually to the Commonwealth Department of Health and Ageing (DoHA) and the Australian Institute of Health and Welfare (AIHW).

As per ***OD 0137/08 Hospital Morbidity Data Reporting Cycle***, all financial year data for 12/13 (1 July 2012 to 30 June 2013) is required to be submitted by sites, validated and corrected by **31st August 2013.**

As you can see, the deadline has now passed and our team would like to now remind sites to please give priority to completing outstanding 12/13 data submissions and edits /report returns **as soon as possible.**

Patient data reporting deadlines

	Public Sites	***Private Sites***	***Small or Remote Country Sites***
Data submission	80% within 2 wks; 20% within 4 wks of patient discharge	Monthly submissions	Within 8 weeks of patient discharge
Edit returns	10 working days from receipt of edit reports	10 working days from receipt of edit reports	10 working days from receipt of edit reports
All 2012/13 financial year data submission & edit corrections	**31 August 2013**	**31 August 2013**	**31 August 2013**

Data Quality (cont.)

Data Quality Edits

As sites are well aware, all data submitted is validated via a series of edit checks and any errors found are returned to sites in the form of 'edit reports'. We are mindful that the process of checking and correcting edits involves regular time and effort by site staff and can often be challenging. Should sites have any queries in relation to this process, please contact a member of the HMDS Data Quality team on either (08) 9222 2339 or (08) 9222 4290.

Fatal Edits	Warning Edits
Critical errors that have been identified. The values must be updated otherwise cases will not be reported or funded.	Non—critical errors that can indicate missing, unusual or possibly incorrect values. Warning edits require sites to verify each case to ensure data items are correctly recorded.

It is also very important for sites to remember to notify IT providers of system or application issues that may be preventing your site from correcting data edits. For example, some private sites continue to have numerous edits due to old suburb and postcode reference tables being used. These errors will just continue to appear until this issue is raised with your IT providers.

In relation to public applications such as TOPAS, webPAS and HCARe, the Data Quality team will raise any data quality issues that relate to application limitations. However, it is imperative that sites also raise these issues with their specific Application Support team as this provides further evidence required to enable issues to be addressed.

Public sites

Edit reports showing warning and fatal edits need to be reviewed and:

- Cases corrected for the specific episode of care, comment updated on edit report and then case reconfirmed / resent via PAS;
- If data is correct, confirm as such with supporting reason in edit comments and return via the Edit report (see example below).

Private sites

Edit reports showing warning and fatal edits need to be reviewed and:

- Cases that are correct need to be confirmed as correct with a supporting reason; or
- If incorrect, provide enough detail for DoH to correct.

Examples of Edit responses:

Warning Edit – if data item is correct:

Error Message:	Diagnosis code A37.9 is a rare diagnosis.
Site Response:	Diagnosis A37.9 has been confirmed as correct by doctor.

Warning Edit – if data item is incorrect:

Error Message:	Postal Address provided. Only residential address is required.
Site Response:	Residential address of patient is 350 Example Street, Perth WA 6000

Edit reports are to be returned to the Data Quality Team via the following email hmds.edits@health.wa.gov.au as a Microsoft Excel spreadsheet attachment.

Please note: the spreadsheet needs to contain **all** columns that were present when downloading the edits and a single additional column containing the hospital's responses to each edit.

3M Codefinder™ tip

During a recent site visit in Perth I was made aware that not all coders understand how the ICD10-AM “Excludes” convention is handled in Codefinder™. Here is a refresher.

Take the example of Gastritis and Duodenitis – code K29.xx. In the Tabular List the following Excludes note is displayed:

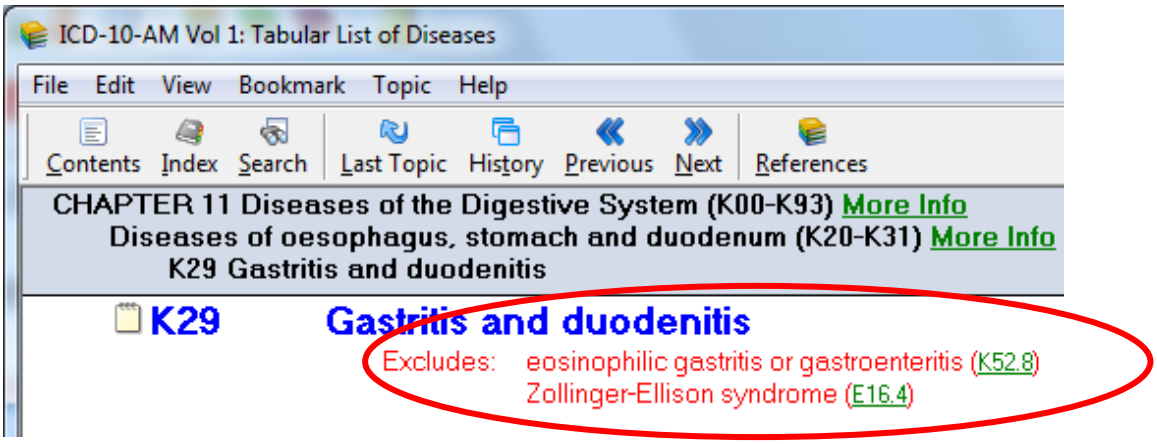

Figure 1

When we look on the Pathway in Codefinder™ the Excludes choices appear as follows:

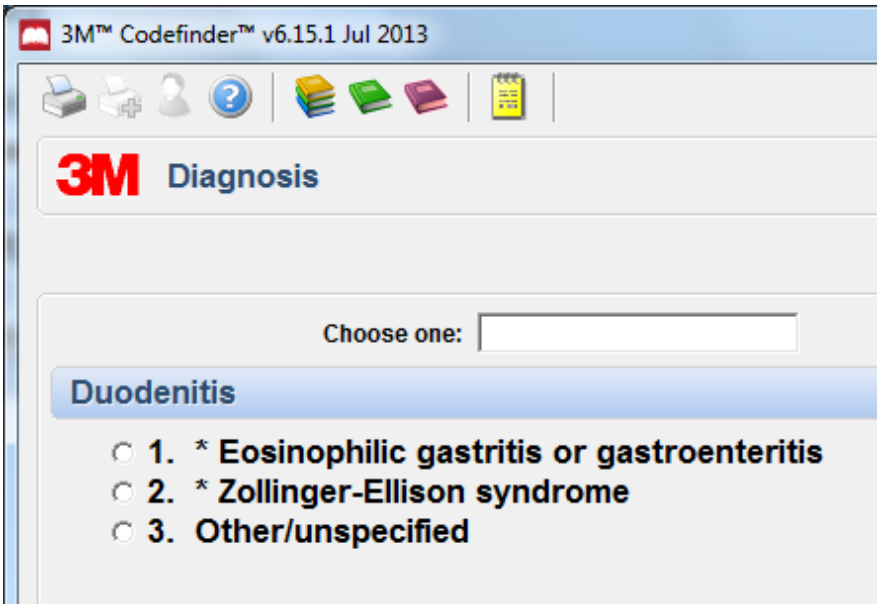

Figure 2

The choices preceded by an asterisk (*) above are the same as the Excludes terms in the Tabular.

The Excludes choices are always listed first on the screen. This ensures the coder considers the Excludes notes before making a choice. Sometimes the Excludes notes listed on a screen will relate to the Excludes at the beginning of a Chapter or a block of codes. By selecting an asterisked choice the code assignment will be as per the Excludes instruction.

3M Codefinder™ tip (cont.)

If a term is both indexed and listed in the Tabular as an Excludes, Codefinder™ will only display the term as an indexed choice. See example below.

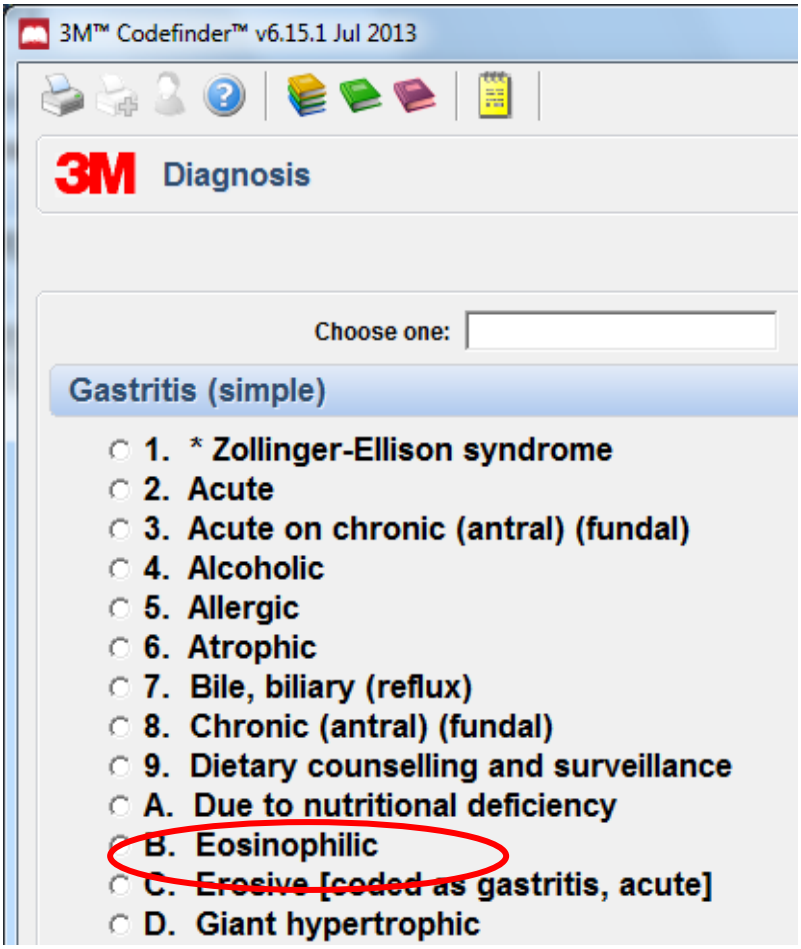

Figure 3

Eosinophilic gastritis is both an indexed term and an Excludes (see Figure 1). The Gastritis pathway will only show this choice as an indexed choice, i.e. it is not listed with an * at the top of the list of options. It appears in alphabetical order because it is an indexed term.

Please contact me if you require more detail on Excludes notes in Codefinder™.

Kathy Wilton (kwwilton@mmm.com)
Senior Clinical Support Consultant.

Coding tip: Premature rupture of membranes (PROM)

During pregnancy the fetus is surrounded by amniotic fluid in the amniotic sac, which is a pair of membranes including the amnion (inner membrane) and chorion (outer membrane). Spontaneous rupture of membranes (SROM) is a normal component of labour, and is caused by the pressure of contractions.

Occasionally spontaneous rupture occurs **prior to commencement of labour**, which is referred to as premature rupture of membranes (PROM), also known as pre-labour rupture of membranes. PROM can occur at any gestational age and may require treatment/intervention. Membranes ruptured greater than 24 hours is considered prolonged PROM, or PPROM (WNHS Clinical Guidelines 2012).

PROM at term (at or beyond 37 weeks)

The risks of PROM at term include maternal and neonatal infection and cord prolapse. Treatment may include any or a combination of the following:

- induction of labour
- antibiotic therapy
- expectant management i.e. waiting for patient to go into labour. This is considered only if certain clinical criteria are met.

PROM prior to 37 weeks

PROM occurring prior to 37 weeks gestation is referred to as pre-term PROM, or PPROM. It is associated with over 60% of premature births, and there is increased risk of perinatal mortality and neonatal morbidity (WNHS Clinical Guidelines 2012).

Treatment may include any or a combination of the following:

- corticosteroids (to accelerate fetal lung maturation)
- antibiotics
- tocolysis

Coding tips

- The index pathways for O42.- *Premature rupture of membranes* are:
  - Rupture, membranes, premature
  - Premature, rupture, membranes
  - Leak, amniotic fluid
  - Hindwater leak

  These terms should be documented for the pathway to be followed. It is accepted that recent terminology of 'pre-labour' rupture is the same as 'premature' rupture.
- Sometimes only "SROM" (not PROM) is documented, requiring antibiotics and/or induction. This should be queried with the clinician to confirm PROM.
- PROM is only coded if it meets ACS 0001 or ACS 0002 e.g. required antibiotics, induction etc.
- If there is documentation of PROM and it meets criteria for coding, the coder needs to calculate the time duration from membrane rupture to onset of labour, based on the categories:
  - Onset of labour within 24 hours
  - Onset of labour between 1-7 days later
  - Onset of labour more than 7 days later
- PPROM can mean either
  - prolonged PROM
  - pre-term PROM
- Sometimes artificial rupture of membranes (ARM) is performed in PROM cases. This is usually in cases of hindwater leak which means the part of membranes over the baby's head is still intact and amenable to amniotomy.

Reference

Women and Newborn Health Service, King Edward Memorial Hospital. 2012. "Clinical Guidelines: Preterm prelabour rupture of membranes". Accessed August 30, http://www.kemh.health.wa.gov.au/development/manuals/O&G_guidelines/sectionb/2/b2.6.1.pdf

Back to basics: Using acronyms in Codefinder™

There have been several instances of coders incorrectly assigning M8041/3 *Small cell carcinoma* for cases of squamous cell carcinoma.

This is likely due to coders typing the acronym "SCC" in Codefinder™ and choosing the first option without reading the list carefully. The list appears as follows:

1. SCC [small cell carcinoma]
2. SCC [squamous cell carcinoma]

Coder spotlight

This issue we interviewed Jody Stroet from Carnarvon Hospital …

How long have you been coding?

13 years

At which hospital did you commence your coding career?

I started coding here at Carnarvon Hospital.

What made you decide to become a clinical coder?

I was nursing full-time and looking for a change, I wanted to study and thought coding would be an enjoyable, interesting career path.

What do you like most about clinical coding?

I like the fact that you are continually learning; it is interesting and at times challenging.

What do you like least about clinical coding?

Nothing that I can say I really dislike.

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

Yes, I went to the 8th ICD-10-AM edition workshop in April. I also go to Geraldton every few months for work and personal development, which is great to be able to code a greater case mix than what we have in Carnarvon; it's also great to catch up with the coding team in Geraldton, they are lovely, knowledgeable and welcoming.

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

Diabetes, but I secretly enjoy coding diabetes.

Describe the coding service at your hospital?

I am the only coder here, I work 22 hours per fortnight and my office is located in the same area as the Drug and Alcohol team. The clinicians are very approachable.