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

Western Australian Coding Rule

1014/06 Closure of ileostomy

WA Coding Rule 1012/01 *Closure of ileostomy* is superseded by ACCD Coding Rule ***Closure of ileostomy with resection*** (Ref No: Q2883) effective 1 October 2014; (log in to view on the ACCD CLIP portal).

DECISION

WA Coding Rule 1012/01 *Closure of ileostomy* is retired.

[Effective 1 Oct 2014, ICD-10-AM/ACHI/ACS 8th Ed.]

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1012/01 Closure of ileostomy

Q.

With reference to an old WA database query W1733, is this query still valid and what constitutes an 'extensive resection'? In the operation notes for closure of ileostomy we are given the measurement in centimetres and therefore don't know when to consider it extensive.

Query W1733 reads:

Q. The index for closure of ileostomy (without resection) 30562-01 [899] has the non-essential modifier without resection, however, the code in the tabular list actually includes the 'without resection' in the code description.

Does this exclude the tidying up of the ileostomy ends before re-joining them?

A. Code 30562-01 [899] includes the tidying up of the colostomy prior to closure, this may involve some trimming and resection of the ends before reanastomosis. However, if there is documentation of more extensive resection as well as re-anastomosis it should be coded separately.

A.

Pieces of intestine removed with colostomy closure or ileostomy closure are part of the operation and coders should not report either separately. If documentation indicates the surgeon has simply removed the small segment of bowel that has been exteriorised or examined the doughnuts associated with an end to end stapled anastomosis do not code a resection. When a true bowel resection is documented, i.e. when the surgeon has found further pathology at the time of closure, a resection code should also be assigned. There is no need to code a re-anastomosis separately as previously advised in W1733. Coders should clarify with the clinician if there is any ambiguity.

DECISION

Coders must read the operation report and determine if a true resection has been performed before assigning a separate resection code. Clarify with the clinician if there is any ambiguity.

[Effective 26 Oct 2012, ICD-10-AM/ACHI/ACS 7th Ed.]

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