Allied health professionals guide to clinical coding and documentation

What do clinical coders do?

Clinical coding is the translation of written clinical documentation into code format.

Coding involves:

- Abstraction of relevant information from the entire medical record including discharge summary, clinical documentation and diagnostic reports;
- Determining which diagnoses and procedures in the admitted episode meet criteria for coding as per mandatory state and national standards; and
- Assigning codes for diagnoses and procedures using the ICD-10-AM/ACHI/ACS classification.

Clinical documentation

High quality clinical documentation promotes effective communication between caregivers and facilitates continuity of patient care. It also facilitates accurate clinical coding – a diagnosis or procedure can only be coded if documented in the medical record. Accurate coding ensures appropriate DRG assignment and funding for the hospital.

Which documentation is used by clinical coders?

Diagnosis and treatment of medical conditions is the responsibility of the treating medical officer(s), therefore clinical coders predominantly use medical officer documentation.

Documentation from clinicians other than medical officers (e.g. nurses, allied health professionals) is also used by coders. It can help to provide clarification and specificity about (or confirm existence of) a diagnosis or procedure documented by a medical officer. More importantly, if a nursing or allied health documented diagnosis or procedure is appropriate to that clinician’s discipline, it can be coded regardless of whether the medical officer has documented it.

Examples

- A diagnosis of pneumonia can only be coded if documented by a medical officer.
- A diagnosis of dysphagia documented by a speech pathologist (which the medical officer fails to document) can be coded because it is appropriate to the speech pathology discipline.
Clinical coding rules

- A diagnosis or procedure documented in the discharge summary must be verified elsewhere in the medical record before it can be coded.
- When there is ambiguous, conflicting, incomplete or non-specific documentation, the clinical coder must consult with a medical officer for clarification.
- Not all clinical documentation is relevant to coding. Only conditions that require treatment, diagnostic procedures, or increased clinical care/monitoring are deemed to meet criteria for coding.

There are some exceptions to this rule, including:
  - Underlying cause, when known and documented, can be coded. For example, “pressure injury secondary to quadriplegia” – even if quadriplegia itself is not treated, it is coded as the underlying cause of the pressure injury being treated.
  - Some conditions are mandatory to code whenever present. For example, diabetes mellitus.

Use of allied health documentation

As per Australian Coding Standards, coding directly from allied health documentation is restricted to conditions appropriate to the allied health professional’s discipline. In the absence of national coding guidelines defining which conditions are appropriate to an allied health discipline, the Department of Health, WA interprets this to mean a condition where an allied health professional alone can initiate and complete treatment.

In seeking diagnostic information, clinical coders read assessment notes in allied health documentation. Coders cannot interpret results from specialised testing/assessment, and rely on allied health professionals to document any diagnosed condition. For example:

- A post-traumatic amnesia assessment should have a final conclusion documenting whether patient has post-traumatic amnesia. Coders cannot interpret scores or other results.
- “Dysphagia review” should have a clear final assessment documenting whether patient has dysphagia.
- Mini Nutrition Assessment (MNA) should have a clear final assessment documenting whether patient has malnutrition.

If you have any queries regarding documentation issues relating to clinical coding, please contact the clinical coding office at your hospital.