Nursing and Midwifery 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, midwives, 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, midwife 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 pressure injury documented by a nurse (which the medical officer fails to document) can be coded because skin integrity management is appropriate to the nursing 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.
- Clinical coders cannot code solely from a diagnostic test result or clinical assessment finding – the condition itself must be diagnosed and documented. For example, a microbiology report showing bacteria isolated on MSU can only be coded if the medical officer documents UTI.
- 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. It is important to specify type 1, 2 or other. The terminology IDDM and NIDDM is outdated and should not be used.

Use of nursing documentation

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

General nursing

The main areas of general nursing that usually require coding are skin integrity and continence.

Skin integrity

Examples of documentation commonly required and used for coding:
- Ulcers – location; type; if pressure injury what is the stage?
- Wounds – location; type e.g. laceration, skin tear, abrasion
- Excoriation – location; cause
- Minor injuries in multiple trauma presentation – location; type e.g. contusion

It is important that any relevant forms and/or stickers are completed thoroughly.
General nursing (continued)

Continence
Examples of documentation commonly required and used for coding:

- High bladder residuals
- Urine retention
- Urine or faecal incontinence
  The coder needs to extract the following information for each admission:
  - Is incontinence persistent prior admission?
  - Is incontinence present at discharge?
  - If incontinence is transient, it can only be coded if managed 7 days or longer during this admission. The coder may use nursing documentation to calculate duration

Other general nursing documentation
Examples of documentation commonly required and used for coding:

- Invasive and non-invasive ventilation
  Coders are required to calculate the duration (hours) of ventilation. ICU forms are helpful for this purpose. In other situations the coder relies on progress notes or other documentation to calculate ventilation hours.
  - Nursing documentation should clearly indicate dates and times ventilation is commenced and ceased to enable accurate calculation of ventilation hours. If there are breaks in ventilation e.g. intermittent CPAP, cessation and recommencement date/time are needed to calculate overall duration.

- Hypoglycaemic episodes in diabetic patients, treated by nursing staff alone
  - Nursing documentation should indicate the diagnosis of “hypoglycaemia”, any known cause, and the treatment provided. BSL readings cannot be interpreted by coders.

Specialist nursing
Below are examples of specialist nursing roles and documentation required by coders.

Tracheostomy and Stoma care
Documentation required: any obstruction, leakage or other complication? Is it non-transient? What, if any, intervention is required?

Diabetic Educator
Documentation required: type of diabetes? Is insulin used? Any complications of diabetes e.g. PVD, retinopathy? Is diabetes poorly controlled? Documentation such as “poorly controlled”, “uncontrolled”, “for stabilisation”, “unstable” is required for the coder to be able to code poor control.
Use of midwifery documentation

**Obstetrics**
Documentation required: a record of labour and/or delivery; any complications that occur; and if intervention is performed, the condition necessitating intervention must be documented.

Examples:
- “PROM” requiring IOL
- “failure of cervical dilation” requiring caesarean section
- “poor contractions” requiring augmentation
- “OP presentation” causing “delayed second stage” requiring vacuum extraction
- “PPH” treated with IV Syntocinon (blood loss volume alone cannot be interpreted by clinical coders)

**Neonates**
- Commencement and cessation date/time for phototherapy of newborns. The coder is required to calculate total hours of phototherapy
- Admission weight of neonates must be documented on all subsequent admissions after the birth episode. It is a mandatory data requirement and can affect DRG.

**Obstetric discharge summaries**
In some hospitals, the STORK summary is regarded as the only discharge summary for delivery episodes. Midwives are recognised as clinicians in Obstetrics, however are not the admitting clinician ultimately responsible for admitted patient care. Therefore, if STORK is to be regarded as the only discharge summary:
- It must be checked and countersigned by the medical officer responsible for admitted patient care
- It will be expected the STORK summary is the instrument by which the care given is communicated to GPs and other health professionals in order to promote continuity of care

This does not preclude medical officers choosing to supply a medical discharge summary over and above the STORK summary.

**Telephone orders**
If a medical officer is not in attendance but is providing telephone orders e.g. after-hours or in remote/rural hospitals - the information exchange must be thoroughly documented. This includes information conveyed to the medical officer, and any diagnosis and treatment order made by the medical officer. Medication orders should be charted by the medical officer when they next attend.

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