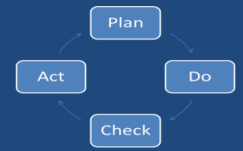


Health Information Services – Clinical Coding Quality Plan 2018/2019



The Central Coast Local Health District (the District), Clinical Coding Quality Plan outlines activities to enable the District to achieve excellence in clinical coding. This plan aligns with the District's strategy of 'Caring for the Coast – every patient every time' by putting programs in place to ensure coding accuracy for every patient acute separation.

This plan aligns with the framework outlined in the 'NSW Health Data Quality Assurance Framework for Activity Based Management' [PD2016_030](#).

The building blocks for an Activity Based Funding system are:



This plan outlines activities for the 'Classification' block to ensure reliability and confidence in Clinical Coded data provided by Health Information Services – Clinical Coding.

1.0 Auditing and Quality Checks

1.1 Performance Indicators in Coding Quality (PICQ):

CCLHD has a local licence of PICQ that sends individual coders 'indicator' emails on a weekly basis. These indicators are a flag for coders to assess the coded episode against validations in the Australian Coding Standards and classification rules. There are approx. 393 potential PICQ indicators; these are divided into categories of F – Fatal Indicator, W1- Warning Indicator 1% threshold, W2- Warning Indicator other, R- Relative Indicator. It is the responsibility of the individual coder to assess these indicators and correct coding if needed.

A formal review of PICQ indicators is conducted quarterly by the Coding Auditor. This review checks that PICQ indicators received by staff have been checked and corrected accurately by the coder.

Outcome: Quarterly PICQ report submitted to the District Coding Manager.
Quarterly audit recorded on the 'HIS Coding Audit Calendar'.

1.2 Long Stay Outlier Audit

A monthly audit is conducted of coded separations where the Length of Stay (LOS) is greater than the upper inlier bound (1.5 x the average length of stay). Coding of these episodes is audited by the Coding Educator and Auditor team. Any coding errors are corrected by individual coding staff.

Outcome: Long Stay Outlier Audit spreadsheet completed monthly.
Copy of spreadsheet with individual coder names removed, sent to ABM unit.
Monthly audit recorded on the 'HIS Coding Audit Calendar'.
Report produced at end of each FY.

1.3 Review of Error Diagnosis Related Groups (DRGs)

The following DRGs, often referred to as 'error DRG's are reviewed on a monthly basis. Coders are encouraged to email auditing staff as soon as an episode with an error DRG is coded. The coding auditor also runs an error report to identify these episodes.

801A GIs Unrelated to Principal Diagnosis, Major Complexity
801B GIs Unrelated to Principal Diagnosis, Intermediate Complexity

801C GIs Unrelated to Principal Diagnosis, Minor Complexity

960Z Ungroupable

961Z Unacceptable Principal Diagnosis

963Z Neonatal Diagnosis Not Consistent W Age/Weight

Outcome: Monthly audit recorded on the 'HIS Coding Audit Calendar'.

1.4 Review of Specific DRGs

The following DRG's are reviewed monthly for any cases where the patient's mode of separation is 'deceased'. These cases may indicate that an inappropriate principal diagnosis has been assigned.

Z61A Signs and Symptoms, Major Complexity

Z61B Signs and Symptoms, Minor Complexity

Z64A Other Factors Influencing Health Status, Major Complexity

Z64B Other Factors Influencing Health Status, Minor Complexity

The following DRG's are reviewed monthly. These DRG's may indicate a coding problem or indicate that the Baby Admission Weight (BAW) has been entered incorrectly.

P02Z Cardiothoracic and Vascular Procedures for Neonates

P03A Neonate, AdmWt 1000-1499g W Significant GI/Vent \geq 96hrs, Major Complexity

P03B Neonate, AdmWt 1000-1499g W Significant GI/Vent \geq 96hrs, Minor Complexity

P04A Neonate, AdmWt 1500-1999g W Significant GI/Vent \geq 96hrs, Major Complexity

P04B Neonate, AdmWt 1500-1999g W Significant GI/Vent \geq 96hrs, Major Complexity

P61Z Neonate, AdmWt <750 g W/O Significant GI Procedure

P62A Neonate, AdmWt 750 – 999g W/O Significant GIs, Major Complexity

P62B Neonate, AdmWt 750 – 999g W/O Significant GIs, Minor Complexity

P63A Neonate, AdmWt 1000-1249g W/O Significant GI/Vent \geq 96hrs, Major Complexity

P63B Neonate, AdmWt 1000-1249g W/O Significant GI/Vent \geq 96hrs, Minor Complexity

P64A Neonate, AdmWt 1250-1499g W/O Significant GI/Vent \geq 96hrs, Major Complexity

P64B Neonate, AdmWt 1250-1499g W/O Significant GI/Vent \geq 96hrs, Minor Complexity

Outcome: Monthly audit recorded on the 'HIS Coding Audit Calendar'.

1.5 Grand Round Case Study Audits

At each Grand Rounds, if a specific case review takes place, the Clinical Coding Educator will identify the MRN with the presenter and conduct a coding audit on the case. The results of this audit are fed back to coders who attended Grand Rounds and the presenter.

Outcome: Grand Rounds Coding Review Audit Report submitted to the District Coding Manager
Audit recorded on the 'HIS Coding Audit Calendar'.

1.6 Speciality/Identified Coding Audits

The Coding Manager and Auditors work closely with the ABM unit to identify clinical specialties, diagnosis or procedures that require a coding audit. These audits also include a focus on Hospital Acquired Complications (HAC) and Condition Onset Flag (COF) data. Recommended audit numbers are between 20-30 records, however this number is to be adjusted on audit need.

Outcome: Speciality Audit Report submitted to the District Coding Manager.
Audit recorded on the 'HIS Coding Audit Calendar'.

1.7 Individual Coder Audits

To ensure quality and accuracy of coding is within acceptable ranges and to identify individual education gaps, individual Clinical Coders are audited as required. A sample of 20-40 records across all specialties and LOS will be selected using the most recent completed month of coding. Blind audits will be conducted with draft results discussed with the coder for potential corrections. Gaps in education will be discussed and addressed with the individual coder and training offered where applicable. Clinical Coding audits are viewed as educational rather than punitive in nature.

Audit Disputes

Where no agreement about correct code assignment can be reached between an Auditor and Coder, the issue will be raised at the monthly Coding Managers meeting for discussion and resolution.

If a disagreement remains on code assignment the query will be submitted to the NSW Clinical Coding Leadership Group for determination.

Outcome: Individual Coding Audit Report submitted to the District Coding Manager.
Audit recorded on the 'HIS Coding Audit Calendar'.

2.0 Coder Education and Training

2.1 Trainee Coder Program

CCLHD provides a trainee coder program which trains newly graduated coders over a 12 month period. Over the duration of their traineeship they access training records from coding specialities, attend coding education days and are mentored by the Coding Educator.

2.2 Coding Education Meetings

Clinical Coders are required to attend bi-monthly Coding Education Meetings run by the Coding Management Team. Coders participate in specialty topic talks, coding exercises, peer reviews of records and presentations from clinical experts.

2.3 Clinical Coding Team Site

The Clinical Coding Team site is an intranet site that is accessible to CCLHD Clinical Coders both at work and home. The site is kept updated with coding resources and education material, including: Clinical Coding Introduction Sheets, Clinical Coding Fact Sheets, Education Day presentations and the NSW Clinical Coding Leadership Group decisions and minutes.

2.4 CCLHD Grand Rounds

Clinical Coders are encouraged to attend Grand Rounds across CCLHD sites. These sessions are designed for clinical review for medical officers; however give clinical coders the opportunity to be kept up to date with advancements in clinical care and speciality case studies.

2.5 ICD-10-AM and DRG edition update

On implementation of each new edition of ICD-10-AM and AR-DRGs all coders are required to attend internal education workshops on relevant changes.

2.6 NSW Health Clinical Coding Leadership Group

The District Coding Manager and 1 representative from the Coding Management Team attend the monthly 'NSW Health Clinical Coding Leadership Group' meeting. Minutes and outcomes of this meeting are distributed to all coding staff.

3.0 Clinician Engagement

3.1 Clinical Coding and Documentation Training

The District Coding Manager and Manager Health Information Services work together to provide training to clinical areas on coding and health record documentation. These sessions are provided on request from CCLHD specialities and departments. A regular session is conducted with JMOs each intake.

3.2 Clinical Documentation Specialist

The Clinical Coding Management Team works closely with the Clinical Documentation Specialist to identify clinical documentation queries, focus areas for audits and documentation improvement initiatives.

3.3 Clinical Documentation Guidelines

Reference Sheets are developed for specialties which outline best practice documentation requirements for clinical coding. These guidelines are developed in conjunction with the ABM unit and clinical representatives. Completed guidelines are published on the CCLHD intranet.

3.4 Coder Clinician Query Forms

Clinical Coders are encouraged to send query forms to clinicians to clarify health record documentation when conflicting or unclear diagnosis impact the DRG. Answered query forms are scanned into the health record to become source data.

3.5 Care Type Change Queries

Clinical Coding staff submit queries on care type changes to the correct CCLHD area. These corrections ensure more accurate coding of Principal Diagnosis.