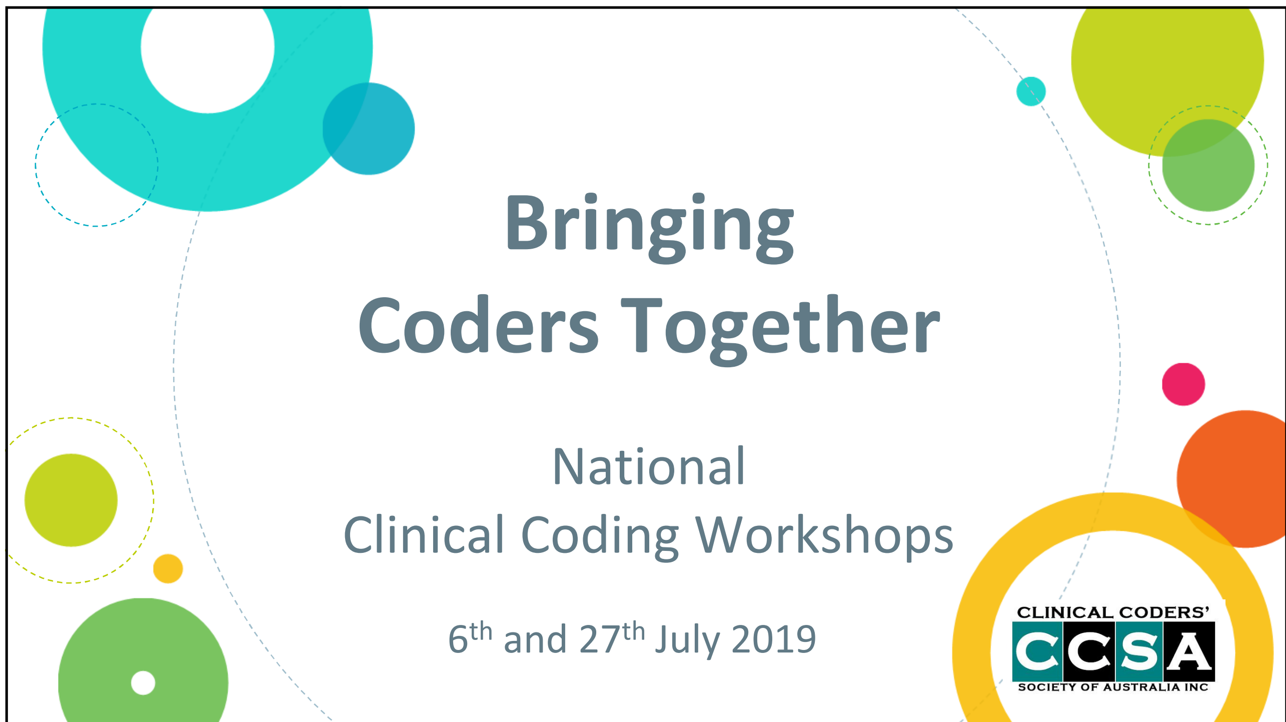

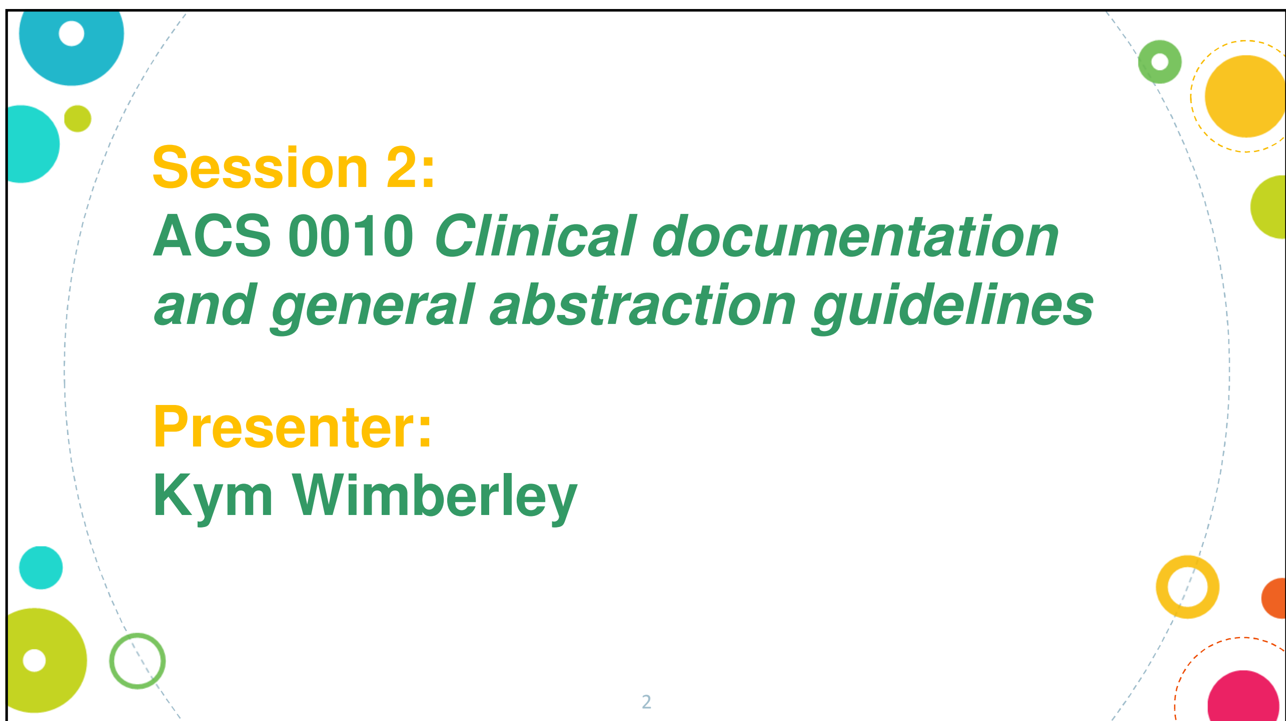

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What has changed ???

Name change from General Abstraction Guidelines

Includes a definition of a HealthCare Record ***New***

Roles/Responsibilities in documentation & abstraction process ***New***

Guidelines for generating Queries to Clinicians ***New***

Test Results and Medication Charts – Shorthand ***New***

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Coding Rules retired

- Clarification on the application of the Code of Ethics (Dec 17)
- CR TN428 FAQ's – Diabetes Education Workshop FAQ's (June 2012)
- CR TN199 - Use of abbreviations, symbols and test result values to inform assignment for abnormal pathology results (Sept 2009)

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Coding Rules retired

- CR Q3224 - Pathology and other test results reproduced or copied into electronics documents (Jan 2018)
- TN1028 - Coding from findings on medical imaging reports (Dec 2015).

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Definition of Healthcare Record

- Paper
- Hybrid – paper and electronic
- Electronic
  - Scanned
  - Scanned/electronic
  - 100% electronic (no scanned records).

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Documentation and Abstraction Process

For classification purposes the primary source of information is the **current** Episode of Care.

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Documentation and Abstraction Process

Information on the front sheet and/or Discharge Summary (or equivalent) must be backed up by documentation within the current episode of care.

Information from the health care record from outside of that directly relating to the current episode of care can help to inform code assignment – but there are rules!

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Rules for coding outside current Episode of Care

- Clarify documentation within the current episode of care.
- Gain further specificity on documentation within the current episode of care.
- Determine the reason for admission.

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Documentation and Abstraction Process

- Past episodes of care (at current or other health facility).
- Referral Letters and other correspondence.
- Emergency Notes.
- Outpatient Notes.

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Documentation and Abstraction Process

Conditions identified from review of past admissions should **NOT** be assigned, unless the conditions are documented in the **current** Episode of Care.

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Roles and Responsibilities

It is NOT the role of a Clinical Coder/Clinical Documentation Improvement Specialist (CDIS)to diagnose. This is the responsibility of a ***Clinician***.

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What is a Clinician

As per the Introduction to the Australian Coding Standards

The term Clinician is used throughout the ACS and refers to the treating Medical Officer but can refer to other clinicians such as

- Allied Health Professionals
- Midwives
- Nurses.

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What is a Clinician

Generally, Medical Officers documentation is the primary source however Clinical Coders can use documentation from other Clinicians if the documented information is appropriate to the clinician.

- Hypogalactia by a Lactation Consultant
- Pressure injuries by a Wound Specialist
- Ingrown nail by a Podiatrist
- Dysphagia by a Speech Pathologist.

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Roles and Responsibilities - Clinician

- Provide a complete and accurate documentation of all diagnoses and procedures in the clinical record and /or Discharge Summary.
- Receive/Answer Coding Queries.

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Roles and Responsibilities - Coder

- Abstracts and extrapolates existing documentation, verifies the information on the Front Sheet/Discharge Summary against the Healthcare Record for that Episode of Care.
- Generates Queries to clarify inadequate documentation or information that is not clear.

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Coding Documentation Queries

- ◎ Conflicting ambiguous, illegible or incomplete documentation
- ◎ Clarifying a diagnosis/procedure
- ◎ No diagnosis
- ◎ Complications – Procedural/Hospital Acquired Complications
- ◎ Condition onset flag (COF)

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Coding Documentation Queries

- ◎ Resolve conflicting documentation from multiple clinicians.
- ◎ Clarifying investigation results.
- ◎ Diagnoses on Front Sheet/Discharge Summary not substantiated with the current episode of care.

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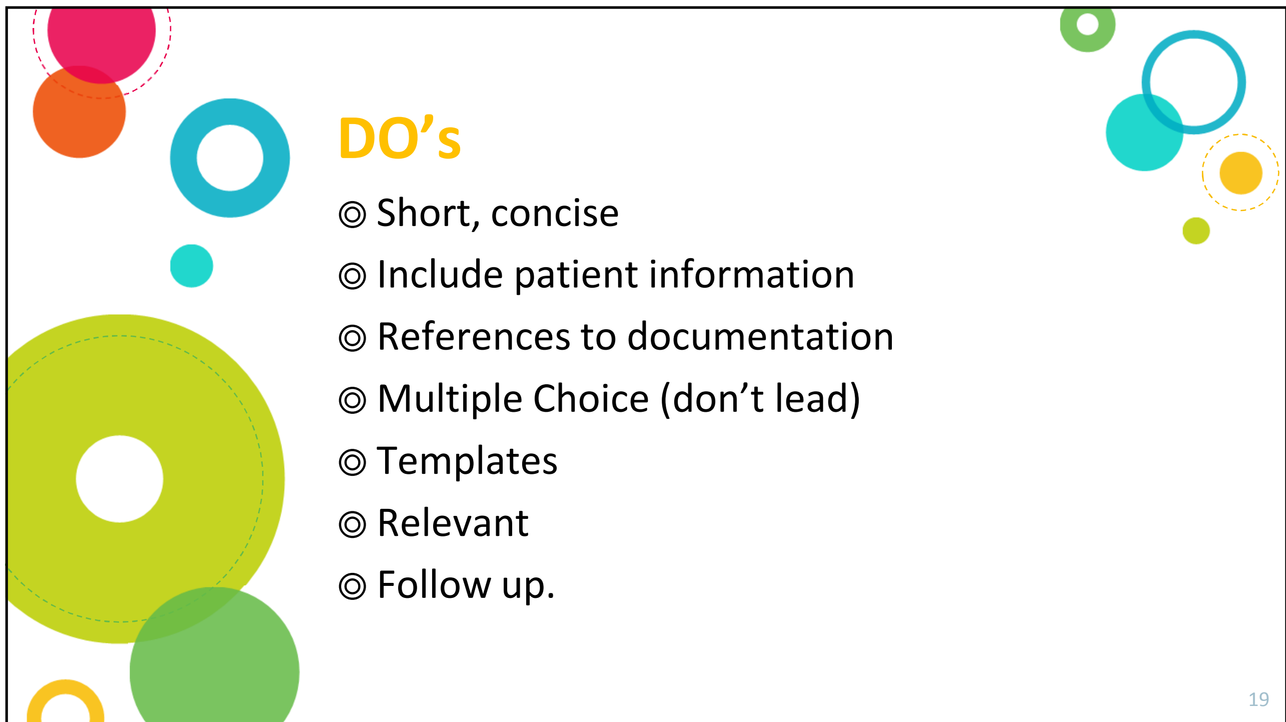

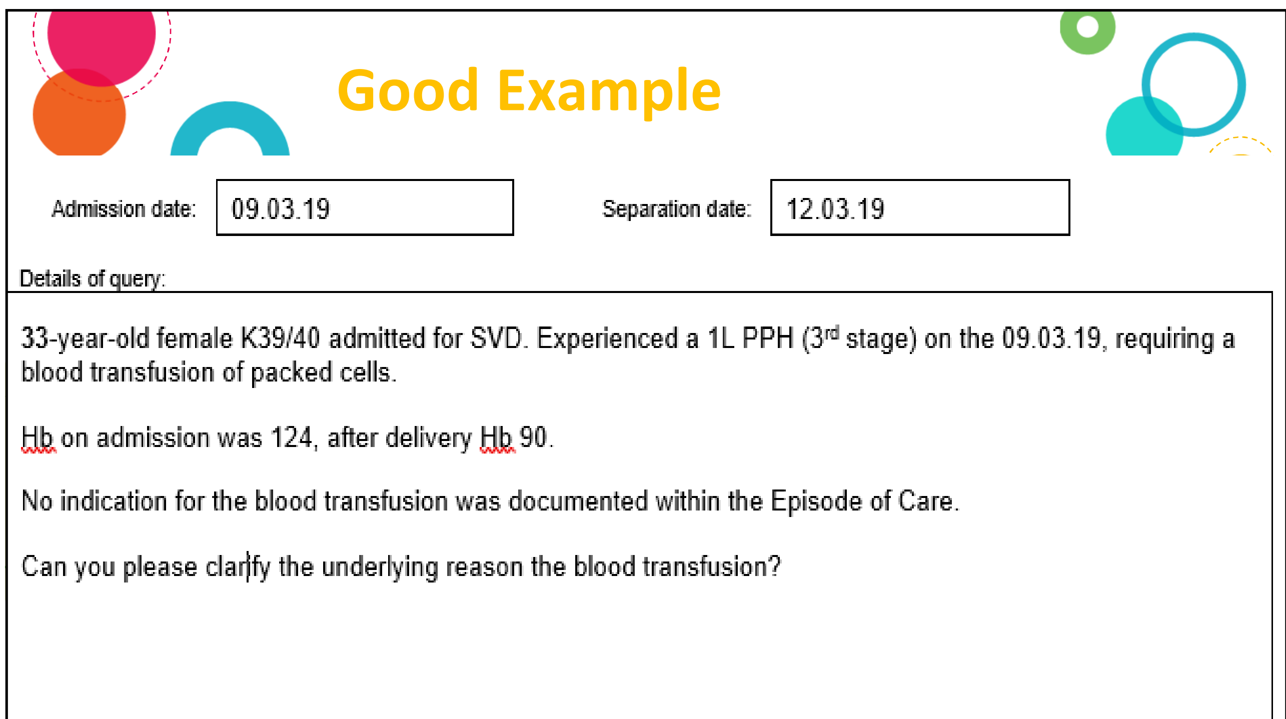

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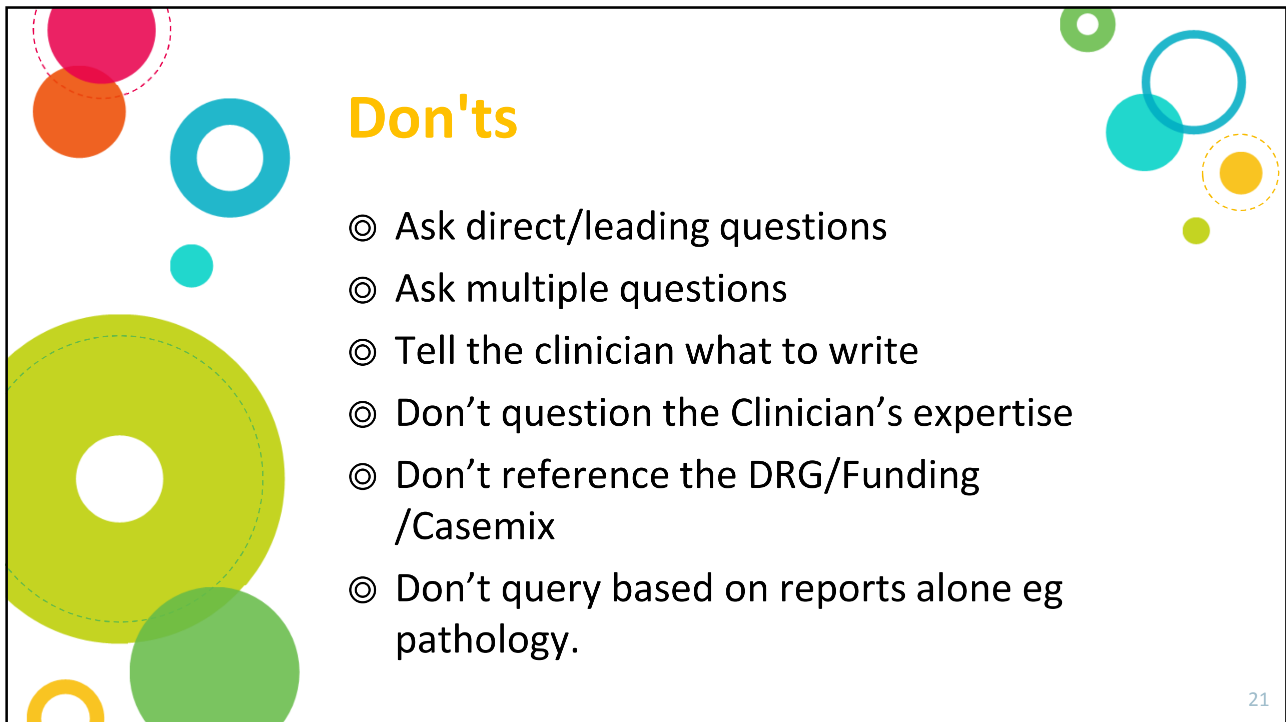

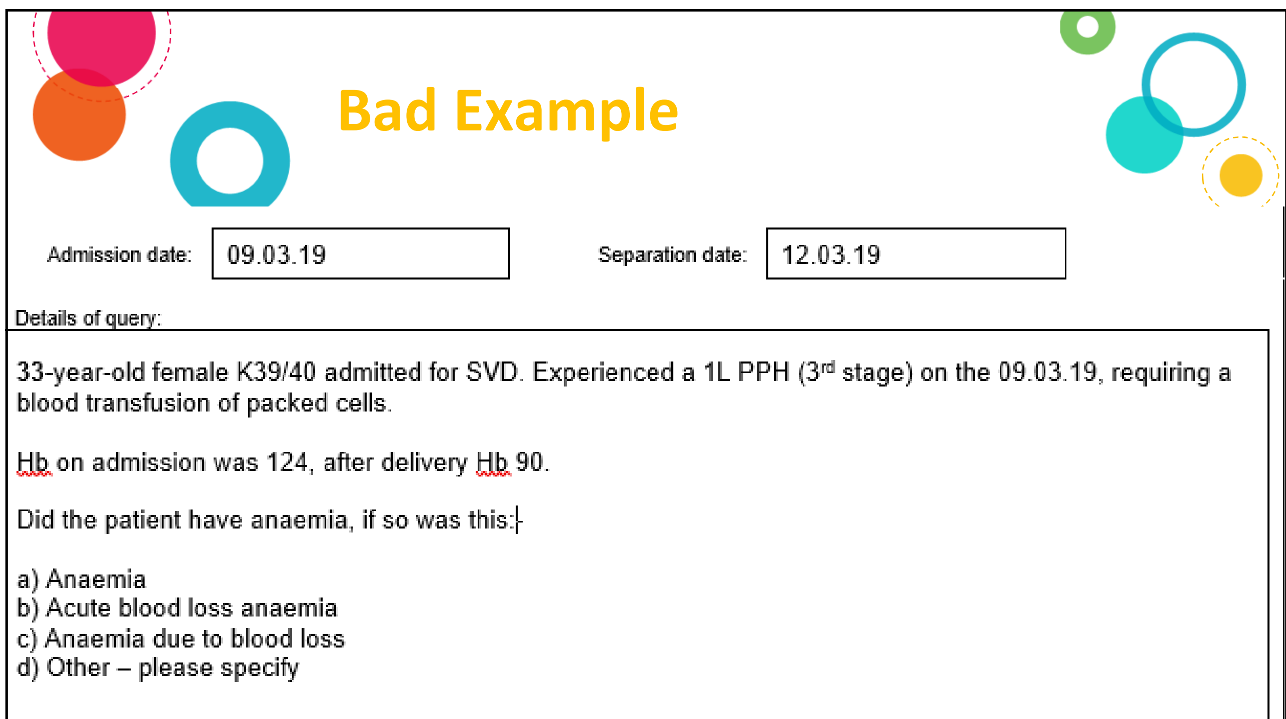

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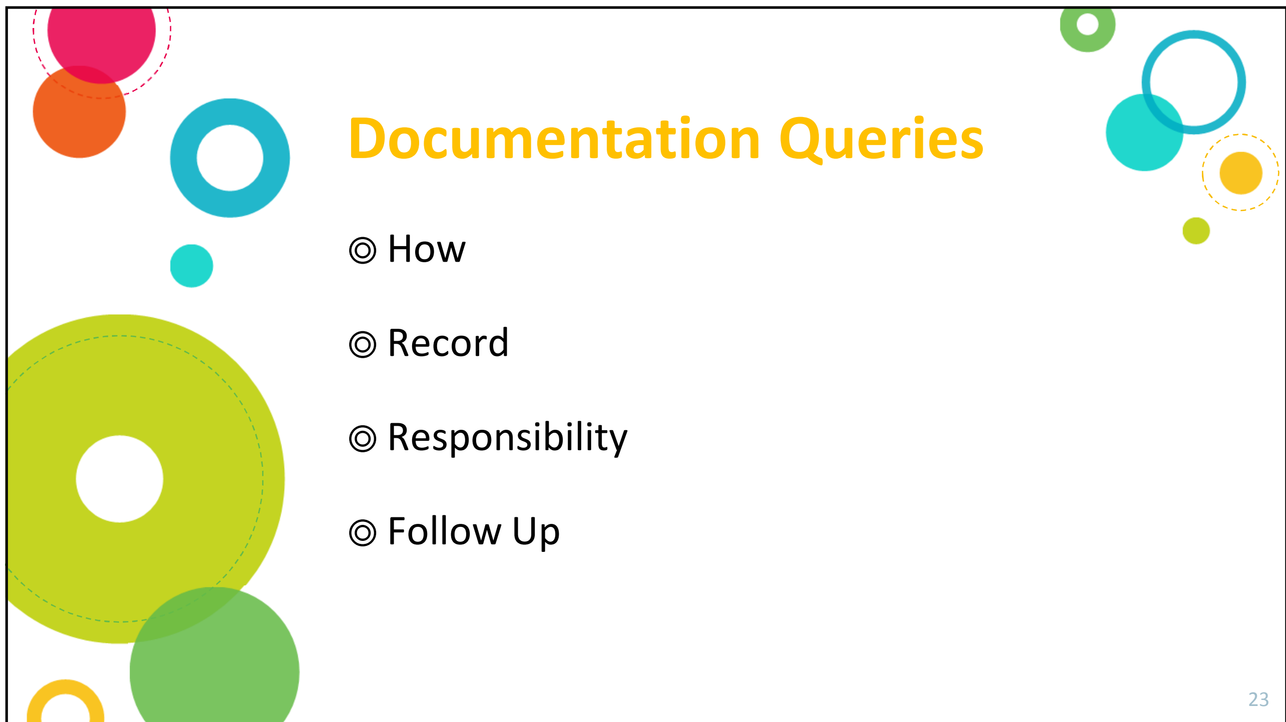

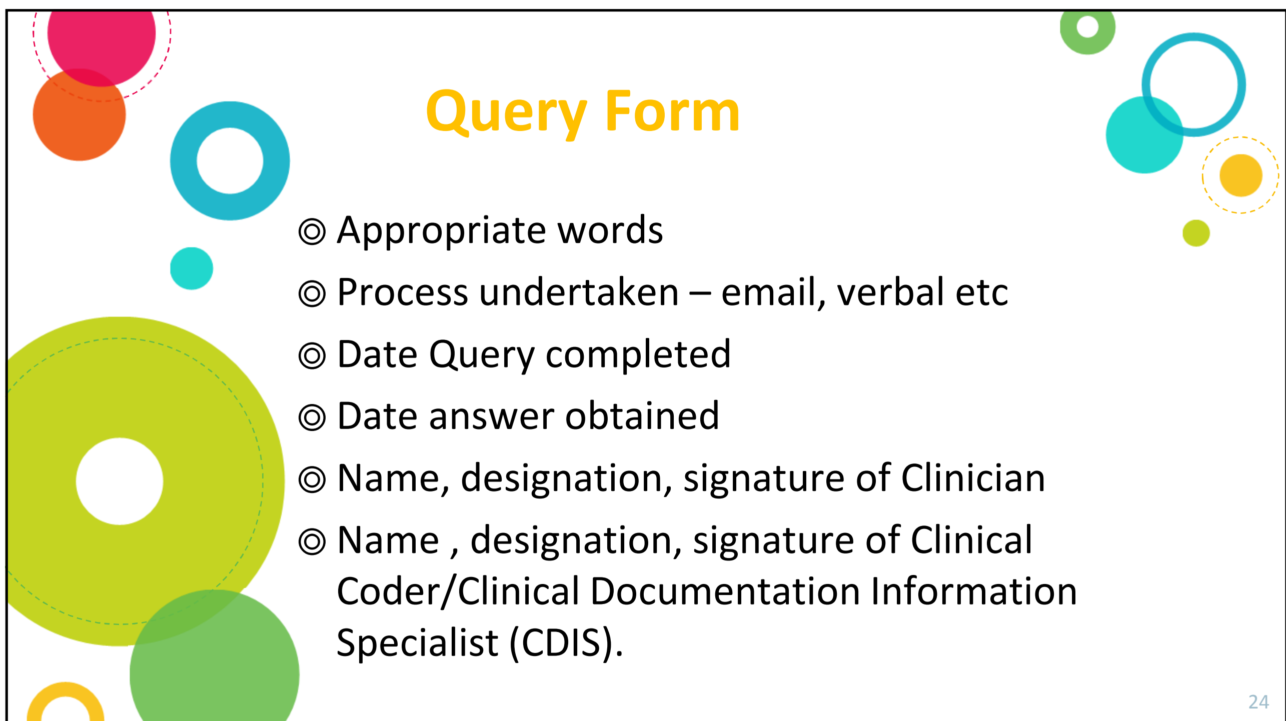

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Test Results and Medication Charts

- Shorthand (including copy and paste) is now commonly used in EHR.
- Shorthand not to be used in isolation - this may include abbreviations and symbols.

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Findings that provide more specificity about a diagnosis

X-ray, pathology and other diagnostic results should be coded when they clearly add specificity to already documented conditions that meet ACS 0001 or ACS 0002.

Example

N20.1 Calculus of ureter where documentation states renal colic and ultrasound shows VUJ stone.

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Findings with unclear, or no associated condition documented

Unless a Clinician can indicate a test result is significant and/or indicates the relationship between the unclear test result and a condition it should not be coded.

Example

K57.30 Diverticulosis of large intestine without perf, abscess, haem on an Abdominal CT Report in the case of Appendicitis.

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Impending or threatened condition

If the Threatened/Impending condition is documented but did not eventuate during the current EOC, refer to the Alphabetic Index to see if the condition is Indexed under the Lead Term *Threatened* or *Impending*

- If listed assign the code
- If not listed, do not code the condition

Example:

Admission for Impending gangrene – No index look up for Impending , gangrene, therefore condition not coded.

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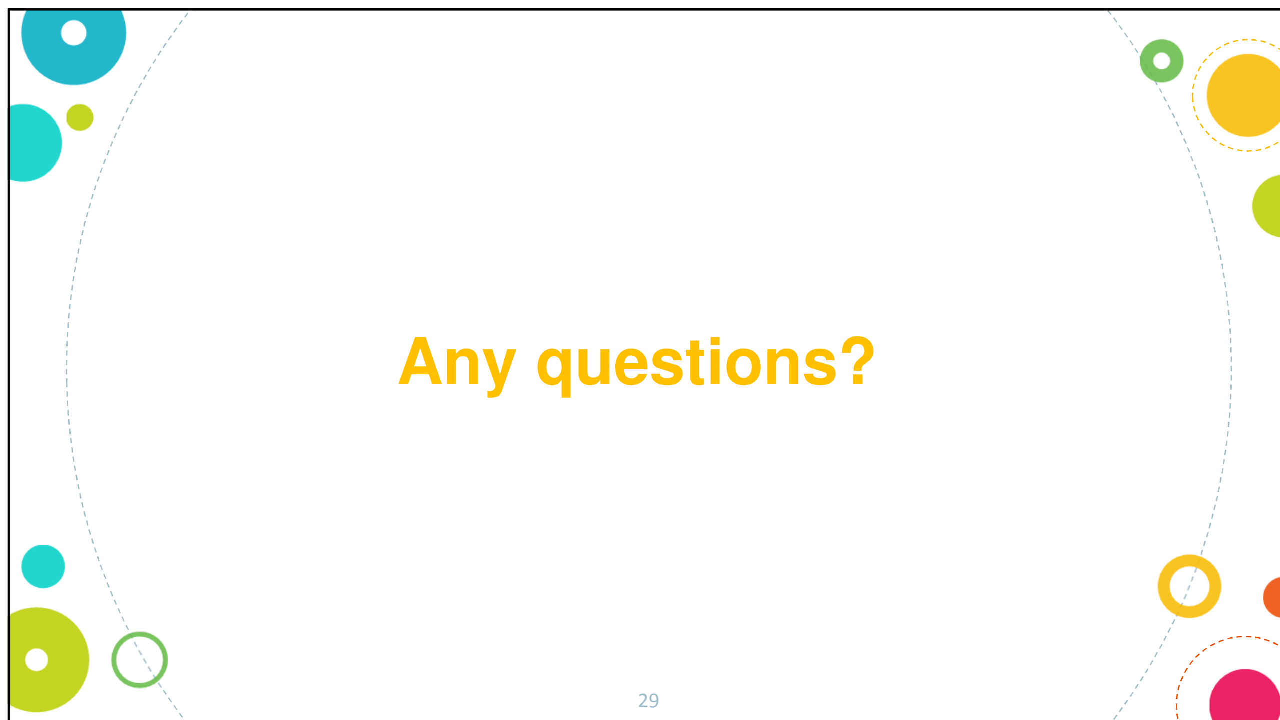

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