Clarification on the application of the "Standards for ethical conduct in clinical coding"

Background

The *Standards for ethical conduct in clinical coding* (formerly the Code of ethics for clinical coders) is a framework that defines and promotes ethical practices associated with clinical coding. Their primary purpose is to support clinical coders and others involved in the documentation clarification process (e.g. clinicians and clinical documentation improvement specialists) by setting out guidelines around ethical behaviours when undertaking the coding process, ultimately producing national consistency in coding practice.

These guidelines have been an appendix to the Australian Coding Standards (ACS) since First Edition (1998). While they were updated at the time Second Edition was released (2000), they remained largely unchanged until they were revised and published on the Australian Consortium for Classification Development (ACCD) website ahead of the implementation of the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (ICD-10-AM)/Australian Classification of Health Interventions (ACHI)/ACS Tenth Edition (on 1 July 2017),

The *Standards for ethical conduct in clinical coding* are standards of conduct, not coding standards and should not be interpreted as such. They are an adjunct to the ACS and are not to be used as a basis for coding audits. Health services should read the *Standards for ethical conduct in clinical coding* in conjunction with this clarification document to facilitate improvements in clinical coding practice. They can also be used as general information to other stakeholders involved in the review of coded data.

Revision

The guidelines were revised by ACCD during the development of the Tenth Edition of ICD-10-AM/ACHI/ACS. This revision was undertaken at the request of the ICD Technical Group (ITG) members who expressed concern that clinical coders were under pressure (particularly in an activity based funding environment) to achieve 'better' Diagnosis Related Group (DRG) outcomes for financial reimbursement. It was purported that clinical coders were asking clinicians 'targeted' or 'leading questions' in order to achieve this outcome. There was also concern that this practice was leading to over coding of certain clinical conditions, including the questionable coding of some conditions as procedural complications to achieve a higher complexity DRG with resultant implications for data quality. Revising the guidelines was a way of addressing this issue.

Another objective for the revision was to make the guidelines more explicit with respect to appropriate use of the interdisciplinary engagement process and the use of clinician queries for the purpose of clarifying diagnostic and/or intervention detail or ambiguity in clinical documentation.

Intent

The intention of the revision of these guidelines has been to:

- strengthen and clarify the wording
- provide examples of behaviours that the national and international clinical coding profession would normally consider to be ethical versus unethical.
- ensure that all stakeholders involved in the coding process are aware of the importance of ethical practice in clinical coding and its supporting processes.

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The *Standards for ethical conduct in clinical coding* are not meant to replace incentives and processes developed within health services to improve clinical documentation and above all ensure quality clinical care. The guidelines should be used by healthcare facilities to support the clinician query process, and the revision clarified how this process can be achieved ethically.

Ethical clinician queries

An overarching principle articulated in the Introduction to the ACS is that analysis of the entire clinical record is required before code assignment and that clinical coders should seek more information if a clinical record is deemed to be inadequate for complete and accurate code assignment.

Coding queries to clinicians should be written so that they:

- include information about the patient, with direct reference to the documentation that has prompted the query
- enhance the clinical truth of the documentation to support quality patient care
- allow clinicians to elaborate (add context) to their response regarding the significance and cause of the diagnosis/condition/event
- do not include leading questions that instruct, or indicate to a clinician what to write as a response
- do not indicate potential financial impact.

Example 1 shows a scenario where a clinician query was initiated because treatment was commenced for which a diagnosis was not documented. Reference to decreased air entry in the background to the query allows the clinician to have all pertinent information at hand when responding. The query also allows the clinician to elaborate as to the cause of the condition/event (if any).

Example 1
Patient underwent total knee replacement on 11/8/2016. Patient noted to have decreased air entry (AE) to both bases by doctor (progress note 12/08/2016 at 2145hrs). There is documentation of ↓ AE by physiotherapist on 13/08/2016 at 0850hrs with cough/breathing exercises and TriFlo (spirometry) commenced.
Ethical query
What condition, if any, caused the decreased air entry and was being treated by the cough/breathing exercises and TriFlo?

Example 2 demonstrates that in some instances, it makes sense for the coder to ask a 'Yes/No' or use a multiple choice format, but this must include the provision for the clinician to elaborate or add context around the response. This will preclude the coding of conditions incorrectly or inappropriately. For example, coding a condition as a post procedural complication when it clearly is a condition that commonly occurs during or following an intervention.

<table>
<tr><th colspan="2">Example 2</th></tr>
<tr><td colspan="2">Patient underwent an appendicectomy under general anaesthetic (GA) on 20/9/2016.

During the intervention, the anaesthetist adjusted the anaesthetic in response to the patient's blood pressure dropping. Apart from the anaesthetic report documentation, there was no other mention of the drop in blood pressure within the episode of care.</td></tr>
<tr><th>Ethical query</th><th>Ethical query</th></tr>
<tr><td>Was the patient's drop in blood pressure an unexpected occurrence?
If yes, is this:
• a diagnosis of hypotension?
• simply a low blood pressure reading?
• a complication of the anaesthetic?

Please tick as many that apply.</td><td>Did the patient have hypotension?

If so, is this:
• a complication of the anaesthetic?
• a routine part of the management of the anaesthetic?</td></tr>
</table>

Ethical use of the interdisciplinary engagement process for pathology/radiology test results

Abnormal pathology/radiology test results as a basis for a query to a clinician are ethical when supported by other documentation in the clinical record (electronic or paper based). This may include, but is not limited to, documentation of the need to repeat tests, progress notes indicating intent to monitor a result, or administration of treatment in the medication chart.

Coding from test results or medication charts that are not qualified within the episode of care is not good coding practice. For example:

- Drugs are often used for various conditions, or may be used as a prophylactic measure.
- A test result that is not within the normal range does not necessarily mean that the patient has an abnormal condition. That test result may be normal for that particular patient.

It is not the role of a clinical coder to diagnose. The responsibility for good clinical documentation lies with the clinician. Good clinical documentation is critical to continuity and quality of patient care, patient safety and is the legal record of a patient's episode of care. Importantly it also supports quality coded data that has multiple use cases, including reimbursement and funding.

Therefore, documentation (electronic or paper based) of the administration of a drug from the medication chart; or a microbiology test result which is not qualified within the clinical record is not enough information for clinical coders to perform the coding function. In these instances, the documentation issues may be clarified with the clinician.

In **Example 3**, a query was initiated because of commencement of a new medication for which no indication was documented. Reference to the pathology results in the background to the query allows the clinician to have all pertinent information at hand when responding.

Example 3
Patient was admitted for laparoscopic appendectomy for acute appendicitis. The patient commenced new medication of Slow K on 3/4, as documented on the medication chart by the clinician. Pathology results from the 1/4, 2/4, 3/4 and 4/4 show K+3.1, K+3.1, K+3.4 and K+3.5 respectively.
Ethical query Why was the patient commenced on Slow K?

In **Example 4** a query was initiated because a blood transfusion was given for which no indication was documented. Reference to the pathology result in the background to the query assists the clinician to provide an informed response

Example 4
Pathology result indicates Hb of 98 prior to a transfusion being given but neither the progress notes or blood transfusion form indicates a reason for the transfusion.
Ethical query Why was the patient given a blood transfusion?

Other points of clarification

The following points of clarification should be noted:

- The date of the release of the *Standards for ethical conduct in clinical coding* has been removed from the ACCD website. As an adjunct to the ACS, this document is always relevant and therefore does not have an implementation date.
- Perceived inconsistencies between the *Standards for ethical conduct in clinical coding* slides presented at the 2016 HIMAA and National Centre for Classification in Health (NCCH) National Conference and those available as part of the ICD-10-AM/ACHI/ACS Tenth Edition Education Modules will be revised to clarify that a clinician query may be sent on the basis of inadequate documentation in any part of the clinical record, including:
    - progress notes
    - consultation requests/reports
    - operation reports
    - anaesthetic reports
    - wound management charts
    - orders for tests and treatment (including medication charts).
- The *Standards for ethical conduct in clinical coding* contain specific guidelines with respect to appropriate use of clinician queries, specifically those sent to clarify existing or missing documentation to support quality documentation and accurate coded data (optimisation) versus those motivated by financial gain (maximisation). Requesting clarification as to the type of pneumonia, for example, rather than coding pneumonia not otherwise specified (NOS) is regarded as optimisation. Optimisation is a process which uses all the documentation within the clinical record to achieve the best outcome and the clinician's response becomes part of the clinical record.
- A clinician query may be sent to 'clarify' existing documentation for any unspecified or ill-defined diagnosis However it is appropriate to assign unspecified and not otherwise specified categories

within ICD-10-AM when documentation as to the specificity of a condition is unavailable or not known.

- The example in the ICD-10-AM/ACHI/ACS Tenth Edition Education Modules which incorrectly implies the drug Resonium may be used to treat hypokalaemia will be amended.
- The ICD-10-AM/ACHI/ACS Tenth Edition Education provided on the ACCD website will be updated to reflect these points of clarification and further education will be provided by ACCD at the HIMAA and NCCH National Conference, 1 – 3 November 2017 in Cairns.
- The Independent Hospital Pricing Authority, in consultation with ACCD, the Health Information Management Association of Australia (HIMAA) and the Clinical Coders Society of Australia (CCSA), will determine where the *Standards for ethical conduct in clinical coding* should reside going forward
- The *Standards for ethical conduct in clinical coding* may need to be refined in light of advances in clinical information systems, such as the Electronic Health Record.