Ex 491

QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF MEEGAN SNELL

1. I, Meegan Snell, Principal Data Quality and Standards Officer, Data Services Unit, Health Information Branch, Queensland Health c/o Queensland Health Building 147-163 Charlotte Street, Brisbane in the State of Queensland acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

3. I am the Principal Data Quality and Standards Officer in the Data Services Unit (**DSU**) at Queensland Health. I have been in this position since April 2003. Attached and marked:

   - **MS-1** is a copy of my current curriculum vitae; and

   - **MS-2** is a copy of my position description.

Medical Records Coding

4. All Queensland public hospitals have coded information contained in patients' medical records and provided it to the DSU since the early 1990's. Prior to this time, various arrangements were in place in regard to the coding of data, for example, some episodes were coded centrally in corporate office and even before this, the Australian Bureau of Statistics were responsible for the collection of coded data.

5. Principally, Queensland Health codes medical records to capture the reason(s) that patients are in hospital and the treatment that they receive. There are a number of purposes for the use of coded data, these include:

   - to facilitate the planning of health services;

   - for epidemiological purposes;

- for research purposes;
- for performance management / benchmarking;
- for resource allocation;
- to some extent for funding purposes;
- to comply with the Australian Healthcare Agreement which requires Queensland Health to provide certain information to the Commonwealth.

6. Medical records coding (**Coding**) at Queensland Health hospitals is generally done locally in the medical records department of the hospital at which the patient was treated. However, at some remote hospitals Coding is done at the base hospital. Coding is done by either a Clinical Coder or Health Information Manager (collectively the **Coder**) depending on the individual hospital.

7. Medical records at all Queensland Health hospitals are coded in accordance with The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (**ICD-10-AM**). The current edition of ICD-10-AM is the fourth edition dated 1 July 2004.

8. ICD-10AM is a modification of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (**ICD-10**) which was published by the World Health Organisation. ICD-10 was modified for use in Australia so that its content was appropriate for clinical practice in Australia.

9. ICD-10-AM consists of five volumes: Volume 1 – Tabular List of Diseases; Volume 2 – Alphabetic Index of Diseases; Volume 3 – Tabular List of Procedures; Volume 4 – Alphabetic Index of Procedures and Volume 5 – Australian Coding Standards.

10. The Australian Coding Standards which are contained in Volume 5 of ICD-10—AM apply to all hospitals (public and private) in Australia. Attached and marked **MS-3** is an extract from the Australian Coding Standards.

11. The Australian Coding Standards provide that:

    - *"a classification of diseases can be defined as a system of categories to which morbid entities are assigned according to established criteria"* (at page 1);
    - *"the purpose of the ICD-10-AM is to permit the systematic recording, analysis, interpretation and comparison of morbidity data collected in different hospitals, states and countries"* (at page 1);
    - *"the ICD-10-AM system enables the translation of diagnosis and procedures and other health problems from words into a alphanumeric code, which permits easy storage, retrieval and analysis of the data"* (at page 1);

- *"the clinical record should be the primary source for the coding of inpatient morbidity data"* (at page 1);
- *"the listing of diagnoses on the front sheet of the clinical record is the responsibility of the clinician"* (at page 5);
- *"it is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet (or a copy of the same) but that analysis of the entire clinical record is performed before code assignment"* (at page 1);
- *"before coding any diagnosis / procedure recorded, the clinical coder must* ***verify*** *information recorded on the front sheet by reviewing the pertinent documents in the body of the clinical record"* (at page 5);
- *"if a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician"* (at page 1);
- *"It is important to seek clinical advice where necessary for:*
  - *verification of diagnoses recorded on the front sheet which are not supported in the clinical record;* ***and***
  - *clarification of discrepancies between investigation results and clinical documentation"* (at page 5).

12. Attached and marked:

- **MS-4** is a copy of Appendix B to the Australian Coding Standards which sets out Basic Coding Guidelines;
- **MS-5** is a copy of Appendix C to the Australian Coding Standards which sets out the Code of Ethics for Clinical Coders; and
- **MS-6** is a copy of Appendix D to the Australian Coding Standards which sets out the Clinical Coders' Creed.

13. Coding occurs once a patient has been discharged. Codes are allocated according to the Australian Coding Standards. As indicated above, it is the responsibility of the Coder to review not only the front sheet of the medical record but the whole medical record including progress notes, investigations, pathology reports, x-rays etc when coding a medical record.

14. Once a medical record has been coded the codes are entered into the Hospital Based Corporate Information System (**HBCIS**) database. There is no limit to the number of codes which can be entered for a particular episode of care.

15. Thirty-five days after the end of each month hospitals are required to extract data from HBCIS and submit it to the Data Services Unit. This data forms the Queensland Hospital Admitted Patient Data Collection. This data is then

validated. The validation process involves a computer program identifying the logical inconsistencies contained in the data. A report in relation to the inconsistencies is forwarded to the individual hospitals so that they can correct any errors in their data. The data collected by Coders is available at all times at the local level.

16. Coders need to understand medical terminology and disease processes as well as the ICD-10-AM classification in order to code accurately. However, a Coder can only code conditions and procedures that are documented in the record. It is not the job of a Coder to 'diagnose' a patient's condition. All codes allocated to a patient are reflective of the actual documentation in the chart. If a Coder believes that the documentation is deficient or has difficulty in the application of a specific code then clinical clarification should be sought from the clinician. The development of the Australian Coding Standards and the structure of the classification should result in the standardised application of all diagnoses and procedures.

17. In Queensland, Coders also have access to the Queensland Coding Committee (**QCC**). I am the Chairperson of the QCC. The QCC is *"a statewide forum for the resolution of queries related to Australian coding standards, clinical coding, edits and grouping"*. Therefore, if a Coder has a Coding query they can direct it to the QCC for advice.

18. Furthermore, pursuant to the two year Clinical Classification Management Project two clinical classification auditors / educators are in the process of visiting most Queensland public hospitals to audit their Coding and to educate Coders to improve the quality of Coding performed.

Signed at Brisbane on 10 August 2005.

[redacted] ....

Meegan Snell
Data Quality and Standards Officer,
Data Services Unit, Health Information Branch
Queensland Health

Bundaberg Hospital Commission of Inquiry

Statement of Meegan Snell

Attachment MS-1

Personal information removed at request of individual.

Personal information removed at request of individual.

Bundaberg Hospital Commission of Inquiry

Statement of Meegan Snell

Attachment MS-2

QUEENSLAND HEALTH

CORPORATE OFFICE

POSITION DESCRIPTION

1.	**Position Number:**	24868
	Position Title:	Principal Data Quality & Standards Officer
	Unit/Branch/Division:	Data Services Health Information Centre Information and Business Management Branch Policy and Outcomes Division
	Location:	Brisbane
	Classification Level:	AO7
2.	**Reports to**	Data Services Unit Manager Health Information Centre
3.	**Date of Review:**	July 2005
4.	**Delegates Authorisation:**	Sue Cornes Deputy Manager, Health Information Centre

/ /2000

5. Purpose of the Position

To manage the support and enhancement of the equality and management of information in Queensland Health data collections.

To manage the development and monitoring of comprehensive programs of data quality improvement.

To manage the provision of education and support in relation to data definitions, standards, clinical coding and data quality improvement.

To provide expert advice on data definition, collection, processing, clinical coding and related matters.

6. Organisational Environment and Reporting Relationships

Information and Business Management Branch is one of three branches accountable to the Deputy Director-General [Policy and Outcomes]. The Branch has a prime focus to provide for compliance with corporate governance requirements and leadership for business reforms throughout Queensland Health with a strong emphasis on corporate information and business management priorities. These services are provided through the following speciality areas located in the Corporate Office in Queensland Health.

- Asset Management
- Corporate Support Services
- Finance
- Purchasing & Logistics
- Information Management Strategy
- Health Information Centre

Role of the Organisational Unit

The Health Information Centre provides a centralised and client focused information collection and data retrieval facility for the processing and dissemination of corporate and other health data to internal and external clients of the Department. The Centre offers a central reference service for information enquiries, Library services and conducts valued-added statistical and epidemiological analysis.

The position is currently located in Corporate Office, Queensland Health Building 147 – 163 Charlotte Street, Brisbane.

Supervises

Organisational Chart

An organisational chart is attached.

7. Primary Duties

7.1 Manage the development of data definitions and standards and facilitate the consistent application of these definitions and standards in Queensland Health data collections.

7.2 Manage the review of identified systems to ensure adequate standards of integrity and the development and monitoring of comprehensive programs of data quality improvement.

7.3 Manage the development and maintenance of the state data dictionary.

7.4 Manage the organisation and/or development of education and support programs in relation to data definitions, standards, clinical coding and data definition, classification and standards

7.5 Represent Queensland Health on national, State, interdepartmental and professional committees in relation to issues of data definition, classification and standards.

7.6 Provide expert technical advice on data definition, collection, processing, clinical coding and related matters.

7.7 Manage negotiations and liaison with suppliers and software vendors regarding requirements for data collections conducted within the Data Services Unit.

7.8 Manage the organisation and/or development of documentation and specifications in relation ta data collections conducted within the Data Services Unit.

7.9 Supervise and manage staff in line with quality human resource management practices with particular reference to employment equity, anti-discrimination, occupational health and safety, and ethical behaviour.

8. Selection Criteria

Your application for this position must specifically address each of the selection criteria listed below. It should also contain the names and telephone numbers of at least two referees, one preferably your current supervisor, who may be contacted with respect to your application. Shortlisting and selection will be based upon these selection criteria.

		Weighting
SC1	Demonstrated high level of knowledge and skills in managing the development and implementation of data definitions, classifications and standards, relating to data collections.	10
SC2	Demonstrated skills in managing the provision of education and support and the development of documentation and specifications in relation to data definitions, standards, clinical coding and data quality improvement.	10
SC3	Demonstrated ability to identify and analyse complex problems, develop and implement remedial strategies and exercise initiative and responsibility.	9
SC4	Demonstrated high level of interpersonal skills in communication, consultation, and negotiation particularly with respect to highly sensitive and confidential data.	8
SC5	Demonstrated high level of ability in the preparation and critical examination of papers, reports and publications.	8
SC6	Demonstrate ability to lead and direct staff.	9
SC7	Demonstrated ability to supervise and manage staff in line with quality human resource management practices including employment equity, anti-discrimination occupational health and safety and equitable behaviour.	7

Bundaberg Hospital Commission of Inquiry

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Attachment MS-3

INTRODUCTION

The *Australian Coding Standards for the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification* (ICD-10-AM) apply to all public and private hospitals in Australia. It is anticipated that revisions will be made on a regular basis and that further editions will follow. The ongoing revision of the *Australian Coding Standards* will ensure that they reflect changes in clinical practice, clinical classification amendments, Australian Refined Diagnosis Related Groups (AR-DRG) grouper updates and various user requirements of inpatient data collections.

These clinical coding standards have been written with the basic objective of satisfying sound coding convention according to ICD-10-AM. Consideration of the various uses of inpatient data collections was secondary. Issues such as DRG allocation, research and planning aims were considered only after the requirement for accurate ICD-10-AM coding was satisfied.

The level of detail in the standards reflects the assumption that users of the document will have had training in abstracting relevant information from clinical records and in the use of ICD-10-AM. It is assumed that coders are aware of and follow ICD-10-AM rules.

The clinical record should be the primary source for the coding of inpatient morbidity data. Accurate coding is possible only after access to consistent and complete clinical information. Without good documentation, coding guidelines are difficult, if not impossible, to apply. It is assumed that coding decisions are not made solely based on information provided on the clinical record front sheet (or a copy of same) but that analysis of the entire clinical record is performed before code assignment.

If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. When a diagnosis is recorded for which there is no supporting documentation in the body of the clinical record, it may be necessary to consult with the clinician before assigning a code.

Sometimes reference to the appropriate section of ICD-10-AM will be enough to explain to a clinician what is required for both diagnosis and procedure descriptions. If this action is unsuccessful, the hospital management should be informed of the inadequacy of clinical record documentation and the resultant effect on the hospital's inpatient data.

The responsibility for recording accurate diagnoses and procedures, in particular principal diagnosis, lies with the clinician, not the clinical coder.

A joint effort between the clinician and clinical coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

DESCRIPTION OF THE INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS – TENTH REVISION – AUSTRALIAN MODIFICATION

A classification of diseases can be defined as a system of categories to which morbid entities are assigned according to established criteria. The purpose of the ICD-10-AM is to permit the systematic recording, analysis, interpretation and comparison of morbidity data collected in different hospitals, states and countries. The ICD-10-AM system enables the translation of diagnoses and procedures and other health problems from words into an alphanumeric code, which permits easy storage, retrieval and analysis of the data.

The 'ICD' was first used to classify causes of mortality as recorded at the registration of death. Later, its scope was extended to include diagnoses in morbidity. It is important to note that although the ICD is primarily designed for the classification of diseases and injuries with a formal diagnosis, not every problem or reason for coming into contact with health services can be categorised in this way. Consequently, the ICD provides for a wide variety of signs, symptoms, abnormal findings, complaints and social circumstances that may stand in place of a diagnosis.

Basic structure and principles of disease classification of ICD-10-AM

The 'core' disease classification of ICD-10-AM is the three character code, which is the mandatory level of coding for international reporting to the World Health Organization (WHO) for general international comparisons. This core set of codes has been expanded to four and five character codes so that important specific disease entities can be identified, while also maintaining the ability to present data in broad groups to enable useful and understandable information to be obtained.

The ICD-10-AM is a variable-axis classification. Its structure is designed principally to facilitate epidemiological analysis. Diseases are organised in the following groups:

- epidemic diseases
- constitutional or general diseases
- local disease arranged by site
- developmental diseases
- injuries

The first two, and the last two, of these groups comprise 'special groups', which bring together conditions that would be inconveniently arranged for epidemiological study were they to be scattered, for instance, in a classification arranged primarily by anatomical site. The remaining group, 'local disease arranged by site', includes the ICD-10-AM chapters for each of the main body systems.

The distinction between the 'special groups' chapters and the 'body systems' chapters has practical implications for understanding the structure of the classification, for coding to it, and for interpreting statistics based on it. It has to be remembered that, in general, conditions are primarily classified to one of the 'special groups' chapters. Where there is any doubt as to where a condition should be positioned, the 'special groups' chapters take priority.

Volume 1 – Tabular diseases

Most of Volume 1 is taken up with the main disease classification composed of 21 chapters. The first character of the ICD-10-AM code is a letter, and each letter is associated with a particular chapter, except for the letter D, which spans both Chapter II *Neoplasms*, and Chapter III *Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism*, and the letter H, which is used in both Chapter VII *Diseases of the eye and adnexa* and Chapter VIII *Diseases of the ear and mastoid process*. Four chapters (Chapter I, II, XIX and XX) use more than one letter in the first position of their codes.

WHO intends the codes U00–U99 to be used for provisional assignment of new diseases of uncertain aetiology and for specific research purposes. U50–U71 are used in ICD-10-AM to classify sporting activities previously classified to Y93.0 *Activity, While engaged in sports*.

The chapters and corresponding letters and group type are listed below:

Chapter	Chapter title	Code prefix	Type
Chapter I	*Certain infectious and parasitic diseases*	A, B	Special
Chapter II	*Neoplasms*	C, D	Special
Chapter III	*Diseases of the blood and blood-forming organs…*	D	By site
Chapter IV	*Endocrine, nutritional and metabolic diseases*	E	By site
Chapter V	*Mental and behavioural disorders*	F	By site
Chapter VI	*Diseases of the nervous system*	G	By site
Chapter VII	*Diseases of the eye and adnexa*	H	By site
Chapter VIII	*Diseases of the ear and mastoid process*	H	By site
Chapter IX	*Diseases of the circulatory system*	I	By site
Chapter X	*Diseases of the respiratory system*	J	By site
Chapter XI	*Diseases of the digestive system*	K	By site
Chapter XII	*Diseases of the skin and subcutaneous tissue*	L	By site
Chapter XIII	*Diseases of the musculoskeletal system…*	M	By site
Chapter XIV	*Diseases of the genitourinary system*	N	By site

Chapter	Chapter title	Code prefix	Type
Chapter XV	*Pregnancy, childbirth and the puerperium*	O	Special
Chapter XVI	*Certain conditions originating in the perinatal per…*	P	Special
Chapter XVII	*Congenital malformations, deformations…*	Q	Special
Chapter XVIII	*Symptoms, signs and abnormal clinical and lab…*	R	N/A
Chapter XIX	*Injury, poisoning and certain other…*	S, T	Special
Chapter XX	*External causes of morbidity and mortality*	U, V, W, X, Y	N/A
Chapter XXI	*Factors influencing health status…*	Z	N/A

The chapters are subdivided into homogeneous 'blocks' of three character categories. In Chapter I *Certain infectious and parasitic diseases*, the block titles reflect two axes of classification – mode of transmission and broad groups of infecting organisms. In Chapter II *Neoplasms*, the first axis is the behaviour of the neoplasm; within behaviour, the axis is mainly by site, although a few three character categories are provided for important morphological types (eg leukaemias, lymphomas, melanomas, mesotheliomas, Kaposi sarcoma). The range of categories is given in parentheses after each block title.

Within each block, some of the three character categories are for single conditions, selected because of their frequency, severity or susceptibility to public health intervention, while others are for groups of diseases with some common characteristics. There is usually provision for 'other' conditions to be classified, allowing many different but rarer conditions, as well as 'unspecified' conditions, to be included.

Basic structure and principles of procedure classification of ICD-10-AM

The procedure classification of ICD-10-AM (ACHI) was developed by the NCCH and is based on the Commonwealth Medicare Benefits Schedule (MBS). The main features of the classification are:

1. A seven character code in the format xxxxx-xx. The first five characters represent the MBS item number and the last two characters were allocated for each new procedural concept derived from the MBS item description.
2. A hierarchical structure with the following axes:
   - First level – anatomical site
   - Second level – procedure type
   - Third level – procedure description
3. Inclusion of many more procedures which can be utilised in noninstitutional settings, such as community based health and ambulatory care.

For further information about the procedure classification see ICD-10-AM, Volumes 3 and 4.

ICD-10-AM AND THE AUSTRALIAN CODING STANDARDS

The ICD-10-AM coding manual is updated biennially in Australia. *The Australian Coding Standards* are designed to be used in conjunction with ICD-10-AM Volumes 1–4.

The Australian Standard is that all hospitals should update biennially to the latest version of ICD-10-AM and that the new version should be in use no later than 1 July of the publication year.

The ICD-10-AM Disease and Procedure Tabular Lists (Volumes 1 and 3) includes an annotation of ▼ next to certain codes which indicates that an *Australian Coding Standard* exists which will assist in the application of the code.

HOW TO USE THIS DOCUMENT

Standards in this document are categorised by site and/or system according to the specialty to which the diagnosis or procedure relates.

For example, the standard on 'gastroenteritis' is in Chapter XI, *Digestive System*, even though the standard includes discussion of code A09 *Diarrhoea and gastroenteritis of presumed infectious origin* which appears in Chapter I, *Certain infectious and parasitic diseases* of the Disease Tabular List of ICD-10-AM (Volume 1).

Operations and procedures are also categorised by site. For example, 'tonsillitis' is discussed in Chapter VIII, *Ear, Nose, Mouth and Throat* (ENMT). Any procedures which can be performed on many sites are included in the 'Procedures' chapter on pages 28–56.

A procedure which involves adjacent sites is categorised into one of the two applicable chapters and should be referenced in the index in the first instance. For example, 'Skull base surgery' involves ENT, plastic and neurosurgeons and is discussed in Chapter VI, *Nervous System*.

The term 'clinician' is used throughout the document and refers to the treating medical officer but may refer to other clinicians such as midwives, nurses and allied health professionals. In order to assign a code associated with a particular clinician's documentation, the documented information must be appropriate to the clinician's discipline.

Numbering system of standard within chapters

Each standard is allocated a four digit ACS number. These numbers are generated by the NCCH as new standards are created and entered into a central database. The number is unique for each standard. When a standard is deleted, the standard and its unique number is retained in the database to allow for time series analysis of coding convention.

The numbers should be used as an identifier if clinical coders wish to contact the NCCH about a particular standard.

Alphabetic index

The alphabetic index refers clinical coders to particular standard numbers and the page on which they appear within this volume.

GENERAL STANDARDS FOR DISEASES

0010 GENERAL ABSTRACTION GUIDELINES

The listing of diagnoses on the front sheet of the clinical record is the responsibility of the clinician. Before coding any diagnosis/procedure recorded, the clinical coder must verify information recorded on the front sheet by reviewing pertinent documents in the body of the clinical record.

In the event that an **investigation result varies from the clinical documentation**, such as a clinical diagnosis of gastric ulcer with 'no evidence of ulcer' reported on histopathology, the case should be referred to the clinician. Although investigation results are critical in the coding process, there are some diseases which are not always confirmed on investigation.

For example, Crohn's disease is not always confirmed on biopsy.

It is important to seek clinical advice where necessary for:

- verification of diagnoses recorded on the front sheet which are not supported in the clinical record, **and**
- clarification of discrepancies between investigation results and clinical documentation.

EXAMPLE 1:

The clinician has recorded on the front sheet a principal diagnosis of fractured neck of femur. Additional diagnoses recorded on the front sheet are pneumonia and duodenal ulcer. Examination of the clinical progress notes revealed that the patient had been hospitalised six months previously for pneumonia and has a healed duodenal ulcer. Only the fractured neck of femur is coded with an appropriate external cause code assigned because neither the pneumonia nor duodenal ulcer are current conditions and/or comply with ACS 0002 *Additional diagnoses*.

Abnormal findings

Laboratory, x-ray, pathological and other diagnostic results should be coded where they clearly add specificity to already documented conditions and they meet the definition of an additional diagnosis as defined in ACS 0002 *Additional diagnoses*.

EXAMPLE 2:

Code the following:

- S72.08 *Fracture of subcapital section of femur* where documentation shows fractured neck of femur and x-ray result shows subcapital fracture
- J21.0 *Acute bronchiolitis due to respiratory syncytial virus* where documentation shows bronchiolitis and pathology confirms RSV as causative agent
- L57.0 *Actinic keratosis* where documentation shows admission for removal of SCC and pathological report shows solar keratosis

Do not code laboratory, x-ray, pathological and other diagnostic results which require the interpretation of the treating clinician to decide their clinical significance and/or relationship to a specific condition.

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Attachment MS-4

APPENDIX B

BASIC CODING GUIDELINES

The Alphabetic Indexes contain many terms not included in the Tabular Lists, and coding requires that both the Index and the Tabular List are consulted before a code is assigned.

The following is a simple guide intended to assist the occasional user of ICD-10-AM.

1. Identify the type of statement to be coded and refer to the appropriate section of the Alphabetic Index.

2. Locate the lead term. For disease and injuries, this is usually a noun for the pathological condition. For procedures, this is usually a noun identifying the type of procedure performed. However, some conditions expressed as adjectives or eponyms are included in the Index as lead terms.

3. Read and be guided by any note that appears under the lead term.

4. Read any terms enclosed in parentheses after the lead term (these nonessential modifiers do not affect the code number), as well as any terms indented under the lead term (these essential modifiers may affect the code number), until all the words in the clinical expression have been accounted for.

5. Follow carefully any cross-references ('see' and 'see also') found in the Index.

6. Refer to the Tabular List to verify the suitability of the code number selected. For disease classification, note that a three character code in the Index with a dash in the fourth or fifth position means that there is a fourth or fifth character to be found in the Tabular List, Volume 1. Further subdivisions to be used in a supplementary character position are not indexed and, if used, must be located in Volume 1.

7. Be guided by any inclusion or exclusion notes under the selected code or under the chapter, block or category heading.

8. Assign the code.

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Attachment MS-5

APPENDIX C

CODE OF ETHICS FOR CLINICAL CODERS

The National Centre for Classification in Health (NCCH) is an Australian centre of expertise in classification of morbidity, cause of death and health interventions. One of the Centre's objectives is to develop and promote standards of coding practice including ethical practice.

This Code of Ethics has been developed by NCCH to provide guidance for clinical coders in reflecting accurately the clinical characteristics of patient and health service interventions.[1] Clinical data are used for research, monitoring public health, and for the planning, evaluation and funding of health services. The Code will also enable clinicians and healthcare administrators to understand the ethical obligations of coders.

1. Participate in quality improvement activities to ensure that the quality of coding supports the use of data for research, planning, evaluation and reimbursement, in the spirit of mutual respect for colleagues.
2. Ensure all information necessary for abstraction and coding processes is available.
3. Apply the Australian Coding Standards (ACS) and other official reporting requirements for the purpose of:
    - abstracting diagnoses and procedures using the entire clinical record
    - selecting and sequencing diagnosis and procedure codes
    - optimising reimbursement only when legitimate.[2]
4. Ensure that clinical record content justifies selection of diagnoses and procedures, consulting clinicians as appropriate.
5. Participate in ongoing education to ensure that skills and knowledge meet the appropriate level of competence.[3]
6. Contribute to ongoing development of classification systems in conjunction with appropriate coding and clinical experts.[4]
7. Observe policies and legal requirements regarding confidentiality of patient related clinical information.
8. Refuse to participate in or conceal illegal or unethical processes or procedures.

Note:

[1] The Code of Ethics was developed by NCCH and endorsed by members of the Coding Standards Advisory Committee (CSAC) in 1999. CSAC includes representatives of: Commonwealth Department of Health and Ageing, state and territory health authorities, private health sector, Australian Institute of Health & Welfare, Casemix Clinical Committee of Australia, Health Information Management Association of Australia, Clinical Coders' Society of Australia, and the New Zealand Ministry of Health.

[2] Reporting requirements may be set by:
- states and territories (eg state data definition)
- national bodies through publications such as *National Health Data Dictionary*, *Australian Coding Standards* and other NCCH publications such as *Coding Matters* and specialty-specific standards

[3] Level of competence may be determined by reference to the Health Information Management of Australia's *Clinical coder national competency standards and assessment guide* or by the national coder accreditation process.

[4] Involvement may be achieved through dialogue with NCCH and other organisations associated with health classification.

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Attachment MS-6

APPENDIX D

CLINICAL CODERS' CREED

Although new codes are introduced regularly, on the whole the ICD-10-AM classification structure remains constant over time. Codes and coding standards need to change to try and keep pace with medicine, but ultimately, clinical coders will often need to make decisions which are based on their **experience and common sense** as well as the resources available to them.

When you look at what clinical coders do objectively, they assign numbers from a structured, classification system to complex, ever-changing medical concepts which are not documented in a standardised way – no wonder it can be difficult! To revisit the fundamental skills of the clinical coder:

- A clinical coder has a thorough, working knowledge of medical science and terminology.
- A clinical coder can read the clinical record and make decisions about the appropriate codes to assign, based on the clinical documentation.
- A clinical coder understands the structure and use of a statistical classification.

The important features of these three points are **medical science, make decisions** and **structure.**

- Medical science is complex and forever changing.
- Decision-making is subjective.
- Structure of the classification is static.

The point is, no matter how much one might hope there will be hard and fast rules to solve all our coding problems, it remains that no amount of rules will ever replace the educated judgments that clinical coders make about specific cases based on the...

Clinical Coders' Creed
These things are the fundamentals of the art and science of clinical coding:

clinical documentation
communication with clinicians
coding standards
conventions
classification experience
common sense
science of medicine

All this serves to highlight the considerable and often forgotten skills of clinical coders.

Decisions in coding based on **Sailing the Seven Cs with the Clinical Coders' Creed** will ensure assignment of a code that is as good as possible – the work of a competent clinical coder.