



Short Guide to Clinical Coding for Clinicians

Good quality coding is an essential component of modern healthcare provision. This short guide has been designed to provide insight in to coding 'best practice'. By working in partnership, clinicians and coding teams can support high quality, safer care and more productive coding.

The NOA Short Guide to Clinical Coding for Clinicians

| General | |
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| Check your coding | Good quality coding requires clinician engagement directly with the coding department. Communication between clinicians and coders needs to be responsive and easy for both sides so that questions can be resolved quickly. |
| Key principle | Clinicians should use clear and unambiguous language. If in doubt - spell it out. |
| Diagnosis | |
| Primary diagnosis | Always confirm which diagnosis is the main condition being treated during the current episode of care. This may not be the same as the "main diagnosis" from a clinical perspective. For example, a patient with cerebral palsy being treated for a contracture or joint problem, will have cerebral palsy coded in a secondary position for that episode. |
| Confirmed diagnoses | Coders are not allowed to code diagnoses which are qualified by "likely", "possible", "query", "?" or "impression" without further clarification. |
| | Diagnoses described as "presumed", "treated as" or as a "working diagnosis" will be coded as though confirmed. |
| No confirmed diagnosis | In the absence of a confirmed diagnosis, detail the main symptoms and signs that were investigated during the current episode. |
| | Coders are advised not to diagnose solely from test results, there must be supporting clinical documentation before codes can be assigned. |
| Comorbidities | |
| Current | Comorbidities need to be documented completely and clearly. |
| | Distinguish between comorbidities that are current and those that are past history (no longer present). |
| Relevant | Be clear about what is 'relevant' to the current case (i.e. affected the management of the patient, affected the care, had an impact on the treatment/medication etc.) versus what really had no impact or was of no particular interest clinically during the stay. |
| Previous episodes | Coders cannot assign codes for comorbidities coded from previous admissions unless there is confirmation documented in the current episode that the condition is still current and relevant. |
| Clarity and precision | |

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| Problem areas | <p>If something is not recorded clearly and unambiguously in the clinical documentation that is available to the coders at the time of code assignment, there is a risk that it will not be coded at all or coded incorrectly. Avoid these common problem areas:</p> <ul style="list-style-type: none"> • Associations and causal relationships between conditions need to be stated clearly. Phrases such as “secondary to” and “complication of” are more clear than “in” or “with” or “complicating”. I.e. make clear the difference between an exacerbation and a relationship. • Record not only what is confirmed, but also be clear about what is ruled out/that the patient does not have (where working diagnoses and impressions change over time). • Avoid using abbreviations as they can lead to code errors unless they are widespread and unambiguous. For example, “PE” can be used for more than one common condition, and abbreviations that relate to tendons or muscles are not understood by some coders and can cause confusion. • Medical shorthand can be coded however there is a risk of incorrect or incomplete interpretation. For example, “↑BP” can't be interpreted as hypertension by a coder and will only be coded as raised blood pressure unless “hypertension” is written. • Avoid using grading systems in place of a confirmed diagnosis description, state both. For example, write “Osteoarthritis grade II” not just “grade II”. |
| Specific examples of how to do it right | |
| Arthritis | <p>Record the exact type of arthritis as soon as it has been proven i.e. osteoarthritis, rheumatoid arthritis etc.</p> <p>For a diagnosis of osteoarthritis, specify if the osteoarthritis is primary or secondary; if it is secondary, state what it is secondary to (trauma, deformity, other disease etc.).</p> |
| Fracture | Specify details within a fracture diagnosis. For example, whether the fracture is open or closed and do the same with the fracture reduction (whether the procedure is open or closed). |
| Back pain | Record a clear diagnosis when patients are admitted for back pain to have a spinal injection. Coders are not allowed to assume what is relevant from previous scans or previous episodes. |
| Osteoporosis | The type of osteoporosis can be coded but is often not recorded. For example, the presence of current osteoporotic fractures, drug induced, osteoporosis of disuse, or post-menopausal etc.. |
| Congenital or acquired? | For deformities, always specify whether a deformity is congenital or acquired. Diagnosis details will affect the procedure codes assigned in some cases. |
| Multiple trauma | Always record in the discharge letter all of the injuries affecting a patient even if some are no longer present by the time of discharge. |

| Operation notes | |
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| Typed operation notes | All operation notes should be produced and stored electronically so they are legible, easily accessible and widely available. Standardised templates can be very useful and save a lot of time. Hand written operation notes can be difficult to read, and important details may be missed and not coded. |
| | Always ensure that an operation note is completed and available in the casenotes by the time of discharge. "See typed op note" in the casenotes where there is no typed operation note produced (and included in the casenotes) at the time of code assignment is a common problem. |
| Operation sheet heading | Operation notes need to be headed with the following information: <ul style="list-style-type: none"> • title of the operation, • site and laterality • operation date • patient name and number |
| | Ensure that the title of the operation corresponds with what the surgeons have actually done. |
| | Be clear in operation titles as to the nature of the procedure. For example, "FCR Sling" is not a full description of "interposition arthroplasty using an FCR sling". |
| Operation detail | Operation notes should include the following information: <ul style="list-style-type: none"> • Operative diagnosis • Operative findings • Clear description when an operation is unusual or differs from the standard method/ technique, and when additional procedures are carried out that are non-standard • Any problems or complications |
| | Avoid eponyms where possible. If using eponyms then describe what the procedure entailed in order to ensure accurate code assignment. |
| Site | Do not assume that the specific anatomy is implicit or obvious. While coders and other users of the medical record may be trained on anatomy, they will never have the same depth of understanding as someone who performs surgery. |
| | Specify the site being operated on as precisely as possible. Conflicting information in the operation record when compared to elsewhere in the notes is common. For example, the notes may say a fractured ankle and the operation record may say a fractured tibia. These are two distinct sites with two different site codes. |
| | Specify the bones that have been reduced/plated/pinned in surgery. 'Ankle' for example, is not specific enough to be coded accurately. A coder won't know whether to record a procedure to ankle joint (which is coded as a reduction of fracture dislocation), a distal tibia/fibula (which would be coded as plating of that specific bone) or a specific part of malleolus (lateral/medial) which would have a separate, more specific code. |

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| Additional procedures | What is a normal part of an operation (“part and parcel”) and what should be coded in addition to the usual code? Make it easy for coders to know when additional operations/ procedures have been done as part of an intervention on a patient. |
| Approach | Describe the methods of approach of procedures especially if there is more than one or the approach is unusual. For example, arthroscopic, open, planned progress from scope to open, unplanned progress from scope to open, osteotomy approach, laminectomy approach, etc. |
| Prostheses and devices | Record all the prosthesis/device details, including location of cement used, permanent/ temporary, flexible or rigid, intra- or extramedullary, internal or external fixation, etc. |
| Revisions | For revision joint replacement surgery, specify the type and cement use of the previous prosthesis and the type and cement use of the newly inserted prosthesis. Different procedure codes are used when the type and cement use of a revision is changed from the previous arthroplasty. |
| Image guidance | Always state the type of image control being used. Also specify if the image control is used only to check position prior to closure. |
| Bone graft | Include the site and laterality of each part of the operation on bone grafts and harvest sites. Specify the type of bone graft used. Clinical codes can capture autograft types such as cancellous strip, morcellised/ chip, pedicle, bone tendon, etc. Other bone graft types can be coded also, such as synthetic and allograft. Specify the site of harvests for autograft. |
| Soft tissue operations | Specify the type of soft tissue operated on as precisely as possible. There are procedure codes for muscle, tendon, ligament, lymph node, nerve, subcutaneous tissue etc. |
| | For ligament operations, specify if ligaments are intra-articular or extra-articular. |
| Fracture reductions | When a patient is admitted for reduction of fracture, make clear if the patient received manipulation in A&E. There are different procedure codes for primary and secondary fracture reductions. |
| | Specify “open reduction” or “closed reduction” in surgical notes for fracture reduction. |
| | Specify if a fracture is intra-articular or involves a dislocation as this will affect procedure code assignment. |
| Osteotomies | Procedure codes for osteotomies can capture the following details: peri-articular, diaphyseal, rotational, angulation, displacement, cuneiform, internal and external fixation, etc. |
| Diagrams | Orthopaedic surgeons often draw diagrams that coders aren’t trained to interpret. For example, an arthroscopy form describing ‘Gr III’ with an arrow to a bone usually implies osteoarthritis, but without the word ‘osteoarthritis’ this information can’t be recorded. Please ensure that your coders have been taught how to interpret diagrams and coding policies on diagram interpretation have been agreed on and documented with the Coding department. |

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If changes need to be made to this guideline, please contact us at info.noa@nhs.net, giving the guideline number and title, details of the change and the rationale behind the change as well as the source of the proposed change – clinician, clinical coder, vanguard project, commissioning, finance, etc.