Ex (488)

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DINAH MONROE

1. I, **DINAH MONROE,** c/- Bundaberg Base Hospital, Bundaberg in the State of Queensland, acknowledge that this written statement is true to the best of my knowledge and belief.

2. I am currently a clinical coder at the Bundaberg Base Hospital. I have been employed in this position since January 2003.

Qualifications

3. I completed a course in Medical Terminology with the New South Wales Department of Health in June 1983.

4. I completed a coding course with the New South Wales Medical Record Association (ICD-9-AM) in 1989.

5. I worked at the Royal North Shore Hospital in Sydney as a supervisor in the Medical Records Department in the late eighties, and part of my role was to assist with clinical coding as required.

6. I completed the Comprehensive Medical Terminology course with Health Information Management Association of Australia (HIMAA) in 2001.

7. I completed the course in Clinical Coding from HIMAA in 2002.

8. In 2001/2002, prior to commencing my current role at Bundaberg Base Hospital, worked at the Royal Prince Alfred Hospital in Sydney. Part of my work at the Royal Prince Alfred Hospital was to assist with coding when required.

9. This year I have completed a further, more advanced course in clinical coding conducted by HIMAA.

Clinical Coding

10. Clinical Coding is the process whereby the information from a patient's clinical chart is translated into an alpha-numeric code according to a set of international standards.

11. The standards used are the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) 4th Edition. The system comprises of three sets of manuals relating to the standards for coding, the classification of diseases and the classification of procedures.

12. Each time a patient is discharged from hospital, the chart is sent to the clinical coding section so that the most recent admission can be clinically coded.

13. Such coding involves a complete review of the chart including the progress notes. These notes may be written by nursing staff, clinicians, allied health professionals and any other staff involved in the treatment of the patient. The coding also involves reviewing the surgeon's notes, anaesthetic records, discharge summary, and radiology, microbiology, haematology, biochemistry and histology reports. The coding process may also include a review of previous admissions and treatment, correspondence and ambulance reports. Any information relevant to that particular admission and treatment of the patient is then coded by reference to the international standards.

Case Example

14. For example, patient 'X' is admitted for planned laparoscopic cholecystectomy (removal of gallbladder) due to gallstones. The patient also has Type II diabetes

mellitus and is insulin dependent. Hypertension (high blood pressure) is also noted in the progress notes.

The patient is taken to the operating theatre for the laparoscopic cholecystectomy under general anaesthetic. During the procedure, it is found the patient has significant adhesions (union of two surfaces that are normally separate) which were unable to be divided laparoscopically and the operation reverts to open cholecystectomy, and is returned to the ward with patient controlled analgesia set up. On return to the ward, the patient has nausea and vomiting postoperatively and is given Maxalon.

On day 2, the clinician documents that the wound appears to be infected. A swab is taken.

On day 3, the patient fell while trying to get out of bed and the progress notes say he fractured his radius (forearm). Patient returns to theatre for open reduction and internal fixation of the fracture under general anaesthetic.

The patient had physiotherapy and occupational therapy while in hospital. The patient was discharged home on day 10 without further problem.

To code this case, I start by looking for the principal diagnosis. To do this, I check the histology report which reads "cholelithiasis with chronic cholecystitis" (gallstones with chronic inflammation of the gallbladder). I look for any co-morbidities (co-existing diseases) or complications relevant to the admission. I read that the patient has diabetes with high blood pressure and is insulin dependent. The codes for these are added as additional diagnoses.

I read in the operation report that the patient had adhesions which required dividing and caused the operation to revert to an open one rather than laparoscopic as was planned and begun.

I check the anaesthetic report to assign the correct anaesthetic codes, and also find that the patient had a PCA (patient-controlled analgesia) which is also coded.

I find in the nursing notes that the patient was nauseous and vomiting and was given Maxalon by the nurse, so I code this.

I see the clinician has documented in the progress notes "wound appears infected – swab taken" so I check the microbiology report and find Staphylococcus aureus (bacteria) was isolated. This is coded as a complication of the surgery.

Reading on in the progress notes, I see the patient fell out of bed and notes say "fractured radius". I check the x-ray report which reads "fractured radius with dorsal angulation" so I code this as well as codes for how and where the accident happened. I look to see if there was any treatment of the fracture and find another operation report with accompanying anaesthetic report. The operation report gives details of an open reduction with internal fixation of the fracture under general anaesthetic so these are all coded.

The progress notes then show that the patient was seen by the physiotherapist and the occupational therapist, so these interventions are coded.

All these codes are then entered into the database. Attached and marked **'DM-1'**is the coding for this case example. Also attached and marked **'DM-2'** is the example of the coding on the hospital database screen.

15. The computer automatically generates the DRG (Diagnosis Related Group) from the coding supplied for each admission. The DRG's are a form of casemix classification relating to inpatient care. Casemix is a scientific tool used to classify patients into meaningful groups.

16. It is not uncommon to enter up to 20 or 30 clinical codes in respect of one admission for a particular patient.

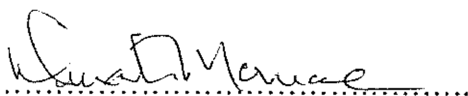
17. The information entered on the discharge summary sheet is only coded if the chart notes and other documentation support the information entered on the sheet.

18. The purposes of clinical coding are as follows:

- to provide relevant data to Queensland Health;
- for statistical purposes;
- for funding and allocation of resources;
- for use by the World Health Organisation; and
- for research.

19. I am able to, and do, provide reports on a regular basis of coded data to clinical staff who are interested in monitoring particular diseases or procedures.

Signed at **Bundaberg** on 14th July 2005.



Dinah Monroe
Clinical Coder
Bundaberg Base Hospital

999999-1 DUMMY NUMBER,DO NOT USE Admit 20 JUN 2005
Gender : Female
Age : 49
Birth Date : 01/01/1956
Separation : Home/Other (9)
Admit Date : 20/06/2005
LOS : 10
Separ Date : 30/06/2005

QLD Peer Group B DRG

H07A OPEN CHOLECYSTECTOMY W CLOSED CDE OR CATASTROPHIC CC

Qld Gr B wt 5.44 ALOS 12.38 LOW 5 HIGH 36.0

PCCL

4 PCCL 4 - SDX is a catastrophic CC

MDC

007 DISEASES & DISORDERS OF THE HEPATOBILIARY SYSTEM & PANCREAS

ICD-10-AM Principal Diagnosis

*K8010 Calculus of gallbladder with other cholecystitis, without mention of obstruction

ICD-10-AM Additional Diagnoses

K660 Peritoneal adhesions
#T8141 Wound infection following a procedure
B956 Staphylococcus aureus as the cause of diseases classified to other chapters
Y836 Removal of other organ (partial) (total) as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure
S5251 Fracture of lower end of radius with dorsal angulation
W06 Fall involving bed
Y9222 Place of occurrence at or in health service area
U739 Injury or poisoning occurring while engaging in unspecified activity
#E1172 Type 2 diabetes mellitus with features of insulin resistance
I10 Essential (primary) hypertension
Z9222 Personal history of long-term (current) use of other medicaments, insulin
R11 Nausea and vomiting

ICD-10-AM Principal Procedure

*3044600 [965] Laparoscopic cholecystectomy proceeding to open cholecystectomy
20/06/2005

ICD-10-AM Other Procedures

3037800 [986] Division of abdominal adhesions
20/06/2005
9251429 [1910] General anaesthesia, a patient with mild systemic disease, non-emergency or not known
20/06/2005
9251800 [1912] Intravenous postprocedural infusion, patient controlled analgesia (PCA)
20/06/2005
4736602 [1429] Open reduction of fracture of distal radius with internal fixation
23/06/2005
9251429 [1910] General anaesthesia, a patient with mild systemic disease, non-emergency or not known
23/06/2005
9555003 [1916] Allied health intervention, physiotherapy

999999-1 DUMMY NUMBER,DO NOT USE Admit 20 JUN 2005

9555002 [1916] Allied health intervention, occupational therapy

'DM-2'.

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REC2.S165     ALERT                INPATIENT ICD CODING                     563 LOGON-BBH
 01 Patient Number [999999-1      ] DUMMY NUMBER, DO NOT USE
          Admitted  20 JUN 05  ->  30 JUN 05  LOS 10    State Average 12.3 8
             D.O.B  01 JAN 1956    Unit SURG  Adm. Type 01         MDC 007
               Sex  F              Ward SURG              Rel. Weight 5.4300
 DRG H07A Open Cholecystectomy W Closed CDE or W Catastrophic CC
                                                               Page 1   of 2
02 ICD Code 03 CF Description                               Block 04 PR Date
   [         ][ ]                                                [         ]
  1 PK80.10         CALC GALLB W OTH CHOLECYSTITIS WO
  2 AK66.0          PERITONEAL ADHESIONS
  3 AT81.41         WOUND INFECTION FOLLOWING A PROCE
  4 AB95.6          STAPH AUREUS CAUSE DIS CLASS OTH
  5 AY83.6          REMOVAL OF OTHER ORGAN (PARTIAL)
  6 AS52.51         FX LOW END RADIUS W DORSAL ANGULA
  7 AW06            FALL INVOLVING BED
  8 AY92.22         HEALTH SERVICE AREA
  9 AU73.9          UNSPECIFIED ACTIVITY
 10 AE11.72         TYPE 2 DM W FEATURES INSULIN RESI
 11 AI10            ESSENTIAL (PRIMARY) HYPERTENSION
 05 Admission Weight (grams)        [     ]
 06 Hours of Mechanical Ventilation [     ]
Er  r Field Number or Code                          Filed  [ ]
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REC2.S165 ALERT INPATIENT ICD CODING 563 LOGON-BBH

01 Patient Number [999999-1] DUMMY NUMBER, DO NOT USE

Admitted 20 JUN 05 -> 30 JUN 05 LOS 10 State Average 12.3 8

D.O.B 01 JAN 1956 Unit SURG Adm. Type 01 MDC 007

Sex F Ward SURG Rel. Weight 5.4300

DRG H07A Open Cholecystectomy W Closed CDE or W Catastrophic CC

Page 2 of 2

02 ICD Code	03 CF	Description	Block	04 PR Date
[ ]	[ ]			[ ]
12 AZ92.22		PERSL H/O LONG-TERM USE OTH MEDTS		
13 AR11		NAUSEA AND VOMITING		
14 30446-00		LAP CHOLECYSTECTOMY PROCEED OPEN	965	20 JUN 05
15 30378-00		DIVISION OF ABDOMINAL ADHESIONS	986	20 JUN 05
16 92514-29		GENERAL ANAESTHESIA, ASA 29	1910	20 JUN 05
17 92518-00		IV POSTPROC INFUS PT CNTRL ANALGE	1912	20 JUN 05
18 47366-02		OPEN RDCTN FRACTURE DISTAL RADIUS	1429	23 JUN 05
19 92514-29		GENERAL ANAESTHESIA, ASA 29	1910	23 JUN 05
20 95550-03		ALLIED HEALTH INTERVTN, PHYSIOTHE	1916	
21 95550-02		AH INTERVENTION, OCCUPATIONAL THE	1916	

05 Admission Weight (grams) [ ]

06 Hours of Mechanical Ventilation [ ]

Enter Field Number or Code Filed [ ]