Clinical Coding Auditor Programme (CCAP) Assessment Day, May 2018

Summary of Common Errors
## Contents

### Introduction

### Practical Paper

| Section A: ICD-10 Coding Scenarios – Maximum number of marks available | 3 |
| Section B: OPCS-4 Coding Scenarios – Maximum number of marks available | 5 |
| Case Studies | 7 |

### Theory Paper

| Section D: National Clinical Coding Standards – Multiple Choice | 11 |
| Section E: National Clinical Coding Standards – Data Extraction and Communication Skills | 11 |
| Section F: Audit Theory Questions – Maximum number of marks available | 20 |

### Conclusions and Recommendations Exercise

12
Introduction

Following positive feedback from the service about previous years ‘Summary of Common Errors’ document, we have decided to continue producing a Summary of Common Errors to include common errors made by candidates sitting the Clinical Coding Auditor Programme (CCAP) Assessment Day held on the 9th May 2018.

The purpose of the document is to support Accredited Clinical Coders who intend to apply for the CCAP. It gives an overview of common errors and covers the Practical and Theory Assessments, plus generic feedback on the Conclusions and Recommendations Exercise.

Not all questions from the assessment papers are included within the Summary of Common Errors, just those questions where a number of candidates made similar/identical errors.

Practical Paper

Section A: ICD-10 Coding Scenarios – Maximum number of marks available 28

- Patient with previous history of deliberate self-harm admitted in a coma following a deliberate overdose of co-codamol and a bottle of vodka in a pub bathroom.
  - Incorrect sequencing of the component drug codes for co-codamal.
    - When a drug has more than one component each component must be coded separately and sequenced according to the order in which the components appear in the drug name (e.g. When coding Co-codamol, codeine must be sequenced before paracetamol).


  - The correct fourth character subdivision for a place of occurrence of pub or nightclub is .5 Trade and service area.


  - Omission of code Z91.5 Personal history of self-harm.

    There are a number of medical conditions and other factors influencing health that must always be coded for each consultant episode when they co-exist in conjunction with another disease that is currently being treated at the time of admission (or develop subsequently). This is regardless of specialty. These have been agreed by the Clinical Comorbidities Working Group as co-morbidities that are clinically relevant - as they always affect the management of the patient’s current consultant episode. Personal history of self-harm features on this list.

- Patient admitted to the intensive care unit with acute severe staphylococcal sepsis due to a staphylococcal infected left total knee replacement. Patient stated as suffering from multi organ failure confirmed as being liver failure and acute renal failure.
  
  o Omission of code B95.8 Unspecified Staphylococcus infection as the cause of diseases classified to other chapters to specify the infectious agent causing the infection in the total knee replacement.

  A code from B95-B98 must be used as a supplementary code to a code classified outside of Chapter I, where a site and a causative organism have been identified and a code that classifies both the site and the causative agent is not available.


- Patient admitted in the early stages of labour with twins at 36+6 weeks, she delivers both liveborn the following day via emergency C-section (at 37 weeks) due to confirmed (previously undiagnosed) moderate pre-eclampsia. 12 hours post-delivery she suffered a post-partum haemorrhage, which necessitated a blood transfusion.
  
  o Incorrect primary diagnosis code selection.

  The main condition treated in this admission is the moderate pre-eclampsia (this was the reason for the emergency c-section); hence this should be sequenced in primary position.

  [DGCS.1 Primary diagnosis in the National Clinical Coding Standards ICD-10 5th Edition reference book (2018)]

  o A number of candidates omitted code O30.0 Twin pregnancy.

  When recording an episode with a normal multiple delivery, a code from category O30.-Multiple gestation must be recorded as the primary diagnosis, unless the patient has a condition classified to another code from Chapter XV on the delivery episode, in which case the appropriate code from category O30.- must be recorded in a secondary position.

  [DCS.XV.14: Multiple gestation (O30) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2018)]

  o Several candidates failed to assign code O60.2 Preterm spontaneous labour with term delivery.

  A code from O60.- Preterm labour and delivery is used if the labour and/or delivery is pre-term (occurring before 37 completed weeks of gestation) whether spontaneous or induced. O60.2 Preterm spontaneous labour with term delivery is used for patients who at some point during the current pregnancy have been admitted in spontaneous preterm labour (before 37 completed weeks) and go on to deliver to term (after 37 completed weeks)
Section B: OPCS-4 Coding Scenarios – Maximum number of marks available 28

- Patient admitted via the Emergency Department where they underwent a manipulation of a right distal radius fracture post the decision to admit. As this was unsuccessful they were taken to theatre where a closed reduction with internal fixation using a plate secured with screws was performed. Image intensifier was used following the procedure to check the position of the fixation.
  
  o A number of errors were made due to incorrect sequencing of the main procedure code, several delegates incorrectly sequenced code **W26.2 Manipulation of fracture of bone NEC** (and associated site/laterality codes) as the main procedure performed.

  The main procedure performed was the closed reduction of distal radius with internal fixation using a plate secured with screws; hence this code should be sequenced in primary position.

  [PRule 2: Single procedure analysis and multiple procedure coding in the National Clinical Coding Standards OPCS-4 reference book (2018)]

- Patient added to a pre-scheduled list for an emergency replacement of an aneurysmal segment of aorta by anastomosis of aorta to aorta to repair a juxtarenal aneurysm. Percutaneous transluminal insertion of stents into both renal arteries under fluoroscopic guidance was performed concurrently to prevent renal failure.

  o Several delegates assigned an incorrect code to classify the emergency replacement of juxtarenal aneurysmal segment of aorta by anastomosis of aorta to aorta. Some delegates assigned a ‘non-emergency’ code, whilst others assigned a code that did not identify the aneurysmal nature of the procedure. Others failed to assign the correct code for replacement of a juxtarenal segment of the aorta.

  The replacement/repair of a juxtarenal abdominal aortic aneurysm/dissection has an increased level of surgical and postoperative complexity, and must be assigned the appropriate code for the replacement/repair of a suprarenal aortic aneurysm/dissection.


  o Some delegates chose the incorrect supplementary stent category, opting for a code from **O20** which classifies stent graft.

  Codes in Chapter L that classify the insertion of stents must be supplemented by a code from categories **L76, L89 or O20**, to indicate the type and number of
stents or stent grafts inserted, as indicated by the Notes at category or code level. When a stent has been inserted and the number and type of stent is unknown, the default code is **L76.9 Unspecified endovascular placement of stent**.

[PChSL3: Insertion of stents and stent grafts in the National Clinical Coding Standards OPCS-4 reference book (2018)]

- Patient admitted for a primary posterior interbody fusion of L4/5 and L5/S1 (PLIF) and a revisional posterior decompression of L4/5 and L5/S1. A laceration to the spinal dura occurred during the procedure and this was repaired using sutures.
  - A few delegates selected an incorrect code to classify the primary lumbar interbody fusion (PLIF).
    - V38.5 Primary posterior interbody fusion of joint of lumbar spine classifies:
      - Posterior lumbar interbody fusion (PLIF).
    [PCSV5: Lumbar interbody fusion (V33.3, V33.6, V38.5, V38.6 and V51.1) in the National Clinical Coding Standards OPCS-4 reference book (2018)]
  - A discectomy code was assigned rather than a code for the posterior decompression of L4/5 and L5/S1, despite there being no mention of a discectomy being performed.
  - Some delegates assigned incorrect codes to classify the suture repair of the spinal dura.

Repair of the spinal dura (as opposed to the dura of the brain) must be coded using A51.8 Other specified other operations on meninges of spinal cord. An additional code(s) from Chapter Y Subsidiary classification of methods of operation must also be assigned to specify the type of repair where this adds further information and the information is documented within the medical record.

[PCSA7: Repair of spinal dura (A51.8) in the National Clinical Coding Standards OPCS-4 reference book (2018)]

- Patient admitted for a wider excision of skin margins following confirmation of a BCC (basal cell carcinoma) on the left side of their external nose. Graft of skin to excision site graft harvested from right cheek.
  - Several candidates neglected to assign the laterality code **Z94.3 Left sided operation** following **E09.7 Graft of skin to external nose** to identify that the skin graft procedure was being performed on the left side of the nose.

When laterality is documented in the medical record, and is not already implicit in the code description, it must be coded.

[PCSZ2: Laterality of operation (Z94)] in the National Clinical Coding Standards OPCS-4 reference book (2018)]
A number of candidates assigned the 4th character .9 Unspecified at category Y58 Harvest of skin for graft. As the site of the harvest was specified (right cheek) and the axis of classification at category Y58 is the site of the harvest, the 4th character .8 Other specified must be assigned.

A few candidates incorrectly assigned a code from Chapter S plus a site code for the external nose to classify the skin graft procedure, rather than assigning the appropriate body system skin graft code.

Skin autografts must be coded as follows:

- When a specific body system skin graft code is available or when the graft is to the skin of the sites listed at the beginning of Chapter S; assign the appropriate code from the relevant body system chapter
- Graft code from Chapter S Skin (if doing so adds further information)*
- Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified by the body system code)
- Z94.- Laterality of operation (if applicable)
- Chapter Y code identifying the type of tissue harvested and the site of the harvest
- Chapter Z site code identifying the site of the harvest (if this has not already been identified within the Y harvest code)
- Z94.- Laterality of operation (if applicable).

[PCSS3: Coding skin grafts and harvests in the National Clinical Coding Standards OPCS-4 reference book (2018)]

Case Studies

Case Study 1 – Trauma and Orthopaedics (22 marks)

A number of candidates failed to assign fifth characters where appropriate to codes from Chapter XIX.

Supplementary fifth characters are used in this chapter to identify open and closed fractures, intracranial injuries with or without open intracranial wound and internal injuries with or without open wound into cavity. They must be assigned when instructed by the note at code, category or block level.

An injury not indicated as ‘open’ or ‘closed’ must be recorded using fifth character .0.


The patient was documented as a pedal cyclist involved in a collision with a bus, several candidates assigned the incorrect 4th character .4 Driver injured in traffic accident at category V14 Pedal cyclist injured in collision with heavy transport vehicle or bus. It was not specified that the patient was the ‘driver’ of the pedal cycle, therefore the 4th character .9 Unspecified pedal cyclist injured in traffic accident must be assigned.
The patient was stated to abuse both cannabis and alcohol, with no further information. Candidates incorrectly coded abuse of both drugs/substances separately rather than assigning **F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances, harmful use.**

Codes in category **F19.- Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances** must be assigned when two or more psychoactive substances are known to be involved it is not evident which substance is contributing most to the disorder.

**[DCS.V.8: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances (F19) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2018)]**

The patient suffered a right-sided subdural haematoma which was evacuated via a burr hole approach from the right side of the cranium. Candidates failed to assign the laterality code **Z94.2 Right sided operation** in addition to the relevant procedure codes for the evacuation of haematoma.

When laterality is documented in the medical record, and is not already implicit in the code description, it must be coded.

**[PCSZ2: Laterality of operation (Z94) in the National Clinical Coding Standards OPCS-4 reference book (2018)]**

The patient also suffered a splenic laceration which was sutured in theatre. Most candidates correctly assigned code **J72.4 Repair of spleen** but some failed to assign code **Y25.1 Suture of laceration of organ NOC** to specify the repair was performed using sutures in addition. A few candidates opted for the unspecified code **Y25.9** instead.

The patient was noted to be suffering from acute renal failure, treated with haemofiltration. A few candidates assigned the incorrect 4th character **.3 Haemodialysis NEC** at category **X40 Compensation for renal failure**, rather than **.4 Haemofiltration**.

The patient received invasive ventilation and this was not recorded by a number of candidates.

Codes within category **E85 Ventilation support** must always be assigned when ventilation support is performed in either an inpatient or outpatient setting.

**[PCSE4: Non operations on lower respiratory tract (E85–E98) and ventilation support (E85) in the National Clinical Coding Standards OPCS-4 reference book (2018)]**
Case Study 2 – General Surgery (17 marks)

- The primary diagnosis was a malignant tumour involving both the rectum and anus, with no point of origin identified. Several candidates incorrectly assigned either C20.X Malignant neoplasm of rectum or C19.X Malignant neoplasm of rectosigmoid junction. The correct code is C21.8 Overlapping lesion of rectum, anus and anal canal.

Primary malignant neoplasms in categories C00-C75 Malignant neoplasms, stated or presumed to be primary, of specified sites, except lymphoid, haematopoietic and related tissue are classified to their point of origin, however when a neoplasm overlaps two or more contiguous (next to each other) sites within the same three character category without any indication of which is the site of origin, the fourth character of .8 (overlapping site boundary) must be assigned. Where a neoplasm overlaps different sites within the same body system and the point of origin of the neoplasm cannot be identified, one of the subcategories listed at Note 5 at the beginning of Chapter II Neoplasms in the Tabular List is assigned.

[DCS.II.3: Malignant neoplasms overlapping site boundaries (C00-C75 and C76.8) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2018)]

- The patient had rheumatoid arthritis of the hips, knees and spine. Most candidates correctly assigned the code M06.90 Rheumatoid arthritis, unspecified, Multiple sites to classify rheumatoid arthritis of the hips and knees but failed to assign M45.X(9) Ankylosing spondylitis in addition to classify the rheumatoid arthritis of the spine.

- The patient’s cancer was investigated with a colonoscopy and biopsy of the rectum, the colonoscopy did not progress beyond the sigmoid colon. Several candidates incorrectly assigned OPCS-4 code H22.1 Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon having failed to follow the excludes note at category H22 Diagnostic endoscopic examination of colon, ‘Excludes: Diagnostic fibreoptic endoscopic examination limited to sigmoid colon (H25)’.

- The patient also has a CT with contrast of the pelvis and an MRI of the abdomen, during the same visit to the radiology department. Many candidates assigned only one code from category U21 Diagnostic imaging procedures to classify both the CT of the pelvis and MRI of the abdomen, whilst others assigned U21.2 Computed tomography NEC to classify the CT of pelvis and also U08.5 Magnetic resonance imaging of abdomen to classify the MRI of the abdomen. Several candidates used two body system category diagnostic imaging codes instead of codes from U21 which led to omission of site codes and further loss of marks.

When one body area is scanned during a single visit to the radiology department using multiple types of imaging or when more than one area is scanned during a single visit to the radiology department using either the same or different types of imaging assign the following codes and sequencing for each different type of imaging used:
• The specific fourth character at **U21 Diagnostic imaging procedures** or **U36 Other diagnostic imaging procedures**

• **Y97 Radiology with contrast** (if used)

• **Y98 Radiology procedures** (with the fourth-character selection being reliant upon the number of areas scanned or duration of the scan)

• **Z site code(s)**

• **Z94.- Laterality of operation** (if applicable)

[**PCSU1: Diagnostic imaging procedures (U01–U21 and U34–U37) in the National Clinical Coding Standards OPCS-4 reference book (2018)**]
Theory Paper

Section D: National Clinical Coding Standards – Multiple Choice

ICD-10 – Maximum marks available 4

This section was very well completed on the whole, any errors appear to be the result of misreading the options given.

OPCS-4 – Maximum marks available 4

Once again, this section was very well completed on the whole, any errors appear to be the result of misreading the options given.

Section E: National Clinical Coding Standards – Data Extraction and Communication Skills

ICD-10 & OPCS-4 – Maximum number of marks available 46

Similar to last year’s Assessment Day, this section was once again well completed with many candidates scoring close to full marks. The following errors were identified by the examiners/reviewers:

- Some candidates correctly explained how a code assignment was contravening a national standard but identified an incorrect code as the code that was contravening the standard, e.g. in the scenario, the coder assigned N19.X Renal failure, unspecified in addition to code N18.4 Chronic kidney disease, stage 4. Candidates correctly explained that N19.X must not be assigned in addition to N18.4 as per DCS.XIV.2: Chronic kidney disease, CKD (N18) but incorrectly selected N18.4 as the code contravening the standard.

- Candidates correctly selected the code that was contravening a national standard but failed to correctly or fully explain the standard that was being contravened, i.e. chose an irrelevant national standard for the particular scenario as an explanation, or did not fully elaborate on their explanations.

- Failing to identify all examples of contraventions of national standards within a particular scenario.

- Omission of standard reference number and/or title.

Section F: Audit Theory Questions – Maximum number of marks available 20

This section was generally well completed with most candidates scoring full, or close to full marks. The main source of error was candidates providing incomplete answers to the question regarding how many days audit Approved Auditors must evidence when submitting their log book and what can be included within the audit days total. A few candidates failed to identify the correct document where the key principles, standards and protocols that an approved clinical coding auditor must follow are found.
Conclusions and Recommendations Exercise

This exercise was completed well. There are a couple of points, however, for future candidates to be aware of where marks can be lost:

- Not to list findings as conclusions. A link should be made between the finding and the error(s) that finding may have caused.

Example of a 'non-conclusion', i.e. finding:
There are currently two vacancies and there is a coding backlog.

Conclusion example:
There are currently two vacancies and there is a coding backlog. This increased pressure for existing coders may have contributed to the errors, such as omitted comorbidities and CT and MRI scans.

- Bear in mind the SMART acronym when writing recommendations which should have been covered during your Report Writing Skills course.

S – Specific
M – Measurable
A – Achievable
R – Realistic
T - Timely

For example:
The two vacant coding posts should be filled within the next 6 months.