Clinical Coding Auditor Programme Assessment Day – May 2019

Summary of Common Errors

Terminology and Classifications Delivery Service
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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 made by candidates sitting the Clinical Coding Auditor Programme (CCAP) Assessment Day held on the 15 May 2019.

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 several candidates made similar/identical errors.

Practical Paper

Section A: ICD-10 Coding Scenarios - Maximum number of marks available 30.

Acute inferior MI patient transferred to Cardiac Cath lab in the same Trust for treatment of his coronary artery disease. Patient is suffering from a ventricular septal defect (VSD) confirmed as occurring following the MI. The patient also suffers from chronic kidney disease stage 3 with renal failure due to hypertension.

- Incorrect sequencing of the primary diagnosis. Some candidates sequenced the coronary artery disease before the acute inferior MI.

  The main condition treated was the acute myocardial infarction. Where the patient undergoes an intervention at the same Trust to treat the coronary artery disease, the acute MI must be recorded as the primary diagnosis, followed by the code for the coronary artery disease, as the MI is considered more clinically significant.


- Some candidates assigned a code for an atrial septal defect (ASD), in preference to the code for ventricular septal defect (VSD). Or this code was omitted completely.

  The ventricular septal defect is stated to have occurred following the acute MI and should therefore be coded. Codes in category I23.- Certain current complications following acute myocardial infarction must be assigned when the complications occurred following an acute myocardial infarction.

  A code from category I23.- can be used in the same episode as a code from I21.- as long as the complication is not concurrent with the MI.

Acute severe coagulase-negative staphylococcal sepsis due to infected joint replacement. Patient admitted for removal of the joint prosthesis, joint washout and spacer insertion. Consultant Microbiologist confirmed the presence of coagulase-negative staphylococcal bacteria as the cause of the infection which was treated with IV antibiotics. During the admission they contracted hospital acquired Norwalk gastroenteritis.

- Candidates assigned the incorrect code from Chapter I to classify coagulase-negative staphylococcal sepsis.
- Some candidates omitted the code to demonstrate severe sepsis.

The patient is confirmed as having acute severe coagulase-negative staphylococcal sepsis and this must be coded using the following codes and sequencing:

A41. - Other sepsis (or the specific type of sepsis recorded in the medical record, in this case the coagulase-negative staphylococcal sepsis)
R65.1 Systemic inflammatory response syndrome of infectious origin with organ failure


- Several candidates omitted or assigned an incorrect code to indicate the cause of the infected joint prosthesis. Candidates assigned B95.8 Unspecified staphylococcus as the cause of diseases classified to other chapters, in preference to the B95.7 Other Staphylococcus as the cause of diseases classified to other chapters.

The joint replacement infection is confirmed as being due to coagulase negative staphylococcus hence a code from B95-B98 must be assigned in addition to T84.5 Infection and inflammatory reaction due to internal joint prosthesis to demonstrate the agent causing the infection.

The standard confirms the following codes and sequencing must be applied:
Code from categories T80-T88 or the code from a postprocedural disorder category B95-B98 Bacterial, viral and other infectious agents


- A few candidates omitted the code to demonstrate that the Norwalk gastroenteritis was hospital acquired.

The Norwalk gastroenteritis is documented as being ‘hospital acquired’ hence code Y95.X Nosocomial condition must be assigned directly after the code for the condition that has been documented as being ‘hospital acquired’ – in this case the Norwalk gastroenteritis.

[DCS.XX.10: Hospital acquired conditions (Y95.X) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]
Pathological fracture of femur due to bony metastases. Primary site confirmed as being unknown by the clinician. Patient taken to theatre for fixation of fracture. Two days post-surgery the patient complained of lower abdominal pain confirmed as being due to urinary retention. A catheter was inserted. Patient confirmed as medically fit but hospital stay extended by 10 days due to a bed in a nursing home being unavailable.

- Some candidates assigned the C80.0 Malignant neoplasm, primary site unknown, so stated as the dagger code, in preference to C79.5 Secondary malignant neoplasm of bone and bone marrow. The pathological fracture occurred because of the secondary malignancy in the bone.

- Some candidates omitted the C79.5 Secondary malignant neoplasm of bone and bone marrow. This would become the dagger code, with the C80.0 Malignant neoplasm, primary site unknown, so stated being coded in addition.

The scenario confirms that the patient sustained a pathological fracture of the femur in neoplastic disease. In order for a code for pathological fracture resulting from neoplastic disease (C00- D48† Neoplasms and M90.7* Fracture of bone in neoplastic disease) to be assigned it must be documented in the medical record that the fracture was due to the neoplasm.

[DCS.XIII.4: Pathological fractures in osteoporosis and neoplastic disease (M80, C00-D48† and M90.7*) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]

- Some candidates failed to reverse the dagger and asterisk codes to correctly show the pathological fracture of the femur in neoplastic disease. The fracture was the main condition treated; M90.7* Fracture of bone in neoplastic disease must be sequenced in primary position, in line with the primary diagnosis definition.

The code that reflects the main condition treated or investigated during the consultant episode must be sequenced in the primary position. The main condition treated here was the fracture. The asterisk code, which demonstrates the fracture can therefore be sequenced before the dagger code that classifies the bony metastases.

[DGCS.1: Primary diagnosis and DGCS.5: Dagger and asterisk system in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]

50 year old patient with early onset Alzheimers dementia admitted with haemophilus influenzae pneumonia and acute confusional state. The patient was confirmed as having type I acute respiratory failure and was given regular nebulisers to make them more comfortable. Pneumonia treated with antibiotics. Comorbidities include chronic obstructive pulmonary disease (COPD), congestive heart failure (CCF), atrial fibrillation and pulmonary oedema.

- Some candidates assigned the incorrect code from Chapter X to classify the haemophilus influenzae pneumonia and added an unnecessary code from B95-B98 to identify the infectious agent.

- Incorrect assignment of the 5th character to demonstrate type 1 acute respiratory failure.
Some candidates assigned F05.8 or F05.9, in preference to F05.1. The acute confusional state was not stated as being ‘caused by’ the pneumonia; therefore F05.1 must be assigned in line with national standards.

A documented diagnosis of ‘delirium’ together with a documented co-morbidity/diagnosis of ‘dementia’ must be coded using the following code:

- F05.1 Delirium superimposed on dementia


Section B: OPCS-4 Coding Scenarios – Maximum number of marks available 26.

Patient admitted for a triple coronary artery bypass graft for extensive coronary artery disease (CAD). Two of the coronary arteries were replaced using saphenous vein grafts harvesting the part of the long/great saphenous vein (LSV/GSV) from the right leg. In addition, an anastomosis between mammary and coronary (left anterior descending) artery was made.

- Several candidates incorrectly sequenced the primary procedure; they did not follow the notes evident at category level in OPCS-4.

The notes located at categories K45 and K40 must be followed to ensure that the procedures are sequenced correctly.

Some interventions/procedures are frequently carried out together but are classified at separate codes or categories. Where this is the case the categories concerned contain instructional Notes to indicate the associated code and correct sequencing.

The following paired codes notes appear in the OPCS-4 Tabular List:

- ‘Use a supplementary code/Use an additional code/Use a subsidiary code’ – use the code this note appears at in primary position.
- ‘Use as a supplementary code/Use as an additional code/For use as a subsidiary code, Use as a secondary code’ - use the code this note appears at in a secondary position.

[PC Convention 2: Instructional notes and paired codes in the National Clinical Coding Standards OPCS-4 reference book (2019)]

- Several candidates omitted the site and laterality codes in relation to the harvest.

- Grafts (other than skin grafts) must be coded as follows:
  - Autografts (graft using material harvested from patient):
    - Body system chapter code classifying the organ/site being grafted*
    - Chapter Z site code identifying the specific site/organ being grafted (if this has not already been identified within the body system code)
    - Z94.- Laterality of operation (if applicable)
    - Chapter Y code identifying the type of tissue harvested and the site of harvest (unless this is identified within the body system code). The site of the harvest is identified within the body system code K40.2 Saphenous
vein graft replacement of two coronary arteries as a result a code to demonstrate the harvest is not required.

- 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).

[PGCS12: Coding grafts and harvests of sites other than skin in the National Clinical Coding Standards OPCS-4 reference book (2019)]

Patient admitted for a panendoscopy to investigate a variety of complaints during which the clinician performed a biopsy of the patient’s larynx followed by an oesophagogastrroduodenoscopy (OGD), which reached as far as the lower oesophagus. The endoscopist was unable to advance any further due to a large obstructing lesion, which was biopsied, an expanding metal stent was inserted to help avoid full obstruction.

- Candidates assigned an incorrect code to capture the biopsy of the lesion in the lower oesophagus. The biopsy taken from the oesophagus was of a large obstructing lesion; hence Y20.3 Biopsy of lesion of organ NOC must be assigned instead of Y20.9 Unspecified biopsy of organ NOC.

When a therapeutic endoscopic procedure is performed that is not an excision and a biopsy is taken at the same time, from the same or a different site, the following codes and sequencing must be applied:

- Therapeutic endoscopy code
- Chapter Z site code (if the therapeutic endoscopy code does not state the site of the procedure or where the site of the biopsy is different to the therapeutic endoscopy)
- Y20 Biopsy of organ NOC
- Chapter Z site code (for the site of the biopsy)

[PGCS10: Coding endoscopic procedures in the National Clinical Coding Standards OPCS-4 reference book (2019)]

- Some candidates failed to capture the endoscopic laryngeal biopsy. A biopsy of the larynx was also performed. E36.1 Diagnostic endoscopic examination of larynx and biopsy of lesion of larynx must be assigned in addition to capture this.

The larynx is part of the respiratory system and as a result cannot be captured by the assignment of a site code in addition to the Y20 Biopsy of organ NOC. An additional procedure code from Chapter E must be assigned to capture this biopsy.

CT head using pre and post contrast and MRI of neck performed during the same visit to the Radiology Department.

- Candidates assigned the incorrect 4th character to capture that single sites have been examined during each scan; the appropriate code to assign to demonstrate this is Y98.1. This must be sequenced after the code from U21 Diagnostic imaging procedures and Y97 Radiology with contrast (where used) in this scenario.

The ‘Notes’ at categories U01–U21 and U34–U37 indicate when additional codes from category Y98 Radiology procedures and Y97 Radiology with contrast, if used, are required.
The CT of the head was performed using pre and post contrast, hence code **Y97.1 Radiology with pre and post contrast** must be assigned in addition to the CT code. Codes within category **Y97** must only be assigned if it is stated in the patient’s medical record that the imaging procedure has been performed using contrast media.

In the case of magnetic resonance imaging, computed tomography and plain x-ray, code **Y98 Radiology procedures** indicates the number of body areas scanned that defines which code must be assigned, irrespective of the time duration taken to perform these scans.

The 'body areas' referred to in the codes in category **Y98** relate to the following nine anatomical regions of the body. These must be used as a guide during code assignment:

- Head
- Neck (including cervical spine)
- Thorax (including thoracic spine)
- Abdomen (including lumbar spine)
- Pelvic region (including all organs in genitourinary system, sacral spine and groin)
- Right leg
- Left leg
- Right arm
- Left arm.

[PCSU2: Radiological contrast and body areas (Y97-Y98) in the National Clinical Coding Standards OPCS-4 reference book (2019)]

Closed reduction and fixation using plate to left ankle joint fracture/dislocation. Reduction performed using image intensifier. Left lower leg immobilised with a plaster cast post surgery. A concurrent open reduction and internal fixation to bilateral distal radial fractures was also performed. The bilateral radial fractures had been reduced in A&E the day before.

- Incorrect sequencing of the primary procedure.
  
  The most invasive/resource intensive operation performed was the reduction of the open fractures due to the greater risk of infection associated with open fractures; hence this code should be sequenced in primary position.

[PRule 2: Single procedure analysis and multiple coding in the National Clinical Coding Standards OPCS-4 reference book (2019)]

- Incorrect codes assigned to capture both the open reduction and internal fixation and the closed reduction and fixation using plate to the ankle fracture/dislocation.

A reduction to the bilateral radial fractures had been performed in A&E the day before; hence the open reduction and internal fixation of the radial fractures was a secondary procedure/reduction.

Secondary reduction and remanipulation of fracture / fracture dislocation codes must only be assigned when the patient undergoes further reduction or remanipulation on the same fracture / fracture dislocation site. The secondary reduction/ remanipulation procedure may be the same or differ from the original procedure. These may be:
The same, for example - primary open reduction followed by further open reduction

or

Different, for example - primary closed reduction followed by subsequent open reduction, or reduction without fixation followed by secondary reduction with fixation.


Case Studies

Case Study 1 – Plastic Surgery (19 marks)

This case study was well completed overall.

• Some candidates assigned individual codes to demonstrate the harmful use of alcohol and cannabis. It is only necessary to assign code F19.1. F17.1 must be assigned in addition, as the patient is confirmed as being a current smoker.

The patient had been told to stop drinking alcohol and avoid his current harmful use of cannabis (two psychoactive substances). The scenario provided does not confirm which is contributing most to the disorder (with 1 Harmful use being added in both instances); hence code F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances, harmful use must be assigned, in preference to F10.1 and F12.1.

A code from category F19.- must be used in combination with F17.1 Mental and behavioural disorders due to use of tobacco, harmful use where the patient is confirmed as being a current smoker.

[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 (2019)]

• The code to demonstrate that the ulcer was infected was omitted by several candidates.

The patient is stated to have a stage III/IV pressure ulcer; where multiple differing stages exist, only one code indicating the highest stage must be assigned. Pressure ulcers with associated infection (infected pressure ulcer) must be coded using the following codes and sequencing:

  o L89.- Decubitus ulcer and pressure area (fourth character will depend on the stage/grade documented)
  o L08.9 Local infection of skin and subcutaneous tissue, unspecified
  o B95-B98 Bacterial, viral and other infectious agents if the infective agent is identified.
[DCS.XII.3 Pressure ulcer and leg ulcer with associated infection, cellulitis and gangrene in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]

Case Study 2 – Obstetrics (15 marks)

- Many candidates assigned codes from O64 Obstructed labour due to malposition and malpresentation of fetus, but there was no mention that the delivery was obstructed; hence a code(s) from O32-O34 must be assigned instead.

  The patient was confirmed as having one baby in the breech position and the other in the OP/face to pubes position. Neither were confirmed as causing an obstructed labour. Codes in categories O32-O34 are assigned when the listed condition is a reason for observation, hospitalisation or other obstetric care of the mother or for caesarean section, at any point during pregnancy, labour or delivery.

  If a condition in categories O32-O34 is diagnosed during labour the code from these categories must still be assigned.

[DCS.XV.15: Maternal care for known or suspected malpresentation of fetus, disproportion and abnormality of pelvic organs (O32–O34) and obstructed labour (O64-O66) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]

- Some candidates failed to assign a code from O60 Preterm labour and delivery to demonstrate the premature labour and delivery or assigned the incorrect 4th character.

  The patient was in labour at 35+2 weeks. This is classified as preterm labour. Preterm is defined as labour or delivery occurring before 37 completed weeks of gestation. A code from category O60 Preterm labour and delivery is used if the labour is spontaneous or induced and if delivery is vaginal or surgical.

  The O60.1 Preterm spontaneous labour with preterm delivery must be assigned as the patient was admitted in preterm labour and went on to deliver preterm twins by any means; one forceps and the other cephalic vaginal delivery.

[DCS.XV.21: Preterm labour and delivery (O60) in the National Clinical Coding Standards ICD-10 5th Edition reference book (2019)]

- Some candidates assigned R24.9 Normal spontaneous vertex delivery to capture the ‘face to pubes’ delivery. Several other candidates assigned an incorrect 4th character to capture the delivery of the first twin. Manipulation was not used to deliver the baby. Therefore R23.2 Non-manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument must be assigned
in preference to **R23.1 Manipulative cephalic vaginal delivery with abnormal presentation of head at delivery without instrument.**

The delivery of a baby with an abnormal cephalic presentation described as ‘face to pubes’ (without using instrumentation) must be coded using a code in category **R23 Cephalic vaginal delivery with abnormal presentation of head at delivery without instrument.**

[PCSR4: Face to pubes presentation (R23) in the National Clinical Coding Standards OPCS-4 reference book (2019)]

- Candidates lost marks due to omitting the codes for the External Cephalic Version. Some candidates assigned **R12.4 External cephalic version**, but lost marks for failing to assign a code from **Y95 Gestational age** in addition.

  There is a note at **R12 Operations on gravid uterus** to assign a subsidiary code to identify gestational age (Y95). The mother is 35+2 weeks pregnant hence code **Y95.1 Over 20 weeks gestational age** must be assigned in addition to code **R12.4 External cephalic version.**

Codes in category **Y95 Gestational age** must be assigned in a subsidiary position, where this information is available, with various codes in Chapters Q and R as indicated by the Notes at category and code level.

[PCSY11: Gestational age (Y95) and PConvention 2: Instructional notes and paired codes in the National Clinical Coding Standards OPCS-4 reference book (2019)]

**Theory Paper**

**Section D: National Clinical Coding Standards – Multiple Choice**

**ICD-10 – Maximum marks available 4**

This section was very well completed overall, 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 overall, 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 48

Like 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 omitted the codes which differed between the Trust and Auditor coding. The corresponding explanations of contraventions and national standard reference and title were also absent. For example, omission of site and/or laterality codes from the answers provided.

- 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. they 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 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 four mandatory requirements that an approved clinical coding auditor needs to comply with in order to maintain their approved status. Several candidates failed to provide examples of the principles of GDPR or provided the incorrect full title for the acronym GDPR.

Conclusions and Recommendations Exercise

Once again, this exercise was completed well overall. 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. This is your opportunity to offer suggestions why you think the mistakes are happening.

- 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. Several candidates omitted timeframes in their recommendations.