HEALTH HOLDING

HAFER ALBATIN HEALTH CLUSTER MATERNITY AND CHILDREN HOSPITAL

Department:	Medical Records		
Document:	Multidisciplinary Policy and Procedure		
Title:	Standardized Diagnosis Codes (International Classification of Diseases – ICD 10AM and Procedure		
Applies To:	All HealthCare Provider		
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1. PURPOSE:

1.1 To utilize standardized diagnosis codes (International Classification of Diseases, 10th, Current Procedure Terminology or Diagnostic Related Groups), procedure codes and definitions so that data can be aggregated and transformed into information by:

1.1.1 Using standardized diagnosis codes

1.1.2 Using standardized procedure codes

1.1.3 Using standardized symbols and definitions

2. DEFINITONS:

2.1 Standardized Codes are classified according to (ICD-10th AM (Australian Modification) system, DRG)

2.1.1 Procedure codes and definitions so that can be aggregated and transformed to be used for research, education, statistics and administrative planning purposes. Being issued and revised by the World Health Organization.

2.1.2 These standardized codes are diagnosis, procedures and definitions that are based on the discharge record of each patient.

2.1.2.1 "The International Classification of Diseases (ICD) is a system developed collaboratively between the World Health Organization (WHO) and 10 international centers so that the medical terms reported by physicians, medical examiners, and coroners on death certificates can be grouped together for statistical purposes. The purpose of the ICD and of WHO sponsorship is to promote international comparability in the collection, classification, processing, and presentation of mortality statistics. Revisions of the ICD are implemented periodically so that the classification reflects advances in medical science.

2.2 Admission and Discharge Sheet

2.2.1 a form that the attending consultant doctor/his designee should complete upon admission and discharge of patient with provisional, final, other diagnosis and procedure done during hospitalization episodes of the patient that can be transformed and aggregated into ICD 10 system. This form must be accomplished by the attending physician or his/her designee. Please refer to the Hospital Policy on Forms, Content and Completeness" MR-12.

2.3 The classification of diseases and related health problems in 22 chapters:

- Certain infectious and parasitic diseases (A00-B99
- Neoplasms (C00-D48)
- Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
- Endocrine, nutritional and metabolic diseases (E00-E89)
- Pregnancy, childbirth and puerperium(O00-O99)
- Certain conditions originating in the perinatal period(P00-P96)
- Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
- Mental and behavioural disorders (F00-F99)
- Diseases of the nervous system (G00-G99)
- Diseases of the eye and adnexa (H00-H59)

- Diseases of the ear and mastoid process (H60-H95)
- Diseases of the circulatory system (I00-I99)
- Diseases of the respiratory system (J00-J99)
- Diseases of the digestive system (K00-K93)
- Diseases of the skin and subcutaneous tissue (L00-L99)
- Diseases of the musculoskeletal system and connective tissue (M00-M99)
- Diseases of the genitourinary system (N00-N99)
- Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
- Injury, poisoning and certain other consequences of external causes (S00-T98)
- External causes of morbidity and mortality (V00-Y98)
- Factors influencing health status and contact with health services (Z00-Z99)
- Codes for special purposes (U00-U49, U78-U88)

3. POLICY:

3.1 To use the Admission and Discharge Sheet in writing the diagnosis and procedures as the basis of the Medical Records Coder when using ICD-10 AM(Australian Modification).

3.2 All discharged Patient Medical Record should have Admission and Discharge Sheet accomplished and filed properly in the Patient's File for Medical Records Coder Personnel reference.

3.3 The Medical Record Coder should also locate the final diagnosis and surgical procedures that need to be coded in the record.

3.4 The Medical Record Coder should also read and review the Discharge Summary Form, Doctor's and Nursing Progress Notes, Operative Reports, Laboratory, Radiology results and other pertinent forms in the record.

3.5 Review Consultation report, operative report, nursing report and other documentation that will clear any discrepancy and inconsistent, and report if such inconsistent are found.

3.6 Code records for disease classification using ICD-10 AM (Australian Modification)

3.7 Code records for operation classification using Australian Classification of Health Interventions (ACHI)

3.8 The Medical Records Coder must submit Quarterly Report to the Medical Records Director of the coded files with the downloaded total number of diseases per month for trending and review

3.9 Records are partly paper based and partly electronic.

4. PROCEDURE:

4.1 Encode the Patient File Number., date of admission, date of discharge and the complete text of the diagnosis and procedures done.

4.2 Select diagnosis codes first to the text option in the computer if the coder is not familiar with the code of a particular diagnosis and procedures, then select the proper code.

4.3 In coding, the primary diagnosis is the first to be coded followed by the secondary diagnosis and so forth. Then the procedures. (procedures as prescribed treatment are all coded)

4.3.1 Enter the number of episodes in the episode option of the computer coding program this will initialize and update the patient number of episode(s)

4.3.2 Enter the diagnosis and procedures in the diagnosis option of the computer coding program this will accept primary, secondary diagnosis, and procedures.

4.4 All completely coded Patient Files should be sent to Sorting Area of Medical Records Department for filing in the Main Shelves of Medical Record Department.

4.5 In any unclear diagnoses or procedures, the coder will return the Patient Medical Record to the Analyst to write deficiency and for completion of attending doctor and to confirm.

4.6 In the event the attending consultant assigned a designee to write the Final Diagnosis or Procedure of the patient, the designee must let the consultant to countersign in the Admission and Discharge Sheet.

4.7 The designee of the attending consultant must be one of team in the care of patient. The designee

must ensure that the diagnosis he written in the Admission and Discharge Sheet is the same as written in the Discharge Summary Form.

4.8 Writing diagnoses or procedures in the Admission and Discharge Sheet/Discharge Summary, no abbreviations or acronyms should be written unless it is commonly used abbreviations such as, MI, DM etc.

4.9 The written diagnoses or procedure must be present in the list of ICD Codes, it must be completely and accurately written accordingly

4.10 Date of Admission and Discharge/Final Diagnosis/Surgical Procedure/Doctors Progress Notes/Nurses Progress Notes must write clearly.

5. MATERIALS AND EQUIPMENT:

5.1 Admission and Discharge Sheet
5.2 ICD-10th AM -System Codes List
5.3 Updated Physician List
5.4 Information Network System Management

6. RESPONSIBILITIES:

6.1 Consultant / Specialist / Resident doctors:
- Completely and accurately fill-out the Admission and Discharge Sheet

6.7 Medical Record Review Committee:
- Reviews random sampling of records coded and reviews difficult or controversial codes.
- Ensure that the coding guidelines are followed from Australian Coding Standards (ACS).

6.8 Head of Medical Record Department:
- Provides personnel for coding and monthly updated physician lists taken from the Medical Affairs Office.
- Report to the concern authorities any discrepancy and inconsistency that the coder reported

6.9 Medical Record Coder Personnel:
- Reports physician's documentation and diagnostic results that are not consistent.
- Ensure that all in-patient discharged files should have been coded within 30 days from the date of discharge

7. APPENDICES:

7.1 N/A

8. REFERENCES:

8.1 International Statistical Classification of Diseases, 10th Revision, Second Edition. Geneva: World Health Organization, 2005.
8.2 http://www.who.int/classifications/icd/en/HistoryOfICD.pdf
8.3 The Health Information Management Association of Australia (HIMAA)
8.4 (CBAHI) National Hospital Standards third Edition 2015 (Effective January 2016)

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		July 10, 2023
Prepared by:	Dr. Shaimaa Biomy Jmal Emara	Quality Facilitator in Medical Administration		
Reviewed by:	Mr. Naif Salman	Medical Records Director		July 11, 2023
Reviewed by:	Mr. Abdulellah Ayed Al Mutairi	QM&PS Director		July 16, 2023
Reviewed by:	Dr. Tamer Naguib	Medical Director		July 17, 2023
Approved by:	Mr. Fahad Hazam Al - Shammari	Hospital Director		July 24, 2023