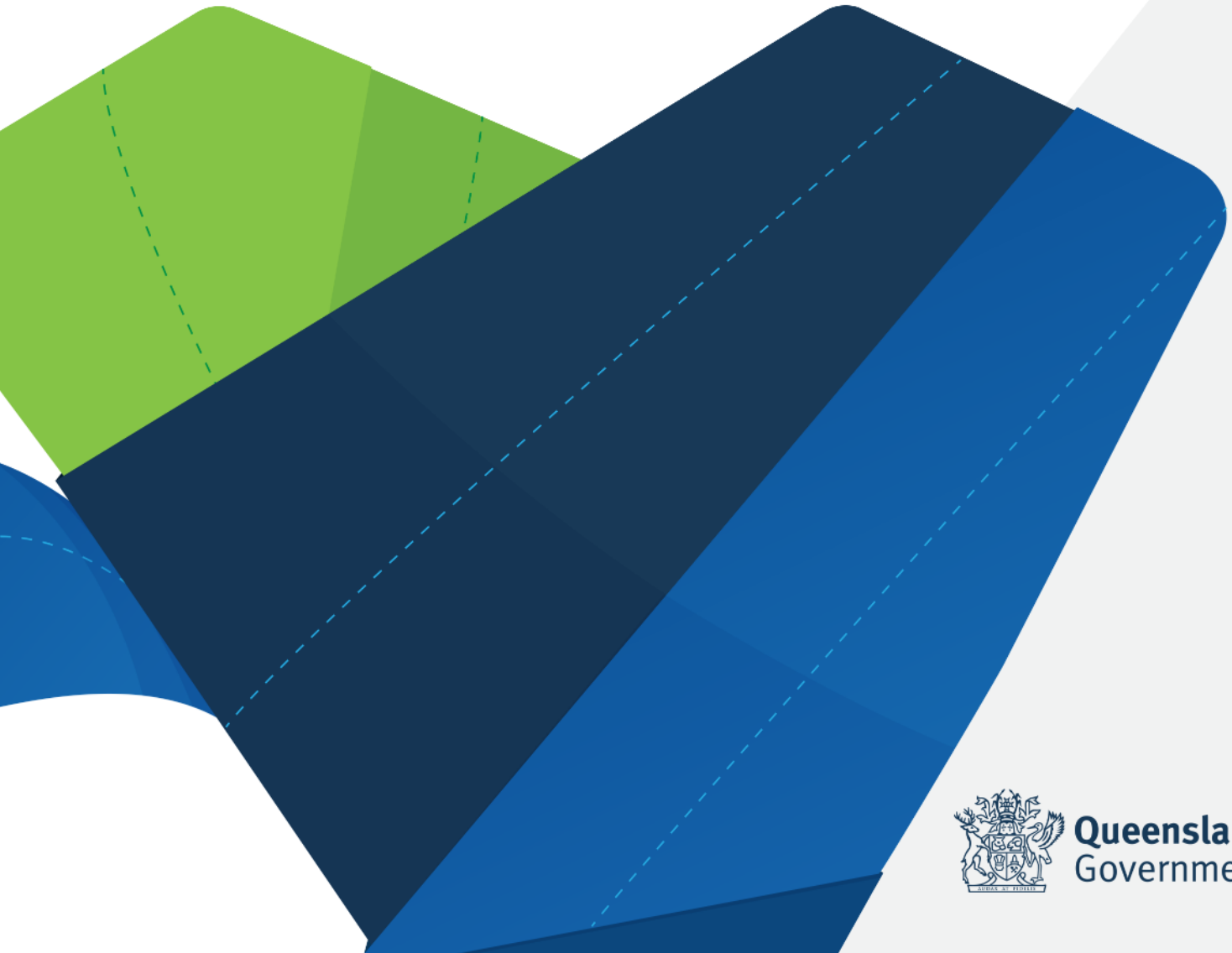
# CCAQ Coding Query Guide

## Clinical Coding Authority of Queensland

March 2023



Queensland Government

## CCAQ Coding Query Guide - 2023

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An electronic version of this document is available at https://qheps.health.qld.gov.au/him-ccn/ccaq

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# 1. Introduction

All clinical coding queries submitted to the Clinical Coding Authority of Queensland (CCAQ) for consideration relate to coding concepts and the interpretation of ICD-10-AM/ACHI/ACS.

CCAQ will accept coding queries from within Queensland only.

These guidelines are to assist personnel responsible for the clinical coding process (clinical coders, HIMS, CDS/CDI, auditors) and to ensure that coding queries submitted to CCAQ are written in a manner that:

- Provides comprehensive information for CCAQ members
- Protects patient/client/staff confidentiality
- Ensures acceptance of the coding query on first submission to the CCAQ.

The CCAQ meets eleven times per year to consider and respond to complex coding queries. Where the CCAQ cannot agree on a definitive response, they may refer the query to the Independent Hospital and Aged Care Pricing Authority (IHACPA) for advice. In these instances, an interim response may be provided to the enquirer pending advice from IHACPA.

All queries must be submitted via email to CCAQ@health.qld.gov.au using the CCAQ Coding Query Form, which can be downloaded from QHEPS. For those unable to access QHEPS, please email CCAQ@health.qld.gov.au for a copy of the query form.

# 2. Developing a coding query

## 2.1 Resolving your own queries

Before sending a query to the CCAQ, every effort should be made to determine the answer using all coding resources available, including but not limited to the following:

**Documentation Issue or Classification Issue**

It is important to determine if your query relates to health record documentation or the coding classification itself. If your coding query relates to a documentation issue, then you must first attempt to resolve the query by clarifying the documentation with the treating clinician (or other clinician who can be of assistance).

The CCAQ advocate the use of clinical documentation queries to resolve documentation issues in the first instance to ensure a quicker resolution of the coding query, promote better documentation practices that support the coding process and reduce the number of queries sent to the CCAQ.

**Index Lead Term/ICD-10-AM/ACHI Conventions**

Ensure you have selected the correct lead term from the documentation. Consider any synonymous terms (word of same or similar meaning) such as haemorrhage/bleeding or leg/limb/extremity. Keep to the words and information documented and note any essential and non-essential modifiers in the Alphabetic Index as these can help clarify the context of the lead term. Finally, consider any cross-references, such as ‘See’ and ‘See also’ or ‘NEC’ instructions and refer to the ICD-10-AM and ACHI conventions. Tabular browsing is not considered good coding practice.

Check for any instructional notes at the chapter, block, category, or code level in the Tabular List. For example, the following is a Note at the beginning of the hernia category (K40 – K46):

*Note: Hernia with both gangrene and obstruction is classified to hernia with gangrene.*

If using a vendor product, validate the pathway against the ICD-10-AM/ACHI hardcopy books where possible. If the query relates to an issue with the vendor product, lodge a query with the vendor rather than submitting a query to CCAQ.

**Australian Coding Standards/ Nationally Ratified Coding Advice**

Search the Independent Hospital and Aged Care Pricing Authority (IHACPA) and the Australian Classification Exchange (ACE) websites for national Coding Rules, FAQs and Errata that may be relevant to your query and determine whether they provide the answer or part of the answer to the query.

**Additional Published Coding Advice**

Consider published CCAQ coding queries and queries from other state coding authorities such as Victorian ICD Coding Committee (VICC) and the Western Australian Clinical Coding Authority (WACCA), however do not use these responses solely to provide the answer as it is not nationally ratified advice and pertains only to the query in question. Instead, use it as a guide to assist in your decision making.

**Reference and Internet information**

Use reference and internet information with caution to assist in your understanding, not to provide you with the answer, as your documentation must still support your code assignment. Include the reference or internet site/URL in your query so that CCAQ members can validate your information source.

**Coder Consultation**

Seek advice from experienced coding peers with a good understanding of ICD-10-AM/ACHI/ACS. It is also recommended that the coder consults with relevant clinicians where the diagnosis or procedure is new or unfamiliar, or where the documentation is ambiguous.

## 2.2 Coding query content

After investigation and consultation, if you're still unable to determine the answer to your coding question, use the following guide to formulate a query:

**Step 1: The Subject**

The subject becomes the title of the query in the published document. It is important therefore that the subject not only clearly identifies the issue but also provides context and focus for the CCAQ discussion.

**Step 2: Background**

Clearly state the issue, provide examples of the documentation from the clinical record, and attach de-identified clinical notes/operation record etc as appropriate. This sets the framework for how the CCAQ members will review your query. Carefully consider if

you have provided all the information to allow the CCAQ members to make an informed decision. Explain any abbreviations used in your query.

**Step 3: The Question**

Ask a clear and specific question. If there are multiple questions, please number them as Q1, Q2 etc. It is also important to specify if the query is seeking a diagnosis code or procedure code, or both.

**Step 4: Suggestions**

Include your code selections and specify the lead terms and index pathways used. Include links and references to any research or published coding queries (national or state) you have consulted. Also include the coding resource (ICD-10-AM/ACHI/ACS books or specific coding software) you're using.

**Step 5: Query deidentification**

Query deidentification is critical. All queries submitted to CCAQ must be in accordance with patient privacy and confidentiality legislation. Any queries not properly deidentified will be returned to the enquirer for amendment.

Queries and supporting documents (operation reports, progress notes etc.) must not contain any direct or indirect information that might identify the facility, the doctor, or the patient.

**Step 6: Review**

Where possible, ask another person (preferably a coder) to review the wording of the draft query to ensure it makes sense.

# 3. Distribution of coding query responses

Coding query responses are emailed directly to the person who has submitted the query once the CCAQ has determined the response.

Coding query advice is updated on a regular basis on QHEPS (for Queensland Health staff) and the Queensland Government website (for private facilities).

Where a query cannot be resolved by CCAQ, it will be escalated to IHACPA for resolution/clarification. In this instance, an interim response will be provided where possible until national coding advice is received.

# 4. Applying coding query advice

The coding advice provided by CCAQ is applicable to the coding query to which it pertains.

Care should be taken when applying this coding advice for similar scenarios. If in doubt, a new query should be submitted to CCAQ.

Where CCAQ coding advice is superseded by national Coding Rules published by the IHACPA, then IHACPA coding rules take precedence.

CCAQ coding advice can be applied to coding practice as soon as it is received or published, unless otherwise directed by CCAQ.

CCAQ coding advice is not to be applied retrospectively.

# 5. Retired CCAQ coding advice

CCAQ coding advice is regularly reviewed to ensure consistency with national coding advice and current coding practice. Advice that is no longer current or has been superseded by classification updates or a national coding rule is 'retired'. Previously published CCAQ advice may be amended to reflect classification updates.

Retired CCAQ coding advice is available for historical reference purposes only. Retired advice is published on a regular basis on QHEPS (for Queensland Health staff) and the Queensland Government website (for private facilities).

# 6. Document control

| Version | Date | Author | Comments |
|---|---|---|---|
| 0.1 | 06/05/2013 | Tracey Matthies, Chair Clinical Coding Authority of Queensland | |
| 0.2 | 12/04/2015 | Tracey Matthies, Chair Clinical Coding Authority of Queensland | |
| 0.3 | 14/12/2017 | Kym, Wimberly, Chair Clinical Coding Authority of Queensland | Document reviewed and updated. |
| 0.4 | 15/07/2020 | Susan Evans<br>Chair Clinical Coding Authority of Queensland | Document reviewed and updated |
| 2.0 | 16/03/2023 | Kristen Wesley<br>Chair Clinical Coding Authority of Queensland | Document reviewed and updated |