First national baseline clinical coding audit in Qatar - results and insights

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Introduction
In late 2011 The Supreme Council of Health in Qatar mandated a unified classification system of diseases and conditions (ICD 10 AM) as part of the prerequisites and preparations for the introduction of the National Health Insurance Scheme (SEHA).

As a result of this all public hospitals achieved full inpatient ICD 10 AM coding starting from January 2013, with private hospitals soon following in July 2013. Since then there hasn't been any study to assess the accurateness and quality of coded data which is being utilized for claims submission.

The aim of the study was to establish the baseline of clinical coding quality and accuracy against clinical coding standards; and to determine the level of coding quality.

Methods
The coding audit used randomized sampling techniques to provide a broad measure of the overall coding performance and to allow for comparison for any future coding audits. The methodology was based on a modified version the Australian Coding Benchmark Audit (ACBA) tool, developed by the National Centre for Classification in Health (NCCH) Sydney, Australia.

A variance slip was used to identify potential coding errors which the hospital was asked to review and either agree or mark for discussion with the audit team. The variance slip was copied by the hospital as a record of the variance and used for education or correction post audit.

In addition a DRG cost weight change was assessed.

There were a total of 1,650 medical records audited from 11 hospitals - 8 public and 3 private.

Results
No exclusion rules were applied in the selection of records for the baseline audit. The largest proportion of specialties represented in this audit are Obstetrics & Gynaecology (14%), General Surgery (12%), Cardiology (10%), Paediatrics (9%), General Medicine (7%) and Plastic Surgery (6%). The total number of specialties covered nationally was 38 different specialties.

In the 11 hospitals audited, there was a total of 1,529 coding errors reported in 1,650 records. The total number of records with a coding error is 648 and a total of 16 documentation errors were registered. The overall national rate for "records with a coding error" is 39%.

Out of the 1,529 coding errors reported, 1,002 errors (66%) were related to diagnoses and 527 errors (34%) were related to procedures.

The 1,529 coding errors also constituted 99 shifts in the AR-DRG (Australian Refined -Diagnosis Related Group). If accepting and correcting all coding errors, 41 of the 99 DRG (Diagnosis Related Group) will be shifted to a higher price DRG while 58 will be shifted to a lower price DRG.

Conclusions
The results of the first national baseline audit on clinical coding quality shows that much work is needed for continual training and education for the coding industry in Qatar. Recommendations for further learning in specific areas in the Australian Coding Standards are highlighted and conducting clinical specialty workshops with particular emphasis on improving coding quality are suggested.

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