UKOA
UK OPHTHALMOLOGY ALLIANCE

Coding Advice for Ophthalmologists for Admissions or Procedures

Clear precise notekeeping: Use clear and unambiguous language. Write legibly. Think about the coding when you document the disorders, procedures and care given	
Do	**Record**: • Primary diagnosis • Co-morbidities • Complications • Cause and place of injury (if relevant) • Primary procedure • Secondary procedure • Treatments, investigations, tests • Discharge summary State clearly associations and causal relationships between conditions. Use phrases such as “secondary to” and “complication of” and avoid the less clear “in” or “with” or “complicating”. Record not only what is confirmed, but also what has been ruled out/that the patient does not have (where working diagnoses change over time).
Do not	Avoid using abbreviations as they can lead to code errors unless they are widespread and unambiguous. • e.g. “PE” can be used for more than one common condition, and abbreviations that relate to extraocular muscles or parts of the eye can cause confusion. • e.g. “↑BP” can't be interpreted as hypertension by a coder and will only be coded as a diagnosis if “hypertension” is written.
Diagnosis	
Primary diagnosis	Make very clear which diagnosis is **the main condition being treated** during the **current episode of care**. Write this down first. This may not be the same as the overall “main diagnosis” from a clinical perspective.
Confirmed diagnoses	**Do** use these wordings in front of the diagnosis: “Confirmed”, “Probable”, “Presumed”, “Clinical”, “Treat as” or “Working diagnosis”. **Do not** use “Likely”, “Possible”, “Query”, “ΔΔ”, “Suspected”, “?”or “Impression” as coders are not allowed to code diagnoses which are qualified by these words without further clarification.

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No confirmed diagnosis	In the absence of a confirmed diagnosis, detail the main symptoms and signs that were investigated during the current episode. Coders cannot diagnose solely from test results, there must be supporting clinical documentation before codes can be assigned.
Comorbidities: Comorbidities need to be documented completely and clearly.	
Current	For the purposes of coding, co-morbidity is defined as: • any condition which is **current** and **co-exists** in conjunction with another disease during the admission (do not include conditions the patient no longer has) • **and affects the management** of the patient's current admission episode. The doctor needs to **re-record during the admission** any relevant co-morbidity that co-exists at the time of admitted care. Coders **cannot use information from previous** hospital admissions to identify and code conditions. Some units tackle this by working with the nurses who record details of non-ocular comorbidities in a pre-op assessment sheet as part of the episode of care.
Relevant	Be clear about what is 'relevant' to the current case (i.e. affected the management of the patient, affected the care, had an impact on the treatment/medication etc.) versus what really had no impact or was of no particular interest clinically during the stay.
Operation notes should be legible, easily accessible and available in the notes. Electronic or typed are ideal as hand written operation notes can be difficult to read, and important details may be missed and not coded. The use of standardised templates can be very useful and save a lot of time.	
Operation notes	Always ensure that an operation note is completed and available in the casenotes by the time of discharge. "See typed op note" or "see op note form" in the casenotes where there is no operation note to be found at the time of coding is a common problem.
Operation sheet heading	Operation notes need to be headed with the following information: • title of the operation • site and laterality • operation date • patient name and number.
	Ensure that the title of the operation corresponds with what the surgeons have actually done.

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Operation detail	Do not use abbreviations in operation titles e.g. "vity/gas" is not a full description of "pars plana vitrectomy with retinal endolaser and intraocular gas tamponade".
	Avoid eponyms where possible. If using eponyms then describe what the procedure entailed in order to ensure accurate code assignment.
	Operation notes should include: • Operative diagnosis • Operative findings • Clear description when an operation is unusual or differs from the standard method/ technique, and when additional procedures are carried out that are non-standard • Any problems or complications.
Site	Specify the site being operated on as precisely as possible. Conflicting information in the operation record when compared to elsewhere in the notes is common. For example, the admission notes may say X and the operation record may say a Y leaving the coder with two distinct sites with two different site codes.
Prostheses and devices	Record all the prosthesis/device details, including iris hooks, capsule tension rings, intraocular lens etc.
Working with coders	
Check your coding	When you finish each recording in the notes during an admission, **check it again** for coding suitability.
Queries and education	Ideally there should be at least **one ophthalmologist** in the department with a specific responsibility to be the **link between the coding department and the eye department**. They should communicate regularly and be easily available to answer queries and teach coders about ophthalmology, anatomy and terminology. Keep a record of queries for future reference or create local coding rules where no clear national standard.
Diagrams	Ophthalmologists often draw diagrams that coders aren't trained to interpret. Please ensure that your coders have been taught how to interpret diagrams and coding policies on diagram interpretation have been agreed on and documented with the coding department.

Date of publication: July 2018