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Letter to the Editor

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Challenges faced by clinical coders with Physicians` documentation

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Dear Editor.

Clinical coding is the process by which clinical information about the patients are transferred into codes to enable grouping of medical activities in a limited number of categories that are easy to process, store and analyzed[1]. The essential element in making a correct clinical coding is the allocation of each diagnosis or procedure in the group category to which it belongs, underpinning the general concept for the quality in clinical coding.

Clinical coding involves the allocation of a code for each relevant diagnosis, condition, disorder or health status and a coder for each relevant procedure and treatment that a patient encounter during their inpatient stay[2,3]. These codes are allocated from the Classification system. Oweghoro states that the International Classification of Diseases and Related Health problems, commonly referred to as ICD is a publication of the World Health Organization(WHO), that permits systematic recording, analysis, interpretation and comparison of morbidity and mortality data collected in different locations[4].

Adio outlined various importance of Clinical coding as a tool for research, statistical purposes, medical audit, quality assurance review, patient billing, education and accreditation for management decision making and other uses[5].Despite the numerous importance of clinical coding, studies from Nigeria established that absence of automation, lack of political will, inadequate clinical coders, coding contempt; suboptimal documentation and gross underutilization of discharge summary are some of the challenges confronting clinical coding[6,7].

Specifically, physicians in Nigeria, who are the major contributors and major users of the patient's health records, have not accorded clinical coding the right that is due to it especially in in their failure to complete discharge summary, their refusal to follow a treatment regime to its logical conclusion, existence of communication gap between physicians and health records professionals, the use of impressions in lieu of definitive diagnosis, to mention but a few, are factors impeding effective clinical coding in Nigeria[7,8].

As a result, accreditation of some clinical departments had been hampered; retrieval of needed information for patients care had suffered setbacks, which has no doubt affected the quality of healthcare service delivery. More so, achievement of the singular objective of healthcare service delivery has continually become a mirage because the system suffers from relevant qualitative and quantitative data starvation.

In order to ensure effective clinical coding, the following are recommended:

1. Discharge summary should be completed for every case discharged.

2. Communication gap between physicians and clinical coders should be breached as much as possible.
3. Physicians should conclude with definite diagnosis as the reason for admission.
4. Physicians' handwritten documentation should be legible enough for coders to understand.
5. Documentation quality and quantity should be given due considerations.
6. Coding tools should be adequate in supply, functional and usable.
7. Computer system and other accessories should be adequate in supply to support large data storage.

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Authors Contribution:

SSO conceived of the study, initiated its design, participated in literature search, article selection and review, data analysis and coordination and drafted the manuscript.