

Practice Incentives Program (PIP) eHealth Incentive

Requirement 3 - Data Records and Clinical Coding

Data Records and Clinical Coding

There are no software conformance requirements for this Requirement.

*Practices must ensure that where clinically relevant, they are working towards recording the majority of diagnoses for active patients electronically, using a medical vocabulary that can be mapped against a nationally recognised disease classification or terminology system. Practices must provide a written policy to this effect to all GPs within the practice. An active patient is a patient who has attended the practice three or more times in the past two years. Medical Vocabularies include SNOMED-CT, **DOCLE**, PYEFINCH and ICPC2+. Nationally recognised disease classification and terminology systems include ICPC2, ICD10-AM and SNOMED-CT.¹*

DOCLE (Doctor Command Language) is a non-numeric health coding and medical classification system. The DOCLE system is used in **Medical Director**.

DOCLE has been modelled on the Linnaean biological classification system since 1995. DOCLE generates clinical codes from ubiquitous health language using an algorithm, hence it is a human readable clinical coding system.

Preparing Your Patient Data in Medical Director

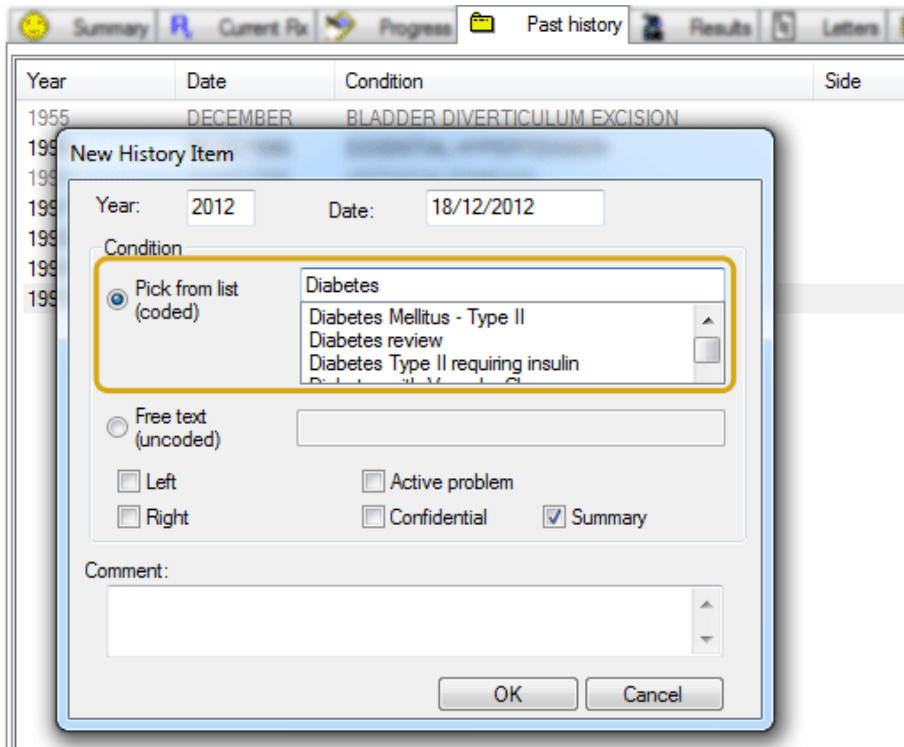
Medical Director Diagnosis Coder

In MD3 there are two ways to enter past medical history items:

- Pick from list (**Coded**) or
- Free Text (**Uncoded**)

Both of these options are available to use in Past History. However if you have entered a diagnosis into the Past History tab that was not selected from the 'Pick from list' it will not be internally coded, and as such will not be found when doing searches. This is particularly important for Chronic Disease Management or when using some supplied decision support options.


For example, if you typed 'Diabetes type 2' into the uncoded section of the Past History tab, rather than using 'Diabetes Type II' from the drop down list, it will not be found when you do a search for Diabetic Type II patients.

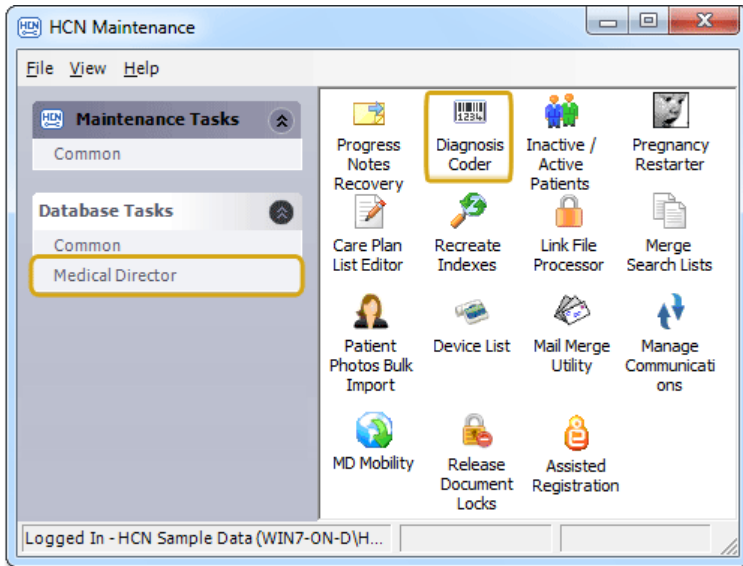


¹ Source: [Practice Incentives Program eHealth Incentive guidelines—February 2013](#)

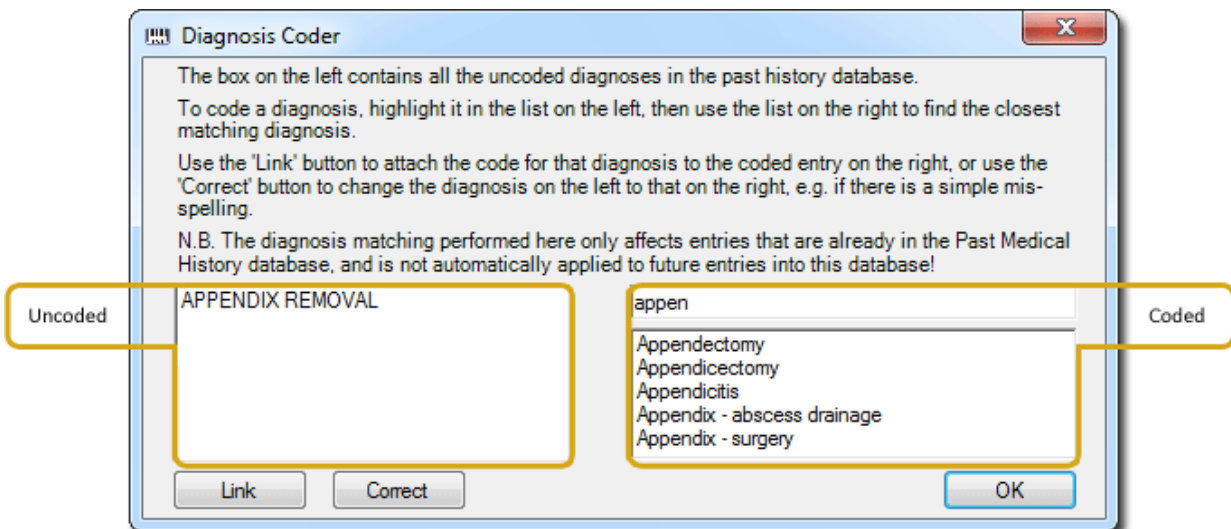
How to Update Uncoded Past Medical History Items

HCN provides a simple utility in HCN Maintenance that enables you to easily find *non-coded* Past Medical History items, and either **link** them to a coded item or **replace** them with the correct coded item.

1. Double click the **HCN Maintenance** icon  to open HCN Maintenance.
2. Select **Medical Director** in the list of Database Tasks on the left of the window.



3. Double click the **Diagnosis Coder** icon. 



The left-hand panel of this screen contains all the uncoded diagnosis entries in the Past Medical History database. The right-hand panel displays *coded* entries that you will select from to pair-up with your *uncoded* entries. Note that the right-hand panel is initially empty, but as you type into the text box above it (in this example *appen*), a list of items is generated underneath.

Simply highlight the entry on the left and the one you want to link or replace it with on the right, and then click either the **Link** or **Correct** button.

The **Link** button will attach the code for that diagnosis to the coded entry on the right.

The **Correct** button will change the diagnosis on the left to that on the right i.e. if the word was misspelled.

Once you have worked your way through all the uncoded diagnosis occurrences, all uncoded items will be replaced and coded, and therefore allow the now coded data to be included when conducting a search.



Important Resources

- **NEHTA PIP implementation overview > Data Records and Clinical Coding**
<http://pip.NEHTA.gov.au/pip-implementation-overviews>
- **RACGP Standards for general practices (4th edition)**
<http://www.racgp.org.au/standards>
- **Australian Medicare Alliance – Data Quality Guide**
http://www.amlalliance.com.au/_data/assets/pdf_file/0006/43971/Data-Quality-Guide.pdf

Checklist

There is no software conformance requirement for Requirement 3. This checklist is to guide practices on what is needed to achieve this requirement:

<input type="checkbox"/>	Practice is taking steps to ensure that majority of diagnoses; where clinically relevant is recorded using clinical coding
<input type="checkbox"/>	A written policy must be in place to encourage the use of clinical coding

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