Information Management

A System We Can Count On

Inpatient Record

| ADMITTING PHYSICIAN | HOSP. NUMBER | ADMIT DATE | ADMIT TIME | ADMIT TYPE | CASE NUMBER |

HEALTH CARD NUMBER

ADMITTING DIAGNOSIS

NAME

SURNAME ON HEALTH CARD

DATE OF BIRTH

SEX

MEMO

AGE

ADDRESS

PHONE

BUS. PHONE

IN EMERGENCY NOTIFY

RELATIONSHIP

PHONE

RELIGION   LANGUAGE   KOSHER

FAMILY PHYSICIAN

REFERRING PHYSICIAN

ALTERNATE LEVEL OF CARE

KNOWN DRUG ALLERGIES   CODE (S)

HCN

PRE ADMISSION COMORBIDITY

POST ADMISSION COMORBIDITY

SECONDARY CONDITIONS

OPERATION FOR TREA...

Lives depend on you fully out patient charts legibly complete and on time

A Guide to Better Physician Documentation

Physician Documentation Expert Panel

November 2006

Ontario

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Acknowledgements

The Physician Documentation Expert Panel was established in September 2005, as part of the Ontario government's Information Management Strategy. The panel met over a period of several months, until February 2006.

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A Message from the Physician Documentation Expert Panel Chair

As chair of the Physician Documentation Expert Panel and on behalf of my fellow panel members, I am pleased to present you with this guide to better physician documentation.

It reflects the collective input and recommendations of a panel of your peers, representing a range of disciplines, and the profession's regulator and association as well as stakeholders, who came together in the fall of 2005 because of concerns about the deficiencies in patient health records due to incomplete, inaccurate and lengthy delays in physician documentation.

As physicians, the health and care of our patients are our greatest concerns, and it is clear to us that inadequate documentation impacts on both patient care and outcomes. A family doctor treating a patient without the benefit of a discharge summary from an acute care physician is working at a disadvantage in a potentially life-threatening situation.

Quality physician documentation shared in a timely manner can help avoid negative consequences, such as adverse medication events.

These are some of the concerns that brought us together to devise strategies and tools to improve physician documentation primarily in acute and ambulatory care episodes. This is an issue that impacts on the quality of patient care and the overall health care needs of Ontarians.

The patient health record is a physician's most powerful communication tool. It is the key to exchanging critical information with all members of the clinical team. It is an essential communication vehicle, not only in a hospital setting, but also in other health care settings.

The health record links acute care physicians with primary care physicians and allows for the transfer of potentially life-saving information. The health record is paramount to the continuity of care. When there is a breakdown in this communication, due to delays in the transfer of information or incomplete and inaccurate information, the consequences can be negative.

Physician documentation also drives the quality of data within the health care system. The information written and maintained in patient health records, once it is collected and aggregated, is used by clinicians, health system planners, researchers, and decision-makers as the basis for important decisions related to the health care needs of Ontarians. Good physician documentation ensures that a better quality of data will be available on which to base critical health care sector decisions.

Poor physician documentation can, in part, be linked to the lack of focus on this issue in medical schools. This inattention to good documentation procedures continues through the internship and residency phase of medical training, which means that physicians are not being adequately equipped to document effectively in the course of their medical training.

Additionally, studies have raised concerns about deficiencies in the documentation of patient charts at Ontario's hospitals, including issues of accuracy and lack of completeness.

To support the goal of improving the quality of physician documentation, a group of my esteemed colleagues and I were asked by the Ministry of Health and Long-Term Care's Health Results Team Lead for Information Management, Adalsteinn Brown, to address this important issue, as part of the Ontario government's Information Management Strategy. In conjunction with the Health Results Team, the panel spent several months creating an information package for physicians, which includes:

- This comprehensive guide, detailing the impact of good physician documentation on patient care and outcomes, as well as the consequences of poor communication
- A chart completion policy template to serve as a standard guide to physicians and hospitals, that will help facilitate the accurate and timely completion of patient charts
- A brochure highlighting the importance of quality physician documentation
- A slide presentation on physician documentation emphasizing the key points from the guide

It is the hope of the panel that these documents will be useful to you and your colleagues in providing a foundation for improving the quality of physician documentation. Complete, accurate and timely physician documentation will enhance patient care and greatly benefit Ontario's health care system.

We would encourage you to share these materials with your medical colleagues. Through better physician documentation we can enhance our most powerful communication tool, the health record, to optimize patient care and ensure that a better quality of data is available for critical health care decisions.

Ralph Z. Kern MD MHSc FRCP(C)
Assistant Professor, Neurology Program Director, University of Toronto

Introduction

Ontario physicians are key to providing the information included in patient health records. These records are a critical component in the quality and continuity of care Ontarians receive in the health care system. The health record is a powerful and crucial communication tool between physicians across the continuum of care. Physicians drive the information in the patient health record, which ultimately gets translated into data and information upon which important health care decisions are made.

The significance of the patient health record is often taken for granted. Many physicians are not fully aware of the regulations governing the completion of the patient health record or that it is a legal document that must be able to withstand scrutiny in court.

This can be linked in part to the lack of focus on this issue in medical schools. This inattention to good documentation procedure continues through the internship and residency phase of medical training. A review of medical schools in Ontario conducted by the Ministry of Health and Long-Term Care's Health Results Team for Information Management (HRT-IM) found that little to no education is provided on the importance of documentation or how to do it properly. Physicians are not being adequately equipped to document effectively in the course of their medical training.

Numerous studies in various jurisdictions have reached troubling conclusions about the quality of patient health records. Too often they have been found to be incomplete or inaccurate, or important patient information has not been passed on to subsequent physicians in a timely or useful manner.

In Ontario, for instance, a 2005 survey conducted by the ministry found that, on average, it takes physicians 35 days to complete their hospital charts. Sixty-three per cent of hospitals submit abstracts to the Canadian Institute for Health Information (CIHI) based on incomplete patient charts. The study concluded that incomplete charts result in standardized codes being assigned based on assumption and inference, leading to an inferior quality of data, the basis for important health care decisions.

Concern over the state of physician documentation, led to the creation of Ontario's first Physician Documentation Expert Panel to examine ways to improve the quality and usefulness of information included in patient health records.

More than 20 physicians from across the province, representing a variety of disciplines and organizations, including the profession's regulator and association, came together because of the great importance of this issue. The panel's objectives were two-fold: firstly, to raise awareness of the state of physician documentation and secondly, to promote accurate, clear, complete and timely documentation of the patient's diagnosis, problems, treatment and progress in the health record.

In examining the current state of physician documentation, the panel focused its attention on the discharge summary component of the health record, which it found to be a critical communication tool between providers to ensure optimal continuity of care. Timely communication through the discharge summary between acute and primary care providers can improve health outcomes, including avoiding adverse medication reactions or reducing re-admissions to hospital.

Although the panel's work focused on health records involving inpatient and ambulatory episodes of care, the consequences are far reaching across the system. Better physician documentation will improve the quality of hospital health records. This will ensure that a better quality of data is available to clinicians, health care planners, researchers and decision-makers.

It is the panel's hope that Ontario's physicians will find the information contained in this guide useful, and that they will benefit from the new chart completion policy template developed by the panel. Good patient care is dependent on it.
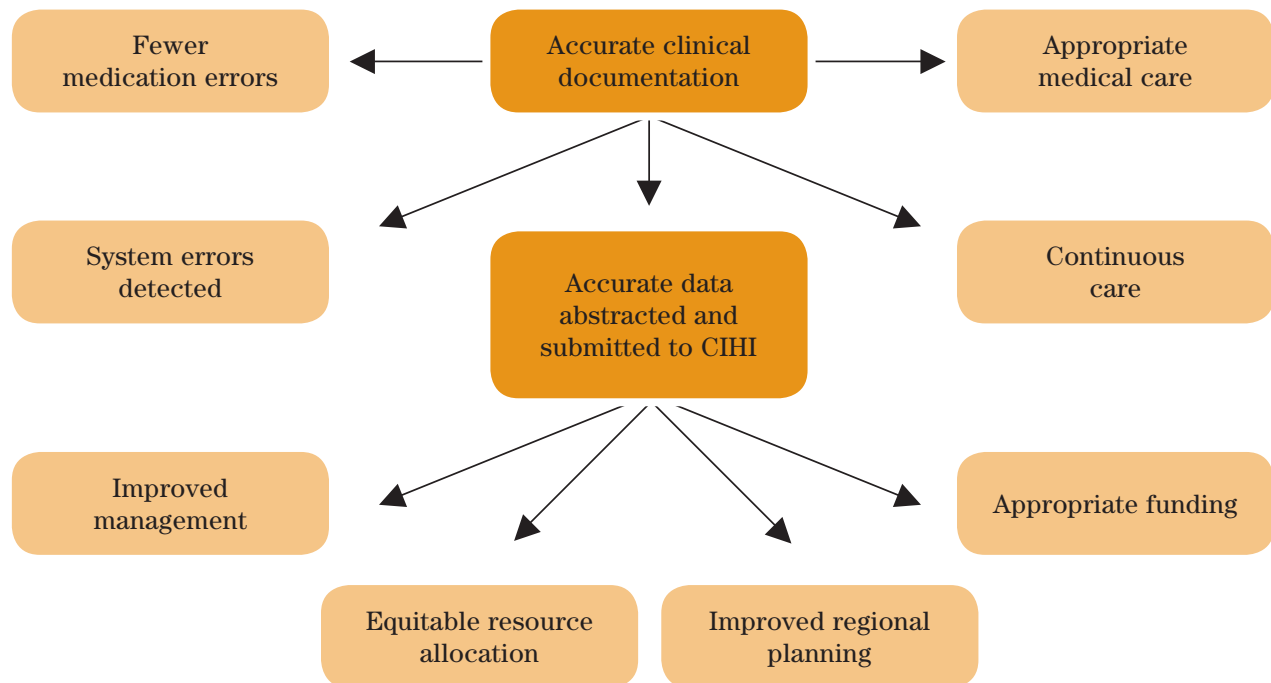
1.0 The Patient Health Record: Importance and Impact

Clinical documentation in a patient's hospital record includes any and all information that relates to the care of the patient during their stay or hospital encounter. It is designed to evaluate the current status of the patient, assist in developing a plan of care, evaluate the care given, and provide for continuity of care. It is critical that it be accurate and complete. Complete and timely health records also ensure that all clinical staff caring for patients in present and future episodes of hospitalization have access to the information they need to deliver optimum care.

Good and complete documentation in a patient's health record has been linked to both quality of care and health care costs (National Coalition for Health Care, Charting the Cost of Inaction, 2003). Detailed and accurate chart documentation facilitates appropriate medical care, helps reduce negative outcomes (such as medication errors) and supports the continuity of care. This section will examine the patient record's impact on:

- patient care and clinical outcomes;
- physician-to-physician communication; and
- the health care system.

The following diagram further demonstrates the impact on patient care and the health care sector as a whole resulting from complete and accurate documentation in the health record.

Fewer medication errors	Accurate clinical documentation → Appropriate medical care
System errors detected	Accurate data abstracted and submitted to CIHI → Continuous care
Improved management	Equitable resource allocation / Improved regional planning → Appropriate funding

1.1 Patient Care and Clinical Outcomes

Recent studies show that approximately 20 per cent of patients experience adverse events during the first several weeks after hospital discharge. The most prevalent type of adverse event is medication-related (adverse drug events); other adverse events include nosocomial infections, procedural complications and diagnostic and therapeutic errors. Some of the factors contributing to post-discharge adverse events are patient-related, such as longer lengths of stay or diagnosis of diabetes mellitus. There are also other factors that contribute to adverse events, including lack of information provided to the patient during discharge and incomplete or delayed discharge information being provided to subsequent care providers.

One-third of these events are preventable and another one-third, while not preventable, could have reduced severity if corrective measures were instituted earlier and more effectively (14). Therefore, it is important to consider the role of documentation in preventing adverse events and improving patient care and safety.

Studies have also shown that patient care can be improved by sending complete and accurate discharge information to the patient's general practitioner in a timely manner (4, 5).

The panel looked specifically at studies that have considered the impact of the discharge summary on health outcomes. One study, conducted by van Walraven and colleagues (32), found that **the risk of re-hospitalization decreased when patients were assessed for follow-up by physicians who received a discharge summary.** The study concluded that discharge summary dissemination of patient-specific hospital information to follow-up physicians might influence important patient outcomes. The other study, conducted by Forster (2003), found that **visits in the emergency department of a teaching hospital in Ottawa were 1.2 hours longer on average for patients with an information gap in their health records than for those without one.**

Many studies have also assessed the discharge summary component of the health record in terms of content, accuracy and timeliness.

Van Walraven and Rokosh (35) have shown that family physicians rate discharge summaries as being of high quality when they were short, delivered quickly, and contained pertinent data that concentrated on discharge information. Summary content that increases the quality of the discharge summary most includes:

- Admitting diagnosis
- Pertinent physical examination findings and laboratory results
- Procedures and comorbidities while in hospital
- Discharge diagnosis/diagnoses
- Discharge medications
- Active medical problems at discharge
- Arrangements for continuing care [follow-up]

Based on these studies, it is the panel's recommendation that the discharge summary should also include:

- Details of medications prescribed at discharge, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment;
- Specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports that need follow-up;
- Information that was provided to the patient about diagnosis, management and expected outcome; and
- A summary of the case.

1.2 Physician-to-Physician Communication

The studies mentioned in Section 1.1 provide further impetus to improve the current standard of communication in order to enhance the continuity of care and subsequent clinical outcomes.

The panel considers the discharge summary as amongst the most crucial pieces of documentation in the health record. It is the basis of communication with subsequent health care providers and, therefore, is essential for the continuity and quality of patient care.

The discharge summary captures a variety of data intended to inform the primary or referring provider of the highlights of the patient care episode. It can serve as a powerful communication tool linking acute care and primary care physicians in the system.

The discharge summary can only be effective if it is complete, accurate and made available in a timely manner. An incomplete discharge summary and/or one that arrives too late, leaves a family physician and the patient at a disadvantage. A primary care physician needs access to this useful and potentially life-saving information quickly. It is critical to a family physician's ability to continue care uninterrupted when they resume responsibility for a patient.

Copies of this information should therefore be provided in a timely manner to all providers involved in the patient's care.

Many patients with complex problems are examined, observed and discharged directly from Emergency Departments or Observation Units. Since the potential for re-admission is high unless the family doctor is provided with notification and information for follow-up purposes, "discharge" or "progress" notes should be forwarded to the family doctor within 24 hours of discharge from these units.

1.3 The Health Care System

Sections 1.1 and 1.2 have considered the importance of collecting and maintaining health information to provide a continuum of patient data and enable health personnel to best treat and care for the patient. But there are other purposes for keeping accurate and complete health records. From a health system planning perspective, high-quality information is integral to research, performance measurement, planning and resource allocation.

Physician documentation forms the basis of clinical coding. National coding standards call for disease and intervention codes to be based on physician chart information. The Canadian Institute for Health Information (CIHI) standard states that nurses' notes, pathology reports, laboratory reports, autopsy reports, medication profiles, radiological investigations, nuclear imaging, and other similar investigations are valuable tools for identifying the appropriate diagnosis code. **However, these diagnoses must be further supported by physician documentation to be classified as significant comorbidities.** Therefore, physician documentation directly drives what is reported in the clinical data.

Inadequate clinical documentation can lead to inaccurate code assignment, which leads to inaccurate representation of patient severity of illness, which, in turn, leads to inaccurate reflection of rates of mortality and complication data. One study found that discharge information used for determining morbidity patterns for health policy and program planning was inadequate (19). This data is used widely for making important decisions that impact the delivery of health care in Ontario (refer to Appendix A for more examples).

In a recent re-abstraction study conducted jointly by the Ministry of Health and Long-Term Care (MOHLTC) and CIHI, the quality of coding of clinical and non-clinical information was evaluated to assess the impact of coding variation on resource utilization.

More than half of the discrepancies with diagnosis coding were attributed to issues related to chart documentation. There were issues with incomplete or conflicting information, differences in interpretation, missed information, and cases where the specified condition was not supported.

The key findings from the re-abstraction study indicate that data elements for admission category, discharge disposition, institution to and institution from, need improved chart documentation. The study points to a need to make improvements to chart documentation so that coding accuracy can also be improved. This will in turn help to improve the quality of information used for research, performance measurement, planning and resource allocation.

2.0 The Current Documentation Environment

Recognizing the importance and impact of the patient health record is one thing; being aware of the requirements for documentation completion is another.

Further to a review of medical schools in Ontario, the ministry found that little to no education is provided on the importance of documentation or how to document. This finding is confirmed by other studies, which reveal that little guidance is given to physicians in preparing discharge summaries (8, 13).

When combined with time limitations, this lack of guidance often leads to discharge summaries being given a low priority so that quality is less than optimal and there is little opportunity for formal feedback. In addition, few physicians are able to meet deadlines for completing their documentation.

This section provides an overview of current chart completion practices by physicians and in hospitals, as well as the legal requirements and policies that are in effect in Ontario.

2.1 Physician Practices

Studies have shown that there are many ineffective procedures related to chart documentation. One of the most frequently reported concerns is individual physician practices. **It has been found that documentation is used more as a tool to recall events rather than as a means to justify treatment decisions,** often leading to a lack of completeness, accuracy and timeliness in completing charts (12, 16).

Studies have noted the lack of accuracy in the documentation, for example, where the final diagnosis following discharge was not correctly recorded in the discharge summary (2). Other studies have noted the lack of timeliness in discharge summaries being completed, and have often found that they were not received by physicians seeing patients after discharge from hospital (31).

A survey of hospital Health Information Management/Records Departments conducted in 2005 by the ministry found that only 11 per cent of hospitals in Ontario have discharge summaries completed and signed within 48 hours. Other studies have noted an appreciable delay between the time that the patient was discharged and the time the information was received by the patient's general practitioner (20, 26).

2.2 Practices in Hospitals

One of the issues related to poor documentation is the requirement for physicians to complete multiple documents with similar content. For example, some hospitals require the most responsible physician to document medications (including dosage) on both the face sheet and the discharge summary. Other hospitals have implemented a Cumulative Patient Profile (CPP), which is a "snapshot" of the critical elements of the patient's medical history, allowing health care professionals to quickly get information on the patient's overall health. **Proper use of a CPP can save time by reducing the need to rewrite information in the progress notes when the information is already contained in the CPP.** It can also help to prevent errors and duplication of documentation. (Refer to the College of Physicians and Surgeons of Ontario's Medical Records Policy for further details.)

Many hospitals are starting to adopt computerized physician documentation systems, which have a significant impact on the content and availability of that documentation. Some hospitals have reported increased accessibility, availability, legibility and organization of the patient information, as well as improved patient outcomes, by reducing medication-prescribing errors (1, 10). Others have shown that these systems also result in increased redundancy, longer documents, increased "clutter" and lack of updates to clinical issues (10, 23).

2.3 Legal Requirements and Hospital By-Laws

2.3.1 The Ontario Public Hospitals Act

Health records consist of information required by regulation and for other purposes such as auditing, teaching, research and accreditation. While used primarily for medical purposes, health records are also legal documents and, therefore, carry legal consequences as a result of their other uses. Provincial regulations should be followed regardless of whether or not the information is needed for clinical or other purposes.

The Ontario Public Hospitals Act sets requirements as to what health information must be recorded by a health facility. Section 19 of Regulation 965 of the act provides that hospitals must ensure that a system exists for keeping a health record for each patient; each entry in a health record should be dated and authenticated by the person who authorized the entry. The regulations outline the content of the health record as well as the timelines for which the health record must be completed. For example, a hospital is required to ensure that:

- Within 24 hours, an admitting note, authenticated by the physician, is placed on the health record.
- Within 72 hours after a patient has been admitted to hospital by a physician, that physician must take a medical history of the patient, give the patient a physical examination, and record, date and authenticate the history and report findings of that examination and the provisional diagnosis.

Appendix B provides further details related to what a health record should include as stated in Regulation 965.

2.3.2 Hospital By-Laws and Chart Completion Policies

Hospitals are given authority to enact by-laws for the governing of their internal affairs. The by-laws must be adopted according to the procedure established in the articles of the incorporating documents of the corporation. They must not contravene any provincial or federal act or regulation. By-laws may outline information, which is to be included in the medical record, and may duplicate and supplement existing provincial legislation. **Therefore, a physician is bound by their hospital by-laws related to documentation.**

Hospitals may also develop their own policies on chart completion. The chart completion policy enables the hospital to define a consistent approach for the completion of health records, ensures the timely completion of health records to support on-going patient care and further, allows the hospital to apply appropriate consequences when health records are not completed according to specified timelines.

A review by the panel of over 100 hospital chart completion policies in use in Ontario and in other provinces revealed that the majority employ a three-step process providing physicians with four to five weeks from discharge to complete the health record. This process is described in Section 3.0.

2.3.3 Privacy Legislation

The Personal Health Information Protection Act, 2004, includes rules for the collection, use and disclosure of personal health information about individuals that protect the confidentiality of that information and the privacy of individuals with respect to that information, while facilitating the effective provision of health care. It states that a health information custodian that uses personal health information about an individual shall take reasonable steps to ensure that the information is as accurate, complete and up-to-date as is necessary for the purposes for which it uses the information. Please refer to the act for further details on the privacy legislation.

2.4 The Regulator and the Association

2.4.1 The College of Physicians and Surgeons of Ontario's Medical Records Policy

The College of Physicians and Surgeons of Ontario (CPSO) regulates the practice of medicine and monitors and maintains standards of practice. The College released its Medical Records Policy in September 2005, which defines the essentials of maintaining records. While it is intended primarily for office-based records, it offers guidance with respect to the principles and requirements for all medical records. The recommendations in this policy are in compliance with the requirements set out in the Ontario Regulations made under the Medicine Act, 1991. Refer to Appendix C for details of the Medicine Act.

2.4.2 The Ontario Medical Association's Standard Inpatient Discharge Form

The Ontario Medical Association (OMA) recently developed a standard inpatient discharge form for hospitals as a result of a directive received from the OMA Council in November 2003, "That a standard provincial discharge information record be established with an appropriate fee for its completion." Refer to Appendix D for a copy of the OMA standard inpatient discharge form template. (A new fee code, entitled "MRP Day of Discharge," was established in the 2005 OMA-MOHLTC Master Agreement for the complete discharge of patients from hospital.)

The form template was developed following an extensive literature review, as well as a review of the discharge documents already in place throughout the province. The template has been structured with the goal of establishing a minimum standard amount of information to be included in a discharge document for all patients leaving hospital. Additional patient information may be required depending on the severity of the hospitalization, or other local arrangements, hospital rules and regulations, or the physician's judgment. The Inpatient Discharge Form is not intended to replace existing discharge summary documents, but rather to facilitate the transfer of hospitalized patients to community-based physicians post-hospitalization. For facilities where no discharge document exists, this template would be a useful resource. For facilities with discharge documents, this form will serve as a valuable comparator.

It is anticipated that with the growing use of hospital-based electronic patient records, such a discharge document could be completed using information already in the patient's electronic file, with a copy given to the patient upon discharge as a reminder, as well as being forwarded to the patient's community-based provider or general practitioner for inclusion in follow-up care.

3.0 The Panel's Chart Completion Policy

A survey of hospital Health Information Management/Records Departments conducted in 2005 by the ministry found that while 90 per cent of hospitals in Ontario have a chart completion policy, only 58 per cent believe that it is effective. During subsequent consultations with hospital administrators, some hospitals said that they actually found suspension of privileges an effective way to improve timeliness of documentation, while other hospitals were not able to enforce their policy.

Examples from hospitals administering effective policies include using a three-step process as stated in their policy for enforcing chart completion by physicians, which allows physicians four to five weeks to complete the health record, i.e.:

1. The hospital's Health Information Management/Records Department alerts the physician when the chart is ready to be completed.
2. If the chart is not complete within two weeks of initial notification, the department sends a written warning that is copied to the Chief of Staff.
3. If the chart is not complete two weeks after issuing the warning, then the hospital's Board of Directors can suspend the physician.

Involvement by the Chief of Staff or Vice-President of Medical Affairs is important in this process.

3.1 Chart Completion Policy Template

The Physician Documentation Expert Panel has developed a chart completion policy template which provides a standard framework for doctors to consistently and effectively complete and communicate critical patient care information. In developing this template, the panel reviewed existing chart completion policies at various hospitals and selected key elements to formulate a comprehensive, but streamlined policy.

The minimum standard for a completed health record that has been developed by the panel, includes the following:

A. General Guidelines

- All documents must be legible
- Use of unapproved abbreviations is strongly discouraged
- Every entry must be authenticated (includes e-signature) and dated by the author
- Transcribed documents are strongly recommended

B. History and Physical

1. A History and Physical must be completed for all inpatients (includes medical, dental and midwifery examinations).
2. All History and Physicals must include:
    i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, gender, date of birth, etc.)
    ii. Chief complaint and present illness
    iii. Past medical history, medications, allergies, family medical history
    iv. Physical examination and assessment
    v. Diagnosis
    vi. Treatment Plan

C. Operative Report

1. An Operative Report must be dictated for each patient for whom an operative procedure was performed.
2. All Operative Reports must be signed by the surgeon performing the procedure.
3. All Operative Reports must include:
    i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, etc.)
    ii. Date of procedure
    iii. Distribution of copies to the referring physician and/or family physician)
    iv. Pre-operative diagnosis
    v. Proposed operative procedure (if different from procedure performed)
    vi. Operative procedure performed
    vii. Description of procedure performed
    viii. Condition of patient during and at conclusion of operative procedure
    ix. Post-operative diagnosis

D. Discharge Summary

1. A Discharge Summary/Final Note must be completed for all inpatients.
2. All Discharge Summaries/Final Notes must be signed and dated by the attending physician.
3. All Discharge Summaries must include:
    i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, Admission and Discharge Dates)
    ii. Distribution of copies to the referring physician and/or family physician
    iii. Brief summary of the management of each of the active medical problems during the admission, including major investigations, treatments and outcomes
    iv. Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment
    v. Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports needing follow-up

Please refer to Appendix E for the chart completion policy template developed by the panel.

4.0 Reporting Requirements

The requirements for Health Information Management/Records Departments in Ontario hospitals are to document *all* diagnoses (most responsible diagnosis, secondary and service transfer diagnoses), pre- and post-admit comorbidities, procedures and treatments, using commonly accepted terminology and abbreviations.

While diagnosis coding refers to the practice of reviewing a patient's health record to identify pertinent health information and reporting it in a standardized format, diagnosis typing is used to indicate the relationship of a diagnosis to the patient's stay in a hospital.

A Diagnosis Type is required for every ICD-10-CA code collected on the Discharge Abstract Database (DAD) abstract. The purpose of the typing is to differentiate conditions that influence the patient's length of stay and/or resource intensity from those that do not. Typing also flags significant conditions that either coexist at the time of admission (pre-admit comorbidity) or develop subsequently in hospital (post-admit comorbidity). Please refer to Appendix F for definitions of key terminology.

The appropriate typing of diagnoses is also important as the information is used for other purposes such as performance measurement, planning and resource allocation. Since diagnoses must be supported by physician documentation, it is important for physicians to understand the criteria. Please refer to Appendix G for the Diagnosis Typing Standards.

CIHI has developed a presentation 'An Introduction to ICD-10-CA and CCI for Physicians' which is intended to provide a broad overview of the classification system and an education package that may be customized by hospitals for their specific needs. The presentation has been developed into modular sections, allowing users to select issues based on relevance to physician audience and time constraints.

5.0 Conclusion

In the months that led to the development of this guide, the panel became even more convinced about the need to improve physician documentation and spread the word about this important issue throughout the health care sector.

As a result, this guide is part of an information package that is being distributed to various stakeholders, including the Ontario Medical Association and the College of Physicians and Surgeons of Ontario, to be provided to their members. It is also being sent to the Council of Faculties of Medicine to be distributed to all medical schools in Ontario, as the panel recognized that there is a serious gap in the education of new doctors as it relates to physician documentation.

Moving forward, this package will be supplemented by additional templates, currently being developed by the ministry, to assist hospitals in evaluating their documentation processes and to improve the quality of their data. A hospital has already been selected to participate in a pilot project to develop these additional tools with the overall aim of supporting improved documentation.

Complete and accurate clinical documentation enhances the quality of patient care and facilitates the reporting of the pertinent health information that is critical for optimal management of Ontario's health care system.

Physicians are the key building blocks to creating and maintaining health data of the highest quality.

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Appendix A – Impact of Documentation on Funding

Hospitals in Ontario are funded with historic global budgets that are annually increased with a funding formula that currently focuses on stability. The formula takes into account the expected cost for delivery of equivalent weighted cases and projected volumes that a hospital will serve, but the range of funding increases is compressed for funding stability. The inputs into the formula are financial and clinical data (cost per equivalent weighted case) combined with population demographics and historic hospital utilization rates (projected volumes). Physician documentation directly drives what is reported in the clinical data via cost per equivalent weighted case and historic utilization rates. The importance of good clinical documentation thus aids in the funding of hospitals and also ensures that the needs of the community patients are not misrepresented. Also, expected length of stay (LOS) is determined by the encoded data. If too many or too few diagnoses are reported, the expected LOS could also be adversely affected.

Example 1:

Incomplete Documentation	Complete Documentation
• Stroke • Alzheimer's Disease with Dementia • Depression	• Stroke • Alzheimer's Disease with Dementia • Depression • Aphasia (type 1)
• Complexity Level 1 • **RIW 1.2257** • ALOS 14.0 • ELOS 6.6	• Complexity Level 3 • **RIW 1.2257** • ALOS 14.0 • ELOS 13.7

Example 2:

Incomplete Documentation	Complete Documentation
• CFE • Pneumonia • Benign Hypertension • Other physical activity	• CFE • Pneumonia • Benign Hypertension • Other physical activity • UTI • Hyperosmolarity and Hypernatremia
• Complexity Level 2 • **RIW 6.88** • ELOS 7.9	• Complexity Level 3 • **RIW 7.52** • ELOS 10.4

Example 3:

Incomplete Documentation	Complete Documentation
• CHF • Pneumonia • Benign Hypertension • Other physical activity	• CHF • Pneumonia • Benign Hypertension • Other physical activity • UTI • Hyperosmolarity and Hypernatremia
• Complexity Level 2 • **RIW 6.88** • ELOS 7.9	• Complexity Level 3 • **RIW 7.52** • ELOS 10.4

Appendix B – Public Hospitals Act

R.R.O. 1990, REGULATION 965
Amended to O. Reg. 204/06
HOSPITAL MANAGEMENT
Records of Personal Health Information

19. (1) Every administrator shall ensure that a system is established for the keeping of records of personal health information for each patient. R.R.O. 1990, Reg. 965, s. 19 (1); O. Reg. 332/04, s. 4 (2).

(2) Each entry in a medical record shall bear the date on which it was made and shall be authenticated by the person who authorized the entry. R.R.O. 1990, Reg. 965, s. 19 (2).

(3) Subsection (2) applies in respect of each entry on a document where the document contains entries authorized by more than one person. R.R.O. 1990, Reg. 965, s. 19 (3).

(4) The medical record for a patient, other than an out-patient, shall include,

(a) the names of the attending physicians, dentists and midwives of the patient;
(b) a history of the patient;
(c) records of all medical, dental and midwifery examinations carried out on the patient in the hospital;
(d) all diagnostic imaging records of the patient, including any videotape of a diagnostic imaging examination or test of the patient if the videotape constitutes the only diagnostic imaging record of the examination or test;
(e) Revoked: O. Reg. 538/99, s. 1 (1).
(f) all provisional and final diagnoses with respect to the patient;
(g) all orders for treatment or investigation with respect to the patient in the hospital;
(h) records of all medical, dental and midwifery treatment carried out on the patient in the hospital;
(i) all consents to treatment obtained in writing with respect to the patient;
    (i.1) all statements referred to in subsection 28 (4) with respect to the patient;
    (i.2) all opinions required to be noted under subsection 25 (5) of the *Health Care Consent Act, 1996* with respect to the patient;
(j) progress notes with respect to the patient;
    (j.1) results of diagnostic imaging examinations or tests;
(k) reports made by a physician, dentist or midwife with respect to the patient of,
    (i) all consultations,
    (ii) all investigative procedures,
    (iii) all operations, anaesthesia and recoveries,
    (iv) results of diagnostic imaging examinations or tests, and
    (v) a post-mortem examination, if one has been performed, where the patient dies in the hospital;
(l) discharge summaries;
(m) orders for discharge with respect to the patient; and
(n) a death certificate where the patient dies in the hospital. R.R.O. 1990, Reg. 965, s. 19 (4); O. Reg. 761/93, s. 9 (1); O. Reg. 17/95, s. 1 (1); O. Reg. 106/96, s. 1 (1); O. Reg. 538/99, s. 1 (1-3).

(5) The medical record of an out-patient, other than an out-patient referred to in subsection (6), shall include,

    (a)   the names of the attending physicians, dentists, midwives and registered nurses in the extended class of the out-patient at each visit;

    (b)   a history of the out-patient;

    (c)   records of all examinations carried out on the out-patient in the hospital by members of the medical, dental, midwifery and extended class nursing staff;

    (d)   all diagnostic imaging records of the out-patient, including any videotape of a diagnostic imaging examination or test of the out-patient if the videotape constitutes the only diagnostic imaging record of the examination or test;

    (e)   Revoked: O. Reg. 538/99, s. 1 (4).

    (f)   all orders for treatment or investigation with respect to the out-patient in the hospital;

    (g)   all consents to treatment obtained in writing with respect to the out-patient;

         (g.1) all statements referred to in subsection 28 (4) with respect to the out-patient;

         (g.2) all opinions required to be noted under subsection 25 (5) of the *Health Care Consent Act, 1996* with respect to the out-patient;

    (h)   records of all treatment carried out on the out-patient in the hospital by members of the medical, dental, midwifery and extended class nursing staff;

         (h.1) results of diagnostic imaging examinations or tests;

    (i)   all reports of investigative procedures carried out on the out-patient in the hospital and all reports of the results of diagnostic imaging examinations or tests;

    (j)   all diagnoses with respect to the out-patient; and

    (k)   a death certificate if the out-patient dies in the hospital. R.R.O. 1990, Reg. 965, s. 19 (5); O. Reg. 761/93, s. 9 (2); O. Reg. 17/95, s. 1 (2); O. Reg. 106/96, s. 1 (2); O. Reg. 538/99, s. 1 (4-6); O. Reg. 64/03, s. 9.

(6) The medical record of an out-patient who visits the hospital solely for diagnostic procedures need only include the orders for the procedures, any consent to the procedures obtained in writing and a record of the procedures. R.R.O. 1990, Reg. 965, s. 19 (6); O. Reg. 17/95, s. 1 (3).

Appendix C – Medicine Act

Medicine Act, 1991 Loi de 1991 sur les médecins
ONTARIO REGULATION 114/94
Amended to O. Reg. 122/03
PART V RECORDS

18. (1) A member shall make records for each patient containing the following information:

1. The name, address, and date of birth of the patient.
2. If the patient has an Ontario health number, the health number.
3. For a consultation, the name and address of the primary care physician and of any health professional who referred the patient.
4. Every written report received respecting the patient from another member or health professional.
5. The date of each professional encounter with the patient.
6. A record of the assessment of the patient, including,
   i. the history obtained by the member,
   ii. the particulars of each medical examination by the member, and
   iii. a note of any investigations ordered by the member and the results of the investigations.
7. A record of the disposition of the patient, including,
   i. an indication of each treatment prescribed or administered by the member,
   ii. a record of professional advice given by the member, and
   iii. particulars of any referral made by the member.
8. A record of all fees charged which were not in respect of insured services under the Health Insurance Act, which may be kept separately from the clinical record.
9. Any additional records required by regulation. O. Reg. 241/94, s. 2.

(2) A member shall keep a day book, daily diary or appointment record containing the name of each patient who is encountered professionally or treated or for whom a professional service is rendered by the member. O. Reg. 241/94, s. 2.

(3) The records required by regulation shall be,
(a) legibly written or typewritten or made and kept in accordance with section 20; and
(b) kept in a systematic manner. O. Reg. 241/94, s. 2.

19. (1) A member shall retain the records required by regulation for at least ten years after the date of the last entry in the record, or until ten years after the day on which the patient reached or would have reached the age of eighteen years, or until the member ceases to practise medicine, whichever occurs first, subject to subsection (2). O. Reg. 241/94, s. 2.

(2) For records of family medicine and primary care, a member who ceases to practise medicine shall,
(a) transfer them to a member with the same address and telephone number; or
(b) notify each patient that the records will be destroyed two years after the notification and that the patient may obtain the records or have the member transfer the records to another physician within the two years. O. Reg. 241/94, s. 2.

(3) No person shall destroy records of family medicine or primary care except in accordance with subsection (1) or at least two years after compliance with clause (2) (b). O. Reg. 241/94, s. 2.

20. The records required by regulation may be made and maintained in an electronic computer system only if it has the following characteristics:

    1.   The system provides a visual display of the recorded information.

    2.   The system provides a means of access to the record of each patient by the patient's name and, if the patient has an Ontario health number, by the health number.

    3.   The system is capable of printing the recorded information promptly.

    4.   The system is capable of visually displaying and printing the recorded information for each patient in chronological order.

    5.   The system maintains an audit trail that,

        i.   records the date and time of each entry of information for each patient,

        ii. indicates any changes in the recorded information,

        iii. preserves the original content of the recorded information when changed or updated, and

        iv. is capable of being printed separately from the recorded information for each patient.

    6.   The system includes a password or otherwise provides reasonable protection against unauthorized access.

    7.   The system automatically backs up files and allows the recovery of backed-up files or otherwise provides reasonable protection against loss of, damage to, and inaccessibility of, information. O. Reg. 241/94, s. 2.

21. A member shall make his or her equipment, books, accounts, reports and records relating to his or her medical practice available at reasonable hours for inspection by a person appointed for the purpose under a statute or regulation. O. Reg. 241/94, s. 2.

Appendix D – Standard Inpatient Discharge Form

This standard inpatient discharge form was developed by the Ontario Medical Association's Committee on Hospitals for use on behalf of patients who are discharged from hospitals. The template, which was approved by the OMA Board of Directors in April 2005, is available on the OMA website (www.oma.org).

Hospital Logo	Name
	Address
	Hospital ID#
	Health Card #
	Telephone (H)
	(W
	DOB DD/MM/YY

Admission Date and Time:	Most Responsible Physician:

Family Physicians Information	Name:	Phone:	Fax:

Discharged Date: Signed Out Transferred Death Transferred to:	*Please bring this sheet with you to your next visit to the doctor/follow-up appointment/ER visit.*

Primary Diagnosis:

Secondary Diagnoses:

Discharge Medications:

Key Investigational Results:	Treatment/Dressings:

Instructions on Discharge and Medical Follow-Up:

Follow-Up arranged with: Date for follow-up:	Telephone #:

I have read and understand the above instructions. Signature: _____ Date: _____	MRP/Discharge Staff Signature: _____ Name/Credential: _____

Please bring this sheet with you to your next visit to the doctor/follow-up appointment/ER visit.

Appendix E – Chart Completion Policy Template

This chart completion policy template was developed by the Physician Documentation Expert Panel.

Hospital Logo	Policy Name
	Policy Number
	Section
	Page

Approval Signature	Date DD/MM/YYYY

Purpose	Completion of a health record after discharge is a component of continuity of patient care. The purpose of this chart completion policy is to define a timely and consistent approach for the completion of health records and the application of consequences when health records are not completed.

Policy:

1. A complete health record must be maintained for all hospital patients as outlined in the Public Hospital's Act, the Medicine Act and the Hospital bylaws, policies and procedures.
2. The health record may be held on the Nursing Unit for up to 48 hours after discharge. Physicians are encouraged to complete (dictate, where appropriate), date and sign all documentation at the time of discharge. It is expected that all documentation shall comply with legislative requirements and hospital policy (see Appendix A), however, the Health Information Management/Records Department shall, at a minimum, check for completion of:
   a. History and Physical
   b. Operative Report
   c. Discharge Summary
3. In the event that there is outstanding documentation, the record shall be assigned to the applicable physician(s) for completion.
4. The Health Information Management/Records Department will make reasonable efforts to facilitate the chart completion process. This includes ensuring that incomplete records are available for physician completion within **3-5 working days post discharge** and physicians are notified of incomplete records in a timely manner.
5. Physicians are required to complete all incomplete records within **14 days** of the health record being made available to complete.
6. Physicians shall notify the Health Information Management/Records Department of prolonged absences to avoid the preparation and distribution of incomplete record notices.
7. Weekly notification shall be sent to all physicians with incomplete records.
8. A third and final notification shall be sent to the physician and will advise the individual that if the outstanding records are not completed within 72 hours, the matter will be forwarded to the Medical Advisory Committee for appropriate action.
9. The Medical Advisory Committee, VP Medical Affairs or Chief Medical Officer reserves the right to recommend suspension of physician privileges when health records remain incomplete five weeks from the date of assignment to the physician. Exceptions include:
   • Physician is granted an extension by the Chief Medical Officer (or equivalent) due to extenuating circumstances (e.g., illness, unplanned leave of absence).
   • The health record is not available for the physician to complete because the patient has returned to the hospital and record has been forwarded to the individual/area providing care.
10. The Chief Medical Officer (or equivalent) will notify the physician with the outstanding health records that his/her privileges are being suspended for failure to complete records.
11. Once the health records are completed, the suspension will be lifted and all privileges reinstated.
12. Suspension of hospital privileges may be reportable to the College of Physicians and Surgeons of Ontario

Chart Completion Policy Template Guidelines

The minimum standard for a completed health record includes the following:

General Guidelines
- All documents must be legible
- Use of unapproved abbreviations is strongly discouraged
- Every entry must be authenticated (includes e-signature) and dated by the author
- Transcribed documents are strongly recommended

History and Physical
1. A History and Physical must be completed for all inpatients (includes medical, dental and midwifery examinations).
2. All History and Physicals must include:
   i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, gender, date of birth, etc.)
   ii. Chief complaint and present illness
   iii. Past medical history, medications, allergies, family medical history
   iv. Physical examination and assessment
   v. Diagnosis
   vi. Treatment Plan

Operative Report
1. An Operative Report must be dictated for each patient for whom an operative procedure was performed.
2. All Operative Reports must be signed by the surgeon performing the procedure.
3. All Operative Reports must include:
   i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, etc.)
   ii. Date of procedure
   iii. Distribution of copies (i.e., referring physician, family physician)
   iv. Pre-operative diagnosis
   v. Proposed operative procedure (if different from procedure performed)
   vi. Operative procedure performed
   vii. Description of procedure performed
   viii. Condition of patient during and at conclusion of operative procedure
   ix. Post-operative diagnosis

Discharge Summary
1. A Discharge Summary/Final Note must be completed for all inpatients.
2. All Discharge Summaries/Final Notes must be authenticated by the attending physician.
3. All Discharge Summaries must include:
   i. Identifying information (e.g., Author's name and status, name of most responsible physician, name of patient, Health Record number, Admission and Discharge Dates)
   ii. Distribution of copies (i.e., referring physician, family physician)
   iii. Brief summary of the management of each of the active medical problems during the admission; including major investigations, treatments and outcomes
   iv. List of diagnoses, including the identification of most responsible diagnosis and pre-admit and post-admit co-morbidities.
   v. Details of discharge medications, including reasons for giving or altering medications, frequency, dosage and proposed length of treatment
   vi. Follow-up instructions and specific plans after discharge, including a list of follow-up appointments with consultants, further outpatient investigations, and outstanding tests and reports needing follow-up

Appendix F – Key Terminology

ICD-10-CA and CCI
- ICD-10-CA is the Canadian enhancement of ICD-10 or the International Statistical Classification of Diseases and Related Health Problems (Tenth Revision) published by World Health Organization
- CCI is the Canadian Classification of Health Interventions developed by the Canadian Institute for Health Information

Case Mix Group (CMG)
- Method of aggregating patients into clusters based on clinical diagnoses, procedures and resource utilization. Within a CMG, there are further refinements by age and complexity. There are 478 CMGs in the 2003 CIHI grouping methodology, divided between 25 Major Clinical Categories (MCC)

Major Clinical Category (MCC)
- Method of aggregating patients more broadly than the CMG methodology. MCC categories generally describe a body system or specific type of clinical problem (e.g., mental disorders, neonates, burns, trauma, HIV). Each most responsible diagnosis is assigned to one of 25 MCC categories in the 2003 CIHI grouping methodology.

Complexity
- Reflects the interaction of multiple diagnoses on length of stay or resources within each CMG group.
- Complexity overlay identifies those acute inpatients with additional diagnoses (other than the most responsible diagnosis) for which a prolonged length of stay and/or more costly treatment might be reasonably expected. These include cases with one or more chronic conditions outside of the primary focus of the acute care episode, cases with multi-system failure, and cases with iatrogenic or other complications. Cases are stratified into four complexity levels. A fifth level, level 9, is used for discharges where complexity is not applied.
  - 1 No complexity
  - 2 Complexity related to chronic conditions
  - 3 Complexity related to serious/important condition
  - 4 Complexity related to potentially life-threatening conditions
  - 9 Complexity not applied
- Enhances the prediction of resource utilization in acute care.
- Complexity is NOT severity.

Resource Intensity Weight (RIW)
- Methodology provides users with a tool to estimate expected resource use and relationships of costs between patient types.
- It is a measure to determine how much it is costing to have this patient in hospital
- This methodology indicates the relative value of treating a patient compared to treating the average patient whose RIW value is 1.0000. For example, an RIW value of 2.0000 represents a patient's visit that resulted in twice the expected resource use of the average patient.
- Values are calculated using actual patient-specific cost data from Ontario, Alberta, and British Columbia.

Most Responsible Diagnosis
- Considered by the physician to be most responsible for the patient's longest stay in hospital. For multiple diagnoses, it is the diagnosis that contributes to the greatest length of stay

Pre-admit Comorbidity
- Describes important condition(s) that influences the patient's length of stay and/or treatment of the patient

Post-admit Comorbidity
- As above, but arises during a patient's stay in hospital

Diagnosis Typing
- The Diagnosis Type is a one-digit code used to indicate the relationship of the diagnosis to the patient's stay in hospital
- A Diagnosis Type is required for every ICD-10-CA code collected in the Discharge Abstract Database (DAD) abstract document
- Diagnosis Type differentiates conditions that influence the patient's stay from those that do not
- The typing flags codes that are post-admission co-morbidities
- It is used in complexity assignment

Authentication
- Definition in Public Hospitals Act, Regulation 965, defines authentication as the identification of oneself as the author of a document or a record by personal signature or by any other means authorized by the board

Appendix G – Diagnosis Typing Standards

Diagnosis Typing applies to all data submitted to the Discharge Abstract Database (DAD). The assignment of a Diagnosis Type to a condition is meant to signify the impact that the condition had on the patient's care. All diagnoses or conditions identified on the DAD must be assigned a Diagnosis Type.

The following diagnosis typing definitions were amended in 2006.

There are multiple Diagnosis Types:

• Most responsible diagnosis (Type M)
• Comorbidity diagnoses (Types 1 and 2)
• Secondary diagnoses (Type 3)
• Morphology codes (Type 4)
• Admitting diagnoses (Type 5)
• Proxy most responsible diagnosis (Type 6)
• Patient service transfer diagnoses (Types W, X and Y)
• External cause, Place of occurrence, and Activity codes (Type 9)
• Diagnoses restricted to newborn abstracts only (Type 0)

Diagnosis Types M, 1, 2, 6, W, X and Y are considered significant Diagnosis Types.

Definition of Comorbidity

Comorbidities are all conditions that coexist at the time of admission or develop subsequently and demonstrate at least one of the following:

• Significantly affects the treatment received
• Requires treatment beyond maintenance of the pre-existing condition
• Increases the length of stay (LOS) by at least 24 hours

To support a determination of significance, there must be documented evidence in the physician's documentation or discharge summary that the condition required at least one of the following:

Clinical evaluation/consultation, excluding pre-operative anesthetic consults, where a new or amended course of treatment is recommended and instituted;

Therapeutic treatment/intervention with a code assignment of 50 or greater from Section 1 of CCI;

Diagnostic intervention, inspection or biopsy with a code assignment from Section 2 of CCI;

Extended the length of stay (LOS) by at least 24 hours;

Therapeutic intervention on the *Flagged Interventions* list in Appendix B (see also the coding standard entitled *Selection of Interventions to Code From Section 1)*; or

Diagnostic Imaging intervention as outlined in the coding standard *Diagnostic Imaging Interventions*.

Diagnoses must be supported by physician documentation as identified in the criteria listed above to be classified as comorbidities. However, nurses notes, pathology reports, laboratory reports, autopsy reports, medication profiles, radiological investigations, nuclear imaging, and other similar investigations are valuable tools for identifying specificity in assigning the appropriate diagnosis code. Conditions documented in these reports may be captured as a Diagnosis Type (3) when there is no physician documentation to support capture as comorbidity.

Diagnosis Type (M) – Most Responsible Diagnosis (MRDx)
A Diagnosis Type (M) is the one diagnosis or condition that can be described as being most responsible for the patient's stay in hospital. If there is more than one such condition, the one held most responsible for the greatest portion of the length of stay or greatest use of resources (i.e., operating room time, investigative technology, etc.) is selected.
• If no interventions have been performed select the first-listed diagnosis as the most responsible diagnosis.
• If no definite diagnosis was made, the main symptom, abnormal finding or problem should be selected as the MRDx.

Diagnosis Type (1) – Pre-Admit Comorbidity
A Diagnosis Type (1) is a condition that existed prior to admission, has been assigned an ICD-10-CA code, and satisfies the requirements for determining comorbidity.

Diagnosis Type (2) – Post-Admit Comorbidity
A Diagnosis Type (2) is a condition that arises post-admission, has been assigned an ICD-10-CA code and satisfies the requirements for determining comorbidity. A post-procedural condition becomes a comorbidity when any one of the following situations exist:
• The condition appears in the physician's documentation as a complication of the procedure;
• The condition is present at discharge; or
• The condition persists post procedurally for at least 96 hours.

If a post-admit comorbidity qualifies as the MRDx, it must be recorded as both the MRDx and as a Diagnosis Type (2).

See also the coding standard entitled, Post-Procedural Conditions and Complications.

Diagnosis Type (3) – Secondary Diagnosis
A Diagnosis Type (3) is a secondary diagnosis or condition for which a patient may or may not have received treatment, has been assigned an ICD-10-CA code and does not satisfy the requirements for determining comorbidity. Diagnoses that are **only listed** on the Front Sheet, Discharge Summary, Death Certificate, History and Physical or Pre-operative Anesthetic Consults qualify as a Diagnosis Type (3) – Secondary Diagnosis. If there is physician documentation elsewhere in the chart that the condition affected the treatment received or required treatment beyond maintenance of the pre-existing condition or increased the length of stay (LOS) by at least 24 hours it then must be determined if it is a Type (1) or Type (2) Comorbidity.

Note: The documentation of ongoing medication for treatment of a pre-existing condition does not in itself denote significance. Conditions not qualifying as comorbidities, if coded, should be classified to Diagnosis Type (3).
Diagnosis Type (3) is not allowed when the entry code is N – Newborn.

Diagnosis Type (W), (X), (Y) – Service Transfer Diagnosis
An ICD-10-CA code associated with the first/second/third service transfer.

Diagnosis Type (4) – Morphology Codes
Diagnosis Type (4), morphology codes are derived from ICD-O (International Classification of Diseases – Oncology) codes describing the type and behavior of neoplasm. These codes are found in Chapter XXII – Morphology of Neoplasms.

Diagnosis Type (5) – Admitting Diagnosis
Diagnosis Type (5) can be used to code the admitting diagnosis when it differs from the most responsible diagnosis code. Its use is determined at the provincial or facility level. Refer to the DAD manual and facility policies to determine the provincial or facility requirement for use of this Diagnosis Type.

Diagnosis Type (6) – Proxy Most Responsible Diagnosis (MRDx)

A Diagnosis Type (6) is assigned to a designated asterisk code in a dagger/asterisk convention when the condition it represents fulfills the requirements stated in the definition for Diagnosis Type (M) – Most Responsible Diagnosis (MRDx). In morbidity coding, asterisk codes are manifestations of an underlying condition and according to the World Health Organization (WHO) rules, must be sequenced following the code for the underlying cause. The underlying cause codes are identified with a dagger symbol (†) in the ICD-10-CA classification. Diagnosis Type (6) is used on the **second line** of the diagnosis field of the abstract to indicate that the manifestation is the condition most responsible for the patient's stay in hospital. When the underlying condition meets the criteria for MRDx, or when it would be difficult to delineate whether it is the underlying condition or the manifestation that meets the criteria for MRDx, the asterisk code is assigned Diagnosis Type (3).

See also the coding standard entitled *Dagger/Asterisk Convention*.
Note: Only one asterisk code is allowed as a Diagnosis Type (6).

Example:

John Doe was a patient with advanced Crohn's disease. He was on maintenance dose of medications for his regional enteritis. This time, he presented with pain swelling and inflammation of the lower back. He was admitted for treatment of sacro-iliac joint arthritis, a complication of the enteritis.	
K50.9† (M)	Crohn's disease, unspecified
M07.4* (6)	Arthropathy in Crohn's disease [regional enteritis]
Rationale:	The arthropathy code is an asterisk code thus it must be sequenced in the second diagnosis location on the abstract. However, since it is the arthropathy that meets the criteria for MRDx (and not Crohn's disease), it is assigned Diagnosis Type (6). Note that K50.9 is not always a dagger code. However, in this disease combination the Alphabetic Index directs that it be used as such with M07.4.

Example:

Patient with known systemic lupus erythematosus presented with hematuria and fever. He was diagnosed with nephritis and admitted for treatment of his renal condition.	
M32.1† (M)	Systemic lupus erythematosus with organ or system involvement
N08.5* (6)	Glomerular disorders in systemic connective tissue disorders
Rationale:	The glomerular disorder code is an asterisk code thus it must be sequenced in the second diagnosis location on the abstract. However, since it is the nephritis that meets the criteria for MRDx (and not Systemic lupus erythematosus), it is assigned Diagnosis Type (6).

Example:

Jane Doe was admitted for meningococcal meningitis.	
A39.0† (M)	Meningococcal meningitis
G01* (3)	Meningitis in bacterial diseases classified elsewhere
Rationale:	This patient has an infectious disorder involving the nervous system and a dagger/asterisk convention applies. However, since it would be difficult to delineate whether it is the underlying condition or the manifestation that meets the criteria for MRDx, the asterisk code is assigned Diagnosis Type (3).

Example:

Mr. F. is known to have Type 1 diabetes mellitus with diabetic retinopathy. He is admitted by an Ophthalmologist for management of his retinopathy.	
E10.30†(M) H36.0* (6)	Type 1 diabetes mellitus with background retinopathy Diabetic retinopathy
Rationale:	Retinopathy is an asterisk code thus it must be sequenced in the second diagnosis location on the abstract. However, since it is the retinopathy that meets the criteria for MRDx (and not Diabetes Mellitus), it is assigned Diagnosis Type (6).

Example:

Mr. F. is known to have Type 1 diabetes mellitus with diabetic retinopathy. His blood sugars have been labile and he is admitted for control of this diabetes.	
E10.30†(M) H36.0* (3)	Type 1 diabetes mellitus with background retinopathy Diabetic retinopathy
Rationale:	In this example, the Diabetes, itself, meets the criteria for MRDx, thus the asterisk code is not assigned Diagnosis Type 6.

Diagnosis Type (7), (8) – Restricted to CIHI – DO NOT USE

Diagnosis Type (9) – External Cause of Injury Code
A Diagnosis Type (9) is an external cause of injury code (Chapter XX – External causes of morbidity and mortality), place of occurrence code (U98. – *Place of occurrence*) or activity code (U99. – *Activity*). Chapter XX codes are mandatory for use with codes in the range S00–T98 *Injury, poisoning and certain other consequences of external causes*. Category U98. – *Place of occurrence* is mandatory with codes in the range W00–Y34, with the exception of Y06 and Y07, and Category U99. – *Activity* is optional.

Diagnosis Type (0) – Newborn
Diagnosis Type (0) is restricted to newborn codes only (admit category N).

In a healthy infant where a code from category Z38. – *Liveborn infants according to place of birth* is the MRDx, any other codes entered on the newborn abstract must be a Diagnosis Type (0).

In an unhealthy infant where a code from the range P00 to P96, or any other code indicating a significant condition in the newborn, is the MRDx, then Z38. – must be a Diagnosis Type (0). In this circumstance, Diagnosis Type (0) can be used to record any additional insignificant conditions that do not affect the newborn's treatment or length of stay and do not satisfy the requirements for determining comorbidity. Additional conditions that meet the criteria of comorbidity are assigned Diagnosis Types (1), (2), (W), (X) or (Y) as indicated by the documentation in the chart.

Note: It is mandatory to assign a code from category Z38. – *Liveborn infants according to place of birth* on a newborn's abstract. Diagnosis Type (3) cannot be applied to any code on a newborn's abstract.

Reference: Canadian Coding Standards for ICD-10-CA and CCI for 2006, Diagnosis Typing Definitions, page 9.