University Hospitals of Leicester NHS
NHS Trust

Clinical Coding Policy

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

Inclusion of

- 4.5 Coding Steering Group – now chaired by the Deputy COO and representation is no longer required from all CMGs
- The role Clinical Coding Champions has been removed from the policy.
- The provision of coding expertise to the Mortality Review Committee has been transferred from the coding auditor to the coding trainer role.
- 4.17.4 & 6.2.4 Coders are advised to attend at least one coding workshop per year.
- Throughout the policy, it is clarified that casenotes are now used for coding certain specialties only

KEY WORDS

Diagnosis, procedure, OPCS, ICD10, audit, payment by results, PbR, Clinical Coding, SNOMED

1 INTRODUCTION and Overview

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust Policy and Procedures for high quality information production in the Trust's Clinical Coding process and compliance with Clinical Classification and international standards.

1.2 Clinical Coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into coded format. The use of codes ensures the information derived is standardised to facilitate ease of data retrieval and directly comparable between patients with similar morbidities.

1.3 This policy describes how the Trust will continually seek to improve local data collection and processing to ensure that the highest quality Clinical Coding standards are achieved. The policy demonstrates the local approach for adherence to Clinical Coding classification standards.

1.4 It explains how Coding knowledge is communicated and how local standards complement the external regulations that facilitate consistency of Coding across organisational boundaries.

2 POLICY SCOPE

2.1 This Policy applies to:

- All clinical staff working for UHL who are responsible for the documentation of patient clinical information.
- All Clinical Coders who are employed by the Trust or supply services to the Trust (e.g. via Agency, bank contract).
- Managers of services in Clinical Management Groups (CMGs), Commissioning and Contract Managers who seek to influence the quality or content of Clinical Coding undertaken.
- Administrative staff responsible for recording clinically coded data.

2.2 This Policy applies to all patient records where diagnoses or operative information is applied in coded format throughout UHL including the Alliance.

3 DEFINITIONS

3.1 **Finished Consultant Episode (FCE)** - a subdivision of a hospital spell in which a specific consultant has responsibility for a patient's care. A hospital spell can be comprised of one or more FCEs.

3.2 **Hospital Spell** – this is a whole hospital stay for a patient, from admission into the Trust to discharge out.

3.3 **ICD-10** - International Classification of Diseases (ICD) version 10. This classification has been devised by the World Health Organisation and its codes cover all reasons for patient admissions to hospital. These codes are widely used internationally

3.4 **OPCS-4** - Office of Population Censuses and Surveys (OPCS) version 4. This classification covers all operative procedures and interventions that patients have undergone during their hospital stay. These codes are used in the United Kingdom only.

3.5 **SNOMED_CT** – SNOMED Clinical Terminology is a structured clinical vocabulary for use in an electronic health record by clinicians, in place of narrative.

4 ROLES AND RESPONSIBILITIES

4.1 Executive Lead

4.1.1 The executive lead for the Clinical Coding Service is the **Chief Operating Officer** who is accountable for provision of this service within the Trust.

4.2 Chief Financial Officer

4.2.1 Responsible for the provision of high-quality Trust data to support reference costing.

4.2.2 Responsible for ensuring that all Trust income is recovered.

4.3 Medical Director

4.3.1 Ensure there is board/senior management level approval of the Trust strategy for clinical engagement in the validation of data including Clinically Coded information.

4.3.2 Sign off local policies for individual Clinical Coding scenarios, where local documentation rules have been recommended.

4.4 Executive Quality Board

4.4.1 Monitor performance on Clinical Coding.

4.5 Clinical Coding Steering Group

4.5.1 Chaired by the Deputy Chief Operating Officer

4.5.2 Representation across a range of clinical, managerial and coding roles.

4.5.3 The group is responsible for improving the quality of coding, via 3 work-streams: clinical engagement, coding integration with the e-hospital programme and coding team resource.

4.6 Clinical Directors

4.6.1 Ensure there is full commitment by Clinicians and Care Professionals to improving the quality and consistency of information held about patients.

4.6.2 Ensure there are regular reviews into the quality of patient activity records and the clinical data recorded to facilitate Clinical Coding.

4.6.3 Monitor the effectiveness of the clinical coding validation process. This is undertaken by clinicians who are responsible for the collection/recording of relevant clinical information which is used as the source for Clinical Coding.

4.6.4 Ensure the application of formal guidance for maintenance of clinical records. For Royal Colleges guidance – see references in Section 9 of this policy.

4.7 Clinical Management Group (CMG) Managers

4.7.1 Ensure procedures are in place to enable Clinical Coders access to relevant core medical records within 24 hours of the patient being discharged to enable Coding to be completed. E.g. a routine transfer process direct from the ward to the Coding office.

Where Clinical Coding is undertaken on wards, ensure a suitable quiet environment is made available in the locality in which Clinical Coding work can be undertaken.

4.8 Consultants

4.8.1 Responsibility lies with the Consultant in charge of the patient's care for ensuring the provision of an accurate diagnosis and treatment description for Clinical Coding.

4.8.2 Take part in regular reviews into the quality of patient activity records and the clinical data recorded to facilitate clinical coding.

4.9 Clinicians and Care Professionals

4.9.1 Record information in clinical records according to standards issued by the Royal Colleges.

4.9.2 Where written clinical information is recorded, this must be clear and legible writing to enable accurate translation by the Clinical Coder. See the Policy for Documenting in Patients' Health Records (B30/2006).

4.10 Head of Contracting

4.10.1 Agree coding and counting changes with commissioners

4.11 Head of Information

4.11.1 Provide lead responsibility for Clinical Coding and manage the delivery of the high-quality clinical coding function within the Trust to meet Clinical Classification Service and local requirements.

4.11.2 Ensure that key performance indicators for Clinical Coding are maintained.

4.12 Clinical Coding Manager

4.12.1 Operational management of Clinical Coding Department, ensuring that this policy is well communicated, and all Clinical Coders are fully compliant with policy standards.

4.12.2 Receipt and dissemination of relevant documentation relating to Clinical Coding across the Trust to endorse consistency and accuracy of coded information.

4.12.3 Responsible for planning and delivery of the Clinical Coding service to run efficiently and effectively for the Trust.

4.12.4 Responsible for on-going development of the service to ensure coded data is accurate, complete and timely.

4.12.5 Ensure that all policy decisions in relation to Clinical Coding at the Trust are made as a result of joint collaboration and understanding between the Clinical Coding department, clinicians who record clinical information and those who use coded information.

4.12.6 Development of competent and trained Clinical Coding staff who are supported in their work, encouraging all staff to gain Accredited Clinical Coder (ACC) status.

4.12.7 Provide a primary source of expertise regarding Coding standards and practice to other Trust managers and to clinicians. This includes engagement with clinicians through education, training, using benchmarking and audit to raise standards of data capture.

4.12.8 Ensure the whole Coding team is trained according to recommended standards and frequency. Maintain local records of staff training.

4.13 Clinical Coding Site Lead

4.13.1 Responsible for workforce management and ensuring that quality Clinical Coding standards are maintained for coding resource and performance for a UHL site.

4.13.2 Ensure policy changes are communicated and applied.

4.13.3 Support Clinical Coder development through action on audit results and regular training ensuring that annual appraisals support the identification of training needs.

4.14 Clinical Coding Auditor

4.14.1 The Auditor is trained and endorsed by the Clinical Classification Service.

4.14.2 Engage with clinicians to clarify issues for both clinicians and coders about how the care delivered should be described in the source documentation for clinical coding purposes.

4.14.3 Provide an on-going programme to assess and enhance the accuracy of Clinical Coding with responsibility for planning, developing, implementing and managing the Clinical Coding audit service. This includes prioritisation of audit requests, evaluation and benefits analysis of potential audits.

4.14.4 Audits are formally presented, as necessary, to stakeholders.

4.14.5 Auditors are themselves responsible for evidencing their continuing professional development including the submission of appropriate records to the Clinical Classifications Service on an annual basis.

4.15 Clinical Coding Trainer

4.15.1 The Trainer is trained and endorsed by the Clinical Classification Service.

4.15.2 Engage with clinicians to clarify issues for both clinicians and coders about how the care delivered should be described in the source documentation for clinical coding purposes.

4.15.3 Support staff within the Trust to gain Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK).

4.15.4 Provide local training expertise to all Clinical Coding Staff and any other staff who the Trust authorises to take on responsibility for Clinical Coding of activity.

4.15.5 Provide Clinical Coding expertise to detailed case reviews within the mortality review process as monitored by the Mortality Review Committee.

4.16 Senior Clinical Coders

4.16.1 Promote and manage activities that encourage professional engagement between Clinical Coders and clinicians to collaborate and share learning.

4.16.2 Ensure there is regular feedback to individual specialties (specific clinicians where appropriate) on the quality of their clinical information capture. Two-way communication is important to ensure that Coders feedback to clinicians on the quality of their clinical documentation and for clinicians to know how their work is coded. Discrepancies can then be reviewed to resolve any Coding errors.

4.16.3 Hold the Accredited Clinical Coder qualification.

4.16.4 Mentor trainee coders during work-based training. Supervise Trainee Coders as required, checking, validating and signing-off the Coding that the Trainees undertake

4.17 Clinical Coders

4.17.1 The Clinical Coding team are professionally skilled and trained in the consistent interpretation of clinical documentation. They are responsible for the translation of clinical diagnoses and procedures into coding schema for each patient's hospital stay.

4.17.2 Work to high professional standards and manage their own coding workload, sharing specialist knowledge or mentoring other coders as required.

4.17.3 Engage with clinicians and medical staff within their own area of responsibility (e.g., a specialty or CMG) to resolve coding queries.

4.17.4 Maintain a commitment to their own professional development, continually improving coding expertise through formal training and self-study. All coders should attend a minimum of 1 workshop each year for their own continual professional development.

4.18 Trainee Clinical Coders

4.18.1 Undertake necessary formal training (21-day standards course) and work with trained Clinical Coders to enhance their understanding.

4.18.2 Undertake self-study modules and take personal responsibility for learning.

4.18.3 Code medical records under the supervision of experienced Senior Clinical Coders.

4.19 Ward Clerk role

4.19.1 Support the clinical coding process by

- applying the orange dot to the casenote cover when the patient is admitted for specialties where the casenotes are used for coding.
- ensuring that data capture of admissions, transfers and discharges is accurate and timely
- filing casenotes as per UHL order (see inside front cover of casenote folder)

- making clinical documentation (especially paper / casenotes) available to the coders as soon as the patient is discharged, for specialties where the casenotes are used for coding.
- supporting coding on the ward for long-stay inpatients.
- informing the coding team if casenotes are expected to be taken off-site, so that a Coder can abstract and analyse the necessary information before removal.

4.20 Waiting List Supervisors and Administrative Staff

4.20.1 Ensure that waiting list additions are coded to the nearest expected operative procedure that the patient is waiting for.

4.20.2 Consult the Clinical Coding Manager to agree new and revised procedure codes required.

4.21 Departmental Computer Systems Managers

4.22 Ensure that computer systems that record Clinically Coded information derived from the input of clinical terms, that coding reference tables are maintained in compliance with the Clinical Classification standards. Tables must be reviewed for ongoing compliance and amended as necessary to reflect updates to standards.

5 POLICY STATEMENTS

Clinical Coding is undertaken primarily on the Patient Administration System by staff (Clinical Coders) who have received adequate formal training and can apply coding in accordance with Clinical Classification Service (CCS) standards.

Coding is applied to each individual Finished Consultant Episode (FCE) within the whole hospital stay (Hospital Spell). Coding will be applied after the patient is discharged from hospital, and all episodes in the hospital stay will be coded (e.g. so that the casenotes are only handled once).

Where current inpatients are known to be in hospital over a long period, Coders may visit the ward to code previous FCEs for the patient, where these are fully documented, and to save time after discharge.

Coding may remain incomplete after first attempt due to the delay in obtaining relevant diagnostic information from tests undertaken (e.g. histology reporting may be up to 2 weeks from test).

5.1 Reporting the Quality of Clinical Coding

A formal report is presented quarterly to the Executive Quality ~~and Performance~~ Board.

5.2 Source Documentation for Clinical Coding

5.2.1 Inpatient and Day Case Coding

The most thorough source of documentation for Clinical Coding is the original electronic or paper medical record. The Coding department will work towards a low level of uncoded activity. As the backlog reduces, it will become essential that the full medical record is made available for coding within 7 days after discharge in order that Payment by Results deadlines are adhered to. Where casenotes are used for coding, wards should make casenotes available for Clinical Coding within 24 hours of the patient being discharged from hospital as part of the discharge process. Where patients are transferred as inpatients to other providers, it is the responsibility of the CMG to ensure that full clinical documentation is returned to the Trust for coding. This must be done within a maximum of 1 week after discharge from that provider organisation.

Where paper records are used, information must be entered in clear and legible writing to enable accurate translation by the Clinical Coder. Ambiguous abbreviations must be avoided and documented in full.

The Orange Dot

For wards where there is agreement with the Coding team that the casenotes will be used for clinical coding, an orange dot should be applied to the front cover when the patient is admitted. This is done by the ward clerk. Orange dots can be obtained from the clinical coding manager or the local site lead. The dot is only removed by the Coder when the casenotes are coded.

The orange dot will be applied to the notes by the ward clerk/staff on admission and removed only by the coder once the notes have been coded. Any notes found with the orange dot on are to be tracked and sent directly to the coding office for coding.

5.2.2 Outpatient and Ward Attender Coding

Non-admitted activity is not comprehensively Clinically Coded at the Trust. Where specific procedures are undertaken (e.g. chargeable under Payment by Results), the relevant OPCS codes will be agreed with the Clinical Coding Manager. The possible procedure codes will be selectable on the clinic outcome form and the OPCS code entered onto the Patient Administration System by the clinic co-ordinator.

5.2.3 Waiting List Intended Procedures

Waiting List staff are mandated to record an intended OPCS procedure code for all elective waiting list additions. Relevant OPCS codes for the specialty will be agreed with the Clinical Coding manager and a pick-list will be provided to waiting list staff for use during waiting list addition processing.

5.2.4 Emergency Department Attendances

SNOMED_CT codes are applied to activity during the clinical episodes by the clinician responsible for the patient's care. This provides indicative coding information for payment and activity information but is not recorded to Classification standards.

5.3 **Diagnoses and Procedures**

The diagnoses must be documented as specifically as is known at the time of recording. The following table shows precisely the terms than can and cannot be used by Clinical Coders for applying appropriate ICD10 codes:

What CAN be coded	*What CANNOT be coded*
Assumed Clinically relevant Compatible with Consistent with Definitive diagnosis (Δ) Impression (Imp) In keeping with Probable Presumed Symptoms – where no definitive diagnosis is made Treat as Working diagnosis	Differential diagnosis (Δ Δ) Likely Maybe Possible ? Suspected

One Primary Diagnosis and up to 98 Secondary Diagnoses may be used if relevant.

5.3.1 Primary Diagnosis This is the main condition treated or investigated during the relevant episode of healthcare. Where there is no definitive diagnosis, the main symptom, abnormal finding or problem should be selected as the main condition.

5.3.2 Secondary Diagnoses All relevant diagnoses must be applied. Where there is insufficient diagnostic information provided to the Coder, the relevant consultant/clinician should be contacted to obtain missing information.

5.3.3 Procedures and Interventions All operative procedures and interventions that patients have undergone during their hospital stay must be documented, including those

undertaken by nursing staff and other professionals.

5.4 Co-morbidities, associated illnesses and complications

Any relevant co-morbidities must be documented by the consultant/clinician. A co-morbidity is any condition which exists in conjunction with another disease. Any comorbidity that effects the management of the patient's current episode of care must be recorded. To comply with Classification standards, comorbidities that are not relevant should not be coded.

'Depth of Coding' refers to the number of diagnoses typically recorded for patients. The Trust will benchmark coding depth against peer organisations. Greater depth of coding does not necessarily indicate higher quality coding.

5.5 ICD-10 and OPCS-4 Instruction Manuals and Standards

All Clinical Coders employed directly by the Trust will be provided with a full current set of Clinical Coding Manuals for their personal use. Electronic versions are available online but it is important that Coders maintain their own Update Notes and have books available for use in exams as necessary.

When amendments are released to the Clinical Coding Instruction manual for ICD-10 or OPCS-4, all Clinical Coding staff will be in receipt of the amendments. Medical staff should be advised by their professional organisations. Where new Clinical Classification guidance is released this is termed 'Coding Clinic'. The Clinical Coding Manager will ensure that all Clinical Coders are in receipt of this insert. The Data Quality Review newsletter will also be circulated. Any staff not in receipt of amendments can obtain them from the NHS Classifications Service.

Where it is necessary to raise queries with the NHS Classifications service, this will be undertaken by the Clinical Coding Training Manager, the Clinical Coding manager or the Clinical Coding Auditor. Resolutions to queries will also be circulated in the same manner as described above.

All changes to Clinical Coding policies are communicated as described in this policy. Any alterations to Clinical Coding practice have change dates and implementation dates provided and should comply with standards and classification coding rules and conventions.

5.6 Clinical Engagement

High Quality Clinical Coding depends on clear and accurate source clinical information. This supports the production of a true picture of hospital activity and the care given by clinicians. Accuracy of medical documentation is essential when the patient is admitted and must be reviewed at every ward round.

All Coders are encouraged to actively engage with clinical colleagues and share learning. This engagement is promoted and managed by the Coding Trainers, Auditors and Senior Clinical Coders.

Activities include

a. Clinical review of medical records where there are examples of activity that the Clinical Coders are having difficulty coding.

b. Coders may accompany a clinician on ward rounds to validate the relevance of clinical documentation.

c. Coders identifying their top problem areas to seek further clarification from Clinicians.

d. Clinicians reviewing a sample of coded activity to appraise coded data;

e. Standardising the format in which diagnoses and procedures are presented in the clinical record;

f. Circulating coding tips (e.g. what can/cannot be coded) to all doctors to clarify what information Clinical Coders are permitted to use;

g. Encouraging all grades of doctor to undertake audit of Clinical Coding.

h. An annual Coding conference as learning for both coders and clinicians.

5.7 Local Coding policies and guidance

Local policies should not conflict with established Coding Classifications Standards.

All Clinical Coding policy and procedure decisions made between the Clinical Coding department and individual clinicians are fully described, agreed and signed off by the relevant personnel.

When new procedures are developed or specific conditions are not immediately accommodated by Coding Classification standards, local policies should be agreed. When errors are identified (e.g. through Audit), local Coding communications may be required.

For local changes, a Local Clinical Coding Policy Template will be used to support appraisal of the change request. All local Clinical Coding Policies should be approved by the Clinical Coding Training Manager, the Clinical Coding Manager and the Clinical Coding Auditors and must be formally approved by the Medical Director or relevant Clinical Lead. The completed templates will be kept in the Clinical Coding file for reference.

Local Coding policies that are agreed and implemented will be documented and provided to all Coders. All Clinical Coders will have access to electronic copies of local coding policies and will sign to confirm they have been read and understood.

5.8 Clinical Coding Audit

5.1.1 The Clinical Coding team includes an Approved Clinical Coding Auditor role. The audit methodology routinely used is as directed by the NHS Digital.

5.1.2 Audit of Clinical Coding is a crucial part of a robust assurance framework required to support the provision of statistically meaningful coded data. This data is relied upon to facilitate the information and clinical governance agendas for both Payment by Results and the development of electronic care records. Clinical coding audits are performed as part of the Trust's continuous data quality programme.

5.1.3 The Trust has established documented audit procedures in place for the regular audit and review of coded clinical data. The audit checks that inputted data complies with Coding Classification standards i.e. correct and incorrect codes, sequencing of codes, irrelevant or omitted codes. The audit also examines the process undertaken for coding and documentation available for use during the coding process.

5.1.4 The Trust aims for accuracy that exceeds 95%. Findings and recommendations are developed into action plans and there is evidence that these actions have been taken.

5.1.5 Thematic audits are undertaken when requested to support local concerns and reviews. There is a documented procedure in place to inform audit requesters of the priorities for this work and to manage their expectations. All ad-hoc audit requests require appropriate scheduling within the audit programme and are formally reported.

5.1.6 The Audit process is as follows:

- The Auditor will undertake the audit within the agreed timescales. This is undertaken using the current Clinical Coding Audit Methodology as directed by NHS Digital.
- The Auditor will prepare a draft report and send to requestor/commissioner
- There will be an opportunity to validate the findings with Clinicians/Managers
- The Auditor will make any amendments and produce and circulate final report

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 Non-Clinical Coders

6.1.1 Within the *Knowing your Business* module on HELM there is a section on Clinical Coding. This is recommended training for all clinicians who record clinical information in the patient's Medical Record.

6.2 Clinical Coders

6.2.1 Clinical Coding training is arranged for all members of the Clinical Coding Team by the Clinical Coding Manager.

6.2.2 All Trainee Clinical Coders will complete a 21-day Clinical Coding Foundation Course before commencement of independent Clinical Coding at the Trust. This course endorses Clinical Classification standards, rules and conventions of ICD-10 and OPCS-4 and Clinical Terms.

6.2.3 All Clinical Coders will complete a 4-day Refresher Course within every 3 years. It is mandatory for all Coders to keep up to date with current coding standards.

6.2.4 Clinical Coders will attend Clinical Coding Specialty Workshops as necessary to increase their coding knowledge. It is expected that all Coders will attend workshops relevant to their current and potential areas of specialty interest. All coders should attend a minimum of 1 workshop each year for their own continual professional development.

6.2.5 Staff who have undertaken Clinical Coding for two years or more can become Accredited Clinical Coders by passing the National Clinical Coding Qualification (UK). The Institute for Health Record and Information Management (IHRIM) deliver the National Clinical Coding Qualification (UK) and candidates who pass both IHRIM practical and theory examination papers are awarded Accredited Clinical Coder (ACC) status by IHRIM.

6.2.6 Clinical Coding Auditor and/or Trainer Training is funded by the Trust for suitably experienced coders to ensure that the Trust maintains approved Clinical Classification Service audit and trainer capability.

7 PROCESS FOR MONITORING COMPLIANCE

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Lead(s) for acting on recommendations
Levels of coding completion	Individual Coders	Daily reporting of uncoded activity	Daily	Clinical Coding KPI report	Site leads
Coding accuracy	Clinical Coding Auditor	Coding audit software	Monthly	KPI report Errors reported back to individual coders. Themes reported to all Coders.	Clinical Coding Manager
Timeliness of coding	Clinical Coding Manager	Uncoded reports	Monthly	CMGS and finance	Clinical Coding Manager and Coding site leads
Depth of coding	Head of Information	Benchmarking against peer organisations	Quarterly	Clinical Coding KPI report	Clinical Coding Manager
Training completion	Clinical Coding Training Manager	Training records	Annually	Annual statement of compliance	Clinical Coding Manager & Site Leads

8 EQUALITY IMPACT ASSESSMENT

8.1. The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this Policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

Clinical Classifications Service Website
https://digital.nhs.uk/services/terminology-and-classifications

Royal College of Physicians: Generic medical record-keeping standards.
https://www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards

Nursing and Midwifery Council – Record Keeping: guidance for nurses and midwives
https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/reps/record-keeping-a-pocket-guide-005-343.pdf

Royal College of Surgeons – Guidance for Clinicians on Medical Records and Notes
https://www.rcseng.ac.uk/standards-and-research/gsp/domain-1/1-3-record-your-work-clearly-accurately-and-legibly/

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

The current version of this Policy will be held on INsite and available to all staff via Sharepoint.

This document will be reviewed every 3 years or during the intervening period if Clinical Classification Standards or local requirements change.