Clinical coding and your data

What is the coding process?

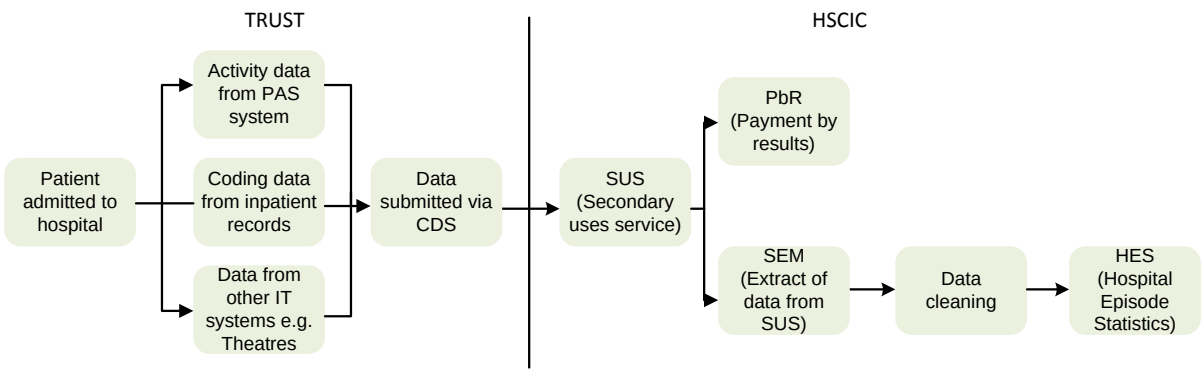
Clinical coding is the process whereby information written in the patient notes is translated into coded data and entered into hospital information systems. Coding usually occurs after the patient has been discharged from hospital, and must be completed to strict deadlines so that hospitals can be reimbursed for their activity under Payment by Results (PbR).

Clinical coders are entirely dependent on clear, accurate information about all diagnoses and procedures in order to produce a true picture of hospital activity and to ensure that the maximum income is obtained for this activity.

How does coding relate to routine data collection?

Figure 1 shows how routine activity data is collected and submitted by hospitals to the Health & Social Care Information Centre (HSCIC). Data on each patient interaction or 'episode' within the hospital is recorded and collected through the patient administration system (PAS). The coding department uses information from the PAS and through coding of the patient notes to populate the commissioning datasets (CDS). CDS data is then sent from the hospital to an external national data warehouse (Secondary Uses Service or SUS). Extracts from SUS are then used for different requirements such as PbR and HES. Hospital Episode Statistics (HES) data is routinely collected in England for all hospital admissions, A&E and outpatient attendances in secondary and tertiary care (though not primary care).

Fig 1: Process of data collection for HES



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How is this data used?

Payment by results

Within England payment historically was often linked to activity and adjusted for casemix, with additional payments being linked to the quality of services through 'best practice' payments. This system aimed to provide a fair and consistent process for hospital funding that did not rely on historic budgets or the negotiating skills of individual managers. The criticism of activity based payments is that they do not cover all aspects of care and that funding purely on activity may actually incentivise unnecessary admissions to hospital. These concerns about activity related payments has led to the development of 'tariffs' that reflect payment for a whole patient pathway, including post admission care or care to prevent admissions. There is ongoing work to evolve the tariff system and to ensure that it incentivises the best treatment for patients. This idea of reflecting payment on improved outcomes and on the patient pathway is called 'Payment by results (PbR)'.
Further information on the tariff system and PbR are listed below:

- Department of Health. Payment by results guidance for 2013-14. 2013 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214902/PbR-Guidance-2013-14.pdf
- Appleby J, Harrison T, Hawkins L, Dixon A. *Payment by results: how can payment systems help deliver better care?* 2012. Kings Fund. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf
- Pate R. *What is payment by results?* 2009. University of Oxford. http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/What_is_pay_by_res.pdf
- NHS Digital

Hospital Episode Statistics (HES)

HES data is designed to enable secondary use that is use for non-clinical purposes, of this administrative data. There are strict statistical disclosure controls in to all published HES data, to ensure that small numbers are suppressed, to ensure that patient confidentiality is maintained.

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Further information can be found here:

- NHS Digital

Improving accuracy of coding to maximise income and data quality

1. Record details of all diagnoses **(including co-morbidities**) and procedures (including those carried out on the ward) clearly in the notes. **Write the primary diagnosis first**.
    a. For injuries - note the cause.
    b. For overdoses - note the drugs.
    c. For infections - note the organism.
    d. For post operative complications – note the complication.
    e. For cancelled operations – note the reason for cancellation.
2. If a clear diagnosis has not been reached, make sure you detail the main symptoms in the notes or discharge summary
3. Any 'query', 'possible' or 'likely' diagnosis, or diagnoses proceeded by a '?' **cannot be coded.** If a histology result is needed for definitive diagnosis, note this down.
4. Avoid the use of new or ambiguous abbreviations (e.g. MS – multiple sclerosis or mitral stenosis). Clinical coders are not allowed to make any clinical inferences.
5. **All relevant co-morbidities MUST be recorded for each current spell;** reference cannot be made to previous spells. Funding is attached to the recording of this data
6. Transfers of care be must be recorded.
7. Details of all diagnoses, co-morbidities and procedures **MUST** be recorded on e-discharge summaries.
8. If image control or minimal access approach is used it should be clearly stated.
9. When recording procedures it is **IMPERATIVE** that the **actual** operation is recorded and not the intended operation.
10. The source documentation should be:
    a. accurate and complete
    b. reflect the patients episode of care
    c. avoid the use of abbreviations
    d. clear and detailed
    e. legible and in indelible ink

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The table below outlines key words that impact on coder's ability to record data from notes, which are then reflected in payments of services

Words that impact on the ability of coders to record information about diagnosis and treatment within a patient episode	
Can code	**Unable to code**
Probable	Likely
Treat as	possible
Presumed	?

For example:

Patient admitted with shortness of breath and no comorbidities:

Doctors documents in case notes **probable, treat as or presumed Pneumonia** → payment =£1409

Doctors documents in case notes **likely, possible or ? pneumonia** → payment =£515

With thanks to the Coding Department at Ipswich Hospital for sharing their local guidance.

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