

CLINICAL CODING POLICY

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VERSION NUMBER	2 (second EPUT version)	
KEY CHANGES FROM PREVIOUS VERSION	3 year review – various changes	
AUTHOR	Head of Electronic Systems and IG	
CONSULTATION GROUPS	Clinical Coding Manager Clinical Advisory Group Medical Director Director of ITT	
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POLICY SUMMARY		
<p>The World Health Organisation (WHO) require organisations to adhere to the national standards and classification rules and conventions as set out in ICD 10 Volumes 1-3 (International Classification of Diseases and Related Health Problems) Clinical Coding Manual and OPCS-4.9 Classifications of Interventions and Procedures). Clinical coding is the translation of clinical statements used within a clinical record into a format suitable to support aggregated statistical datasets in line with mandated National Standards. The aim of this process is facilitate data retrieval to support information analysis. This data is also used for statistical and analytical purposes.</p>		
The Trust monitors the implementation of and compliance with this policy in the following ways:		
Peer audits are performed on a monthly basis. The clinical coding manager is responsible for the implementation and compliance. Yearly Information Governance Toolkit audits.		
Services	Applicable	Comments
Trustwide		
Essex MH&LD	✓	
CHS		

**The Director responsible for monitoring and reviewing this policy is
Executive Chief Finance & Resources Officer**

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLINICAL CODING POLICY

Assurance Statement

This policy document details the clinical coding policy and procedures regarding the appropriate clinical coding of Trust activity.

1.0 INTRODUCTION

1.1 The World Health Organisation (WHO) require organisations to adhere to the national standards and classification rules and conventions as set out in ICD 10 Volumes 1-3 (International Classification of Diseases and Related Health Problems) Clinical Coding Manual and OPCS-4.9 (Classifications of Interventions and Procedures).

2.0 PURPOSE

2.1 Clinical coding is the translation of clinical statements used within a clinical record into a format suitable to support aggregated statistical datasets in line with mandated National Standards. The aim of this process is facilitate data retrieval to support information analysis.

2.2 Good quality clinically coded data enables:

- Assessment of health needs
- The sharing of information between healthcare organisations and clinicians
- Effective resource management
- Audit
- Epidemiological studies

2.3 The purpose of this policy and procedure document is to:

- Support accurate, complete and timely clinical coding for information and clinical governance purposes
- Support commissioning local information requirements and the information for commissioning data sets, mental health minimum data sets and activity costing
- Support continuing improvement of clinically coded data within the organisation through systematic quality assurance procedures
- Support adherence to mandated National Standards (rules and conventions that govern code allocation)
- Support clinical processes and outcome measures

3.0 SCOPE

- 3.1 This policy details the procedures regarding the clinical coding of all inpatient activity. The Policy is for use by all staff (clinical and non-clinical) involved in the clinical coding process.

4.0 RESPONSIBILITIES

4.1 Executive Medical Director / Associate Medical Director

- 4.1.1 To raise awareness and support the process for obtaining a diagnosis and to convert into an ICD-10 code.
- 4.1.2 To emphasise the need for the medical team to give a primary diagnosis on all out patient letters to the GP.

4.2 Consultants and Doctors

- 4.2.1 Consultants and Doctors will be responsible for the completion of the GP discharge summaries where a final diagnosis and comorbidities are clearly written. Doctors should be made available to the coding manager/coder (by phone, regular meetings or emails) to ensure that any queries are answered on time.

4.3 Director of ITT

- 4.3.1 The Director of ITT has overall responsibility for ensuring that clinical coding is appropriately collected and recorded on Trust information systems. This responsibility will be delegated, on a day to day basis, to the Head of Systems and IG.

4.4 The Head of Systems and IG

- 4.4.1 The Head of Systems and IG will be responsible for:

- Ensuring ACC qualified coders are employed
- Ensuring timely and accurate clinical coding information is collected and available to support Commissioning / Payment by Results (PbR)
- Ensuring appropriate audits are undertaken, as required

4.5 Clinical Coding Manager

- 4.5.1 The clinical coder will be responsible for the validation of the GP discharge summary/assessment unit discharge note.
- 4.5.2 The clinical coder will be responsible for capturing all relevant diagnoses with ICD-10 codes and OPCS-4.9 codes for a patient's episode of care (e.g. primary and secondary codes) including co-morbidities.

- 4.5.3 The coders should be trained in using the Trust's electronic records IT systems, currently the south uses Mobius and records are fully electronic and the north uses Paris and some records are still in paper format.
- 4.5.4 The Coding Manager will be responsible for auditing coding on a monthly basis and provide feedback and training when necessary. The coding manager should organise peer audits where coders will audit a sample of each other's work and the coding manager check against his coding and provide feedback.
- 4.5.5 The Coding Manager should lead a departmental staff meeting once a month where issues and audit results will be discussed and training needs if any should be highlighted. The Coding Manager should provide training as necessary and organise attendance of training courses as necessary.

5.0 AIMS AND OBJECTIVES

5.1 It is EPUT's policy that:

- Clinical coding is accurate, complete and timely
- All Inpatients admitted under the care of the Trust will have an ICD-10 diagnosis code recorded
- All procedures involved in the capture of information for clinical coding purposes are clearly defined to ensure compliance with and clarification of individual coding processes
- All quality assurance procedures for clinical data coding are detailed in this document, including clinical coding audit measures to support improvements in the standard and quality of coded data in this organisation
- Clinical coding is timely and reflects accurately the main condition that was treated and any associated co-morbidities that affected the management of the patient or contribute to the patient's condition including those mandated for national capture such as diabetes.
- All those involved in the clinical coding process will be trained in the appropriate use of the encoding schemes they are required to use.
- Clinical coders will be qualified and receive regular refresher and update training in line with National Standards

6.0 TRAINING

- 6.1 Clinical teams (coders) will receive coding training as part of their professional qualification.
- 6.2 Clinical teams (coders) will receive refresher training in relation to clinical coding through their professional bodies or via in-house approved training methods.
- 6.3 Non-clinical teams (coders) will be trained accredited to ACC standards and will receive appropriate refresher training through the Trust.

6.4 Training requirements will be as follows:

Mandatory	Core	Update Interval	Staff Category	Delivery Method
ACC Accreditation	Refresher	3 years or when changes to process requires as determined by WHO	Non-clinical	On / off site training course

7.0 MONITORING AND REVIEW

7.1 External Audits - Information Governance and Audit Commission

7.1.1 In line with the recommendations of the Information Governance Toolkit an external audit of coded records will be conducted annually. This will be carried out by an accredited external auditor who is recognised by the NHS CfH and is experienced in performing clinical coding audits in the mental health organisations.

7.1.2 Auditors are expected to consider codes to be accurate if they describe:

- The actual condition of the patient and any procedures performed as completely as is possible within the constraints of the scheme used and the intended use of the coded data.

7.1.3 There are three dimensions to this:

- Individual codes – do these accurately reflect the clinical statements
- Totality of codes – do they represent all the relevant clinical details
- Sequencing of codes – are the codes in the correct sequence as defined by the conventions and rules of the encoding schemes

7.2 Internal Audit

7.2.1 Monitoring of the completeness of episodes will be undertaken every month by the Trust's coding manager. Auditing will be done by the Trust's coding manager on a monthly basis and report to Head of Records

7.2.2 All audit reports will contain the background information on what was audited, why, and outcome data will be reported to Medical Director and the Director of ITT for action as appropriate.

7.2.3 This policy and its associated procedures will be audited within the Performance Department's policy compliance timetable.

8.0 REFERENCE / OTHER RELEVANT DOCUMENTS

- Data Protection Act 2018
- The General Data Protection Regulations 2016
- Connecting for Health Clinical Coding Guidance Document (2007)
- World Health Organisation (WHO) ICD-10 International Classification of Diseases and Related Health Problems Volumes 1-3
- OPCS Classification of Interventions and Procedures Version 4. 7 Volumes 1-2
- Confidentiality Procedure (CPG59b)
- Information Sharing (CPG9c)

This is not an exhaustive list.

END