These procedural guidelines detail the requirements for clinical coding in line with national / local guidance and will ensure that appropriate recording is maintained to support Commissioning / Payment by Results (PbR) across the Trust.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

Yearly Information Governance Toolkit audits and monthly peer audits.

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The Director responsible for monitoring and reviewing this procedure is Executive Chief Finance Officer
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLINICAL CODING PROCEDURE

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1.0 INTRODUCTION

1.1 These guidelines detail the procedures regarding the collection and recording of clinical coding information / data for all in-patient and consultant led care.

1.2 These guidelines will outline the procedures to be followed by both clinical and non-clinical staff in the collection and recording of clinical coding information / data.

2.0 PROCEDURES

2.1 2.1.1 Clinical Coders

2.1.1.1 Clinical coders will be responsible for the maintenance of up to date clinical coding manual and reference books.

2.1.1.2 The consultant in overall charge of the patient’s care will be responsible for ensuring the provision of an accurate diagnosis that describes the main condition being treated. This will be in the form of the relevant ICD-10 code.

2.1.1.3 Information regarding the patients’ diagnosis or diagnoses and procedures/interventions that have been performed or undertaken will be provided by the Consultant psychiatrist or a designated care coordinator responsible for the patients care at discharge from each inpatient consultant episode.

2.1.1.4 Where there is no mental or behavioural disorder identified and there is no other diagnosis identified, the reason for the admission should be clearly stated, using the following codes:

- Z00.4 General psychiatric examination not elsewhere classified (if neither patient nor doctor can find evidence of mental disorder)
- Z03.2 Observation for suspected mental health and behavioural disorders (if mental disorder suspected by one or both but not proven)
- Z71.1  Person with feared complaint in whom no diagnosis is made (if patient thinks there is a mental disorder but the doctor does not)

2.1.1.5 In the case where there is no primary diagnosis or a primary diagnosis cannot be established but there is a mental disorder, then the presenting symptoms and signs should be coded upon discharge.

2.1.1.6 Co-morbidities must always be coded in line with the up to date coding clinics. NB these clinics are updated periodically and this procedure will be changed to reflect these updates.

2.1.1.7 **Smoking** – If the patient is currently a smoker regardless of how many cigarettes they smoke then code as harmful use unless the clinician describes it as addiction.

2.1.1.8 Alcohol consumption that has an adverse effect or affect the patients mental health should be recorded in the notes and coded as mental and behavioural disorder F10.1 code should be used and z72.1 should be used if a social drinker with no effect on their mental health.

2.1.1.9 The clinician should make a decision based on the charts used to diagnose obesity. Always record obesity reasons e.g. Due to high calories intake or drug induced etc.

2.1.1.10 **Self Harm** - Self-Harm code is always included. In the case of a patient who self-harmed twenty years ago and was admitted currently with self-harm then it becomes relevant and needs to be coded accordingly.

2.1.1.11 **Non-Compliance** – If the non-compliance is part of the illness or patients insight even if it is knowingly and deliberate this need to be coded.

2.1.1.12 **Drug Allergies** – these are only coded when there has been an impact on the patients treatment within their stay.

2.1.1.13 **Nosocomial (Hospital Acquired) Conditions Y95** – these must always be coded and the appropriate codes used e.g. chest infections, pneumonia or other infections.

2.1.1.14 The completion of all clinical coding will take place within the following time frame:

- A diagnosis must be provided on a clinical coding pro-forma at the end of a inpatient consultant episode within 3-working days.
A final statement of diagnosis or diagnoses will be provided to the clinical coding department within 5 working days of discharge as an admitted patient.

Outpatients - a primary diagnosis code (main condition treated and in case of dual diagnosis both diagnosis recorded) should be recorded on the outpatient clinic report a copy of which will be sent to the GP.

2.1.1.6 Where clinical staff provide the ICD-10 code(s) to describe the mental or behavioural diagnoses, this will be done using the ICD-10 Classification of Mental and Behavioural Disorders – Clinical Descriptions and Diagnostic Guidelines (WHO).

2.1.1.7 If a patient is still an in-patient, on the 28th day following admission, an initial diagnosis must be provided on the pro-forma.

2.1.1.8 For any missing diagnoses, the relevant Consultant responsible for that episode of care will be contacted for a diagnosis and ICD-10 code.

2.1.2 Non-Clinical Coders

2.1.2.1 Non-clinical coders / ACC qualified coders will be responsible for the maintenance of up to date clinical coding manual and reference books.

2.1.2.2 Non-clinical classification practitioners will assign codes in line with UK National Standards using the ICD-10 Classification of Diseases and Health Related Problems V10 (Volumes 1 and 3) and the OPCS 4.7 Classification of Interventions and Procedures.

2.1.2.3 When a query arises, reference will be first made to the National Standards contained in the Clinical Coding Instruction Manual (currently CCIM v2 ICD-10 and CCIM v3 OPCS 4.7). In the event that this does not supply a satisfactory answer the query should be discussed with an ACC qualified clinical coding specialist, if the query is of a code allocation nature. If the ACC qualified coder cannot come up with a code accepted by both the consultant and coder then the matter should be referred to HSCIC. If the query is not a code allocation the treating clinician should be contacted.

The clinical coder should have regular meetings with the relevant consultants where the coder will discuss any problems or queries.
2.1.2.4 For any missing diagnoses, the relevant Consultant responsible for that episode of care will be contacted for a diagnosis and ICD-10 code.

2.1.3 Anomalies

2.1.3.1 Where the query resolution is considered to have set a precedent, the result will be written up and included in this policy and its associated procedures document. **NB:** all query resolutions of a clinical nature must be agreed and signed off by a Consultant.

2.2 Validation of Clinically Coded Data

2.2.1 Completeness

2.2.1.1 The Head of Electronic Systems & IG / ACC qualified coder will extract reports from the Trust’s information systems (South Essex use Mobius and all records are electronic while the north use Paris and some records are in paper form). Which will highlight any missing / uncoded episodes, which the Head of Electronic Systems & IG / ACC qualified coder will ensure are followed up.

2.2.1.2 By the 12th of the following month all inpatient records will be validated for the inclusion of at least the primary diagnosis. Where none has been provided or appears to be incorrect, the consultant psychiatrist in charge of the episode will be asked to provide within 3 working days an appropriate code or amended alternative.

2.2.1.3 In the event that the coder has a query and further information/ clarified is required the Appendix B should be forwarded to the relevant consultant.

2.2.1.4 Samples of coded data will be taken on an annual basis from all specialties for clinical coding audit. Data samples will be validated against the case notes, summaries and proformas. The clinical coding manager will perform monthly audits for both north and south and organise peer audits (coders will audit each other and discuss results at the team meetings).

2.3 Acceptable Clinical Coding Accuracy

2.3.1 Whilst it is the intention that all clinically coded data is accurate and complete and therefore the Trust will aim to achieve a level 3 in the Information Governance Toolkit, which relates to 90% accuracy for primary coding and 80% for secondary coding in its coded data set, realistically given the nature of the Trusts activity in terms of the long term nature of many of the inpatient episodes, there will be differences of opinion in the clinical coding of some the activity at audit.
2.3.2 These procedural guidelines as detailed below show those areas where discrepancies may occur and provide resolutions to these in the absence of National Standards / ambiguity in this arena.

2.3.3 However it should be noted that clinical coding policies / procedures will not contravene National Standards contained in the NHS CfH Clinical Coding Instruction Manual(s).