Clinical coding

Introduction

Clinical coding is defined by Connecting for Health as '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 a coded format which is nationally and internationally recognised' (Harding, 2009). It involves classifying diagnoses, procedures and other categories of care. It is necessary for various clinical and statistical purposes, including:

- Payment by Results
- Data accuracy for individual consultants
- Hospital Episode Statistics
- External audits
- Planning
- Research.

For diagnoses, the World Health Organization's International Classification of Diseases ICD-10 criteria are used. For procedures and interventions, the UK-specific Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures OPCS-4 system is used.

Coding relies on legible, comprehensive, accurate documentation by clinicians. It is not a new concept, although it has become more prominent in recent years with NHS changes and increased scrutiny. Effective coding results in the production of high-quality, statistically-meaningful data.

Clinical coders

Hospital trusts employ clinical coders to translate patient records into detailed standard activity codes. Coders are non-medical but often have a human biology background and train on the job to gain a recognized qualification and accreditation. However, there is no dedicated coding degree in the UK, unlike elsewhere in the world.

Clinical coding has a good career structure. After 12–24 months of classroom and work-based experience of coding many specialties, a trainee will be required to take an assessment to become a qualified clinical coder. A high standard is set and expected. All coders are encouraged, after gaining wide experience, to take a national examination to become an Accredited Clinical Coder.

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Coders need a wide knowledge of anatomy and physiology. An in-depth knowledge of medical terminology is essential, as is an enquiring mind and the ability to read clinicians' writing. Coders need to be able to work to strict deadlines and to communicate with all levels of staff on complex matters, which is an everyday part of the job. Coders also work with coding assistants.

Coding specifics

Coders rely on various sources of information, such as discharge letters, full clinical records and computerized investigation results. They need to know:

- Diagnoses
- Treatments (including high-cost drug regimens and chemotherapy)
- Procedures (including use of specialist equipment, devices and implants)
- Theatre re-visits
- Radiological investigations and interventions
- Comorbidities.

Simple investigations such as blood tests and electrocardiograms are coded if the patient is specifically admitted for that procedure. Interventions such as 'blood transfusion' and 'intravenous iron therapy' are also coded if the patient is specifically admitted for these. Computed tomography and magnetic resonance imaging scans are always coded if documented.

In the current era of acute medicine and high turnover, patients are frequently discharged before a diagnosis is confirmed – for example before microbiological culture results are back. If there is no definitive diagnosis made at the point of discharge, then all presenting symptoms are coded, such as pyrexia, dizziness, headache. Coders can check tissue biopsies on the trust's electronic pathology system and code the results, such as carcinoma or adenoma. It is nationally mandated by the NHS that coders cannot code a 'possible' diagnosis. Nor can they code a 'query' diagnosis – that is, one preceded by a question mark. However, coders can code a 'probable' or 'treat as…'.

Coders have to work to strict deadlines and trainees often have little concept of the magnitude of the challenges they face. Completion of coding is usually required to be on a particular day of the month after the month of discharge. For example, if a patient is discharged in March, coding may have to be completed by 5 pm on 15 April. Many trusts will have pockets of good practice and less optimal practice.

Your role

It is important to keep the medical notes legible, completed and up-to-date and to fill in the discharge letter fully. The GP is likely to know the patient's pre-existing conditions, but coders need them, so they must be stated. You should not dictate anything onto tape or digital that has not been written in the notes (Hooke, 2009).

It is not acceptable to put a procedure in place of a diagnosis. If there is no diagnosis, coders use signs and symptoms recorded in the notes, as described above. However, this takes time and can be imprecise. Hence, it is better to give a definite diagnosis if possible. Also, avoid abbreviations – for example, 'MS' could stand for mitral stenosis or multiple sclerosis. An experienced coder will be able to work this out from the context, but you cannot rely on this, and it creates extra work for him/her. When dictating, ask the secretary to type out the word(s) in full, at least the first time in the letter.

You may feel that you have little time to spend on filling in discharge and other documentation and that direct patient care takes priority. This may apply particularly if there is a quick turnover on your ward or unit. However, proper information contributes positively to safety and governance. It also ensures that the trust receives the income it deserves from primary care, which can improve working lives for staff. Ultimately, your consultant may be told if there are persistent difficulties with your documentation and timeliness. If you are unsure about anything, then ask your consultant, a coder or a manager.

You may come across your clinical coders around the hospital, and one of them may present at your induction or teaching session. A coder may contact you to clarify something you have written (or not written) in the notes or discharge letter. Theirs is a difficult job and they are under great pressure to meet stringent deadlines. You should treat them with respect and work with them to solve the problem. If you get chance, ask to visit the coding department and find out how it all works. The staff may be busy, but they will welcome your interest. You will find it a good learning experience and gain a greater understanding.

Coders and information analysts may be able to assist junior doctors in identifying patient cohorts and compiling reports for research or audit, such as 'All patients admitted with a diagnosis of X within the last 5 years'. It is best to contact the information manager or equivalent within your trust, who can liaise with the coders to supply the correct codes to search on.

There is a drive to introduce more active clinician involvement in clinical coding. This can vary greatly. There may be joint meetings between doctors and coders. There may be active consultant review of all coding, or a sample. If you get chance to become involved, this could be valuable experience and give you a different perspective from the one you might gain just from normal clinical practice.

Conclusions

Clinical coding is about classifying activity for clinical and non-clinical purposes. It is important for foundation doctors to play their part in ensuring that data are accurate and up to date. It is part of patient care, governance and income generation. Clinical coders are valuable members of staff whose job is not straightforward. BJHM

Dr R Hooke would like to thank the clinical coders and managers who have helped with this article.
Conflict of interest: Dr R Hooke has worked in both management and medicine. Her views are her own and do not necessarily reflect those of her employer or any other organization that she is associated with.

Harding J (2009) Data Quality for Improvement – the clinical coder's perspective. www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/noncoders/codingnoncoders.ppt#292,3,What is Clinical Coding? (accessed 5 October 2011)

Hooke R (2009) Dictation: a guide for the foundation year doctor. *Br J Hosp Med* **70**(5): M66–7

FURTHER INFORMATION

Connecting for Health Clinical – Coding for non-coders
www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/noncoders

International Classification of Diseases (ICD)
www.who.int/classifications/icd/en/

Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures OPCS-4.6
www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/codingstandards/opcs4/opcs-4.6

Royal College of Physicians
www.rcplondon.ac.uk/sites/default/files/improving-clinical-records-and-clinical-coding-together.pdf

KEY POINTS

- Make sure you keep records legible, complete, accurate, comprehensive and up to date.
- On discharge documentation, record precise diagnoses and procedures, without using abbreviations.
- Keep to the required timescales.
- Treat clinical coders with respect and comply with their requests for clarification.
- Ask if you are unsure about any aspects of clinical coding.
- Ask politely if you need any reports compiling for your own audit or research.

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