

Clinical Coding Policy for Admitted Patient Care in Mental Health

Version number :	1.11
Consultation Groups	Information Governance Steering Group
Approved by (Sponsor Group)	Information Governance Steering Group
Ratified by:	Quality Committee
Date ratified:	23 rd June 2021
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Implementation Date :	June 2021
Last Review Date	March 2021
Next Review date:	March 2024

Services	Applicable
Trustwide	x
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
1.1-1.4	March 2008	Clinical Records Development Manager	Draft	For consultation
1.5	May 2008	Clinical Records Development Manager	Draft	2 week standard for coding inpatients confirmed by HCG
1.6	November 2012	Clinical Records Development Manager	Final	Minor amendments on role changes
1.7	February 2013	Clinical Records Development Manager	Final	Updated to reflect practice at the Trust
1.8	March 2015	Information Governance Assets Manger	Final	Revision in terms of content, format, roles and responsibilities
1.9	August 2018	Clinical Coding Consultant	Final	Review and revision
1.10	February 2019	Clinical Coding Consultant	Final	Review to comply with audit recommendations
1.11	March 2021	Clinical Coding Consultant	Final	Updated to reflect practice at the Trust. Title updated

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1.0 Introduction

Clinical Coding is the process whereby all diagnoses and procedures for an inpatient episode are converted into internationally used ICD10 diagnosis codes and OPCS4 procedure codes. These codes are converted electronically into a funding category called an HRG code which enables the Trust to invoice commissioners for each patient episode of care. Accurate billing is therefore dependent on accurate clinical coding, which in turn is dependent on the accuracy and completeness of the clinician's documentation of the patient's medical history, diagnoses and procedures carried out during the episode of care.

2.0 Purpose

The purpose of this document is to promote good practice and consistency of information being produced through the clinical coding process in East London NHS Foundation Trust. It has also been designed to incorporate the requirements of the Data Accreditation process and Data Security and Protection Toolkit to ensure information produced during the coding process is accurate and adheres to local and national policies.

3.0 Implementation of ICD-11

The World Health Assembly (WHA) adopted ICD-11 in May 2019. Whilst it is expected that all member states should follow suit and adopt ICD-11 by January 2022, no decision has yet been made regarding its implementation in the UK. This policy will be updated as appropriate to reflect any changes in the current roadmaps.

4.0 ICD-11 and SNOMED CT

As of 1st April 2020, the Trust has a duty to report SNOMED CT codes in addition to ICD-10, and eventually ICD-11, codes. The World Health Organisation (WHO) will provide a matrix to convert ICD-11 codes in to SNOMED CT codes. Once implemented, the Trust will use the conversion matrix to ensure all ICD-11 codes assigned to Finished Consultant Episodes are translated in to appropriate SNOMED CT codes to comply with mandatory reporting requirements. This will be an automatic, background process performed on RiO.

5.0 Duties and responsibilities

5.1. Chief Medical Officer

Has overall responsibility for the implementation of this policy and to ensure engagement of medical staff in documenting each episode of care accurately and completely.

5.2. Clinicians

Must accurately and completely document the patient's medical history, and for each episode of care, all diagnoses and procedures. This information should be available on discharge summaries and be available on the RiO clinical system or other electronic system within 48 hours of the patient's discharge. Clinicians will instruct medical secretaries and assigned administrators on the ICD10 codes that need to be entered on each Finished Consultant Episode. (FCE).

5.3. Medical secretaries / assigned administrators

Must enter the ICD10 diagnoses codes as instructed by the clinician onto the FCE on the RiO clinical or other electronic system within ten working days of patient discharge, using the process defined in the ICD10 Clinical Coding RiO crib sheet or other system crib sheets found on the intranet. If the appropriate codes are not available within the patient notes the responsible clinician must be approached for clarification.

5.4 Clinical Coder

The clinical coder validates the ICD10 codes assigned for every inpatient episode using information from the discharge summary and other documentation on the RiO or other clinical system.

The clinical coder contacts the relevant consultant responsible for the episode of care if there are any queries regarding diagnosis, medical history or procedures.

The external clinical coder uses RiO or other reporting systems that have specifically been set up from Reporting Services 2016 to list the FCEs for the previous month. This will be used to ensure all ICD10 codes are validated for every FCE in that month.

5.5 All staff

The Trust takes security and confidentiality of patient information and of sensitive information very seriously. Internal measures include:

- All staff contracts include commitment to dealing with patient identifiable information in accordance with Trust policies.
- All coding staff are aware and maintaining their awareness of the policies and procedures governing the disclosure and sharing of data both internally and with external organisations.
- All staff must be aware that it is Trust policy that any information being forwarded to external sources for coding queries should be completely anonymous.
- All coding staff are aware of who the Caldicott guardian is, should issues in security and confidentiality of patient identifiable information arise
- All staff are trained in and are familiar with and have access to the confidentiality and security documentation

5.6 Summary of staff responsibilities and training

Role	Tasks/responsibilities	Training requirement
Clinicians	<ul style="list-style-type: none"> • Perform diagnosis • Assign ICD10 code • Inform admin staff of the correct code within agreed timescales. 	Covered in medical training.
Administrative staff and Medical secretaries	Data entry onto RiO or other electronic system. (if code not available on notes MUST refer to clinical staff for clarification)	RiO or other relevant system training RiO or other electronic clinical system crib sheets
Clinical Coder	Validate the ICD10 codes on all inpatient FCEs	ACC accredited with NHS Classification Service and the Institute of Health Record and Information Management (IHRIM).Accredited

		clinical coder
All staff	Maintain confidentiality of patient information	Annual Data Security & Protection Toolkit refresher training

6.0 Process

6.1 Information Source

Clinicians must ensure that the complete diagnosis and ICD-10 codes are recorded in the progress notes on RiO, prior to a patient's discharge. Administrative staff enter these codes onto the RiO system using the appropriate RiO process crib sheet or other electronic system crib sheet. At the end of each month the clinical coder will then extract the information and enter it onto the relevant Diagnosis field in RiO or other electronic system. Included should be any underlying medical illnesses, socioeconomic factors or any relevant information which may prolong a patients' length of stay.

6.1.1 Primary Diagnosis

The main condition treated or investigated during the relevant episode of care.

6.1.2 Secondary Diagnosis

Any relevant conditions that contribute to the patients' stay, and any chronic comorbidities that impact upon the patients' long-term health.

7.0 Clinician validation of clinical coding

Where the information or discharge summary is unclear or inadequate for accurate coding of the FCE, the clinical coder will e-mail the relevant consultant for clarification of the primary and secondary diagnoses.

8.0 Clinical Coding audits

The accuracy of the clinical coding is audited by external clinical coding auditors on an annual basis. These auditors are fully ACC accredited with NHS Classification Service and the Institute of Health Record and Information Management (IHRIM).

9.0 Monitoring

The resulting reports, findings and recommendations from the annual external clinical coding audit are taken to the Information Governance Steering Group for information and action.

10.0 Related policies and procedures

10.1 Individuals should read the following associated policies and procedures:

- Information Governance and IMT Security Policy
- Health Records Policy
- Data Quality Policy
- RiO crib sheets and procedures
- Other electronic system crib sheets and procedures