Clinical Coding Policy

Version: 3.1

Executive Lead: Executive Director of Quality & Medical Leadership
Lead Author: Head of Information Management and Compliance

Approved Date: 16th April 2014
Approved By: Information Governance & Records Group

Ratified Date: 29th April 2014
Ratified By: Policy Panel

Issue Date: 30th June 2015
Review Date: 27th May 2017

Target Audience: This policy is for use by:
- All Trust staff involved in the coding of patients activities and should be read with the conjunction with the Trust’s Care Records Management Policy and the Data Quality Policy, available on the Trust’s Intranet.
Preface

P1 - Version Control History:
Below notes the current and previous Version details full history is in

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V3</td>
<td>27th May 2014</td>
<td>Senior Information Governance Analyst</td>
<td>Current</td>
<td>Annual Review</td>
</tr>
<tr>
<td>V3.1</td>
<td>May 2015</td>
<td>Senior Information Governance Analyst</td>
<td>Current</td>
<td>Annual Review</td>
</tr>
</tbody>
</table>

P2 - Relevant Standards:
A) Information Governance Toolkit 514 – based on Audit
B) Information Governance Toolkit 516 – based on Training
C) Information Governance Toolkit 506 – based on Data Quality
D) Information Governance Toolkit 508 – based on Validating Information
E) Equality and RESPECT: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

P3 - The 2012 Policy Management System and the Policy Format:
The PMS requires all Policy documents to follow the relevant Template.
- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services, how they work and who can access them.
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.
- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance’s which will need to go back to the Approval Group annually.

Symbols used in Policies:
**RULE** = internally agreed, that this is a rule & must be done the way described
**STANDARD** = a national standard which we must comply with, so must be followed

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hptf.nhs.uk
All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
## Contents

<table>
<thead>
<tr>
<th>PART:</th>
<th>Page:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preface</td>
<td></td>
</tr>
<tr>
<td><strong>Preface concerning the Trust Policy Management System:</strong></td>
<td></td>
</tr>
<tr>
<td>P1 - Version Control History</td>
<td>2</td>
</tr>
<tr>
<td>P2 - Relevant Standards</td>
<td>2</td>
</tr>
<tr>
<td>P3 - The 2012 Policy Management System &amp; Document Formats</td>
<td>2</td>
</tr>
<tr>
<td><strong>PART 1</strong> Preliminary Issues:</td>
<td></td>
</tr>
<tr>
<td>1. Summary</td>
<td>4</td>
</tr>
<tr>
<td>2. Purpose</td>
<td>4</td>
</tr>
<tr>
<td>3. Duties and Responsibilities</td>
<td>4</td>
</tr>
<tr>
<td><strong>PART 2</strong> What needs to be done and who by:</td>
<td></td>
</tr>
<tr>
<td>4. Clinical Coding Team Responsibility</td>
<td>5</td>
</tr>
<tr>
<td>5. Clinical Coding requirements from clinicians</td>
<td>5</td>
</tr>
<tr>
<td>6. Training - Who is required to be trained</td>
<td>7</td>
</tr>
<tr>
<td>7. Equality and RESPECT</td>
<td>7</td>
</tr>
<tr>
<td>8. Process for monitoring compliance with this document</td>
<td>8</td>
</tr>
<tr>
<td><strong>PART 3</strong> Associated Issues</td>
<td></td>
</tr>
<tr>
<td>9. Version Control</td>
<td>9</td>
</tr>
<tr>
<td>10. Archiving Arrangements</td>
<td>9</td>
</tr>
<tr>
<td>11. Associated Documents</td>
<td>9</td>
</tr>
<tr>
<td>12. Comments and Feedback</td>
<td>10</td>
</tr>
<tr>
<td><strong>Appendix 1</strong> Coding Clinic Ref 88 List of Comorbidities</td>
<td>11</td>
</tr>
</tbody>
</table>
PART 1 – Preliminary Issues:

1. Summary

The World Health Organisation (WHO) states that ‘International Classification of Diseases and Related Health Problems (ICD) is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas at different times. The ICD is used to translate diagnosis and other health problems from words into alpha-numeric code which permits easy storage, retrieval and analysis of data.’

The OPCS (Office of Population Censuses and Surveys) Classification of Interventions and Procedures (OPCS-4) is a statistical classification for clinical coding of interventions and procedures undertaken in the NHS reflecting current clinical practice.

It is a mandatory obligation to collect and submit ICD-10 and OPCS-4 data to the WHO for the production of international statistical and epidemiological data.

2. Purpose

This policy is intended to promote good practice and consistency of information produced during the clinical coding process. It is based on guidance from the Health & Social Care Information Centre (HSCIC) and has been designed to incorporate the requirements of the Data Accreditation process. This ensures information produced during the coding process is accurate and adheres to local and national policies.

The policy details the procedures relating to the clinical coding of all admitted patient care. It outlines the responsibilities of clinical and administrative staff and the timescales in which coding should be completed.

This policy is for use by all Trust staff involved in the coding of patient activities and should be read in conjunction with the Trust’s Care Records Management Policy and the Data Quality Policy, available on the Trust’s Intranet.

3. Duties and Responsibilities

RULE

To adhere to the rules, conventions and national standards, as set out in the WHO ICD-10 Volumes 1-3, Clinical Coding Instruction Manual ICD-10 and OPCS-4 and the latest publication of the Coding Clinic.

To input accurate and complete coded information into the Trust’s Electronic Patient Record (EPR) system within the designated time scales to support the information requirements of HPFT.

To ensure all staff involved in the clinical coding process receive regular training to maintain and develop their clinical coding skills, regardless of experience and length of service.

To ensure continual improvement of clinical coded information within the Trust through systematic audit and quality assurance procedures.

To ensure all staff are aware of the Trust’s security and confidentiality policies when using patient identifiable information.
4. Clinical Coding Team Responsibility

To extract the relevant information from the medical record to assign codes using ICD-10 and OPCS-4, for each Finished Consultant Episodes (FCE) for the admitted patient care.

When clinical information is unclear within the medical record, the clinical coder will liaise with the responsible clinician via email and use the information given as guidance to assign the correct code for the diagnosis.

The clinical coder must input accurate and complete clinical coded information onto the Trust’s EPR system, within the designated time scales.

To keep up to date and comply with any clinical coding changes as instructed in the latest edition of the Coding Clinic as published on the HSCIC website.

When a clinical coding query arises, the clinical coder must follow the recognised query mechanism as published on the HSCIC website and keep a record and implement the resolution.

To engage with the clinicians to raise awareness of the requirements of clinical coders to achieve accurate and complete Clinical Coding.

To facilitate enquiries for coded information from within the Trust.

To maintain links with other mental health trusts to assist with quality assurance nationally.

It is locally agreed that if the medical record states a diagnosis of ‘Learning disability’ the coder will assign a code from the chapter - Mental Retardation (F70-F79) instead of F81.9 which is the code you would assign if you index the term ‘Learning Disability’. This comes in the chapter F81 Specific developmental disorders of scholastic skills.

5. Clinician’s Responsibilities

Clinicians will be responsible for providing all the information required within the EPR to achieve accurate and complete clinical coding.

This will be in the form of a comprehensive transfer/discharge summary within 14 days as agreed by the Discharge and Transfer of Service Users within the Transfer and Discharge Policy. This should include all primary and secondary diagnoses which are relevant to the patient’s episode of care.

The Clinical Coding definition of a primary diagnosis is the main condition treated or investigated during the FCE. If no firm diagnosis can be made, the main symptom, abnormal finding or problem should be selected. Consequently, a diagnosis of a patient in remission cannot be the primary diagnosis if they have been treated for their acute condition during their inpatient stay.

Factors specified by the clinician, which they consider to be relevant to the patient’s current condition e.g. non-compliance with medical treatment, current stressors and any particular social issues can also be coded. The statement of “due to” would indicate clearly the
connection. For example: relapse of Paranoid Schizophrenia “due to” non-compliance of medication or depression “due to” family dispute and financial problems.

Clear and precise statements are key to accurate clinical coding as the Clinical Coders cannot use information supplied as “impression”, “likely”, “possibly”, “may be”, “provisional” or “?”. It is appreciated that a patient’s condition will probably change during their episode so a definitive decision at the end of the episode will provide an accurate primary diagnosis.

Information supplied on the EPR by Clinicians needs to be clear and concise to assign quality coding. The ICD10 contains very specific codes which can only be assigned if the detailed clinical information is supplied. For codes to be valid, they must consist of 4 digits. In the absence of specified information about the diagnosis, the Clinical Coder must assign .9 as the forth digit which means unspecified. E.g. – Paranoid Schizophrenia codes to F20.0 however Schizophrenia codes to F20.9, unspecified.

It is required by the WHO to submit specified co-morbidities in secondary positions as they are considered to have an impact on the patient’s level of care. Some examples of these conditions are: hypertension, diabetes (specified as to type), COAD/COPD, chronic heart conditions (e.g. Angina IHD), kidney disease, blindness, deafness and asthma. This is in-line with Ref 88: Coding of Co-morbidities (Coding Clinic November 2012), V2.3 as seen in Appendix 1.

There is a requirement to collect information about smokers as per quoted instructions given in the Clinical Coding manual:- ‘Smoking in any amount regardless of frequency will always have an adverse effect. When it is stated that a patient smokes, code F17.1 must be assigned. If further information is given such as dependence the 4th character may change. Z72.0 must not be assigned.” A patient who has a history of smoking would be assigned Z86.4.

Clinicians are also required to record any infections (including the organism if known), injuries (and how they occur) or any medical conditions which require treatment during a patients episode, for example acute on chronic renal failure as these also need to be coded.

Any interventions or procedures performed during admitted patient care must be documented on the EPR. This includes Electroconvulsive Therapy (ECT). The start of each course of treatment must be clearly recorded along with the date of each follow up session. Other procedures which can be recorded are suturing of wounds and urinary catheterisation.

Clinician feedback in a timely manner is essential to the clinical coders, this will assist and improve the quality of the final coded data to enable the Trust to meet the required national timescales.

The coders need to apply rules and conventions before final confirmation is made. Clinicians must refrain from using the confirmation status field on the EPR as this overrides any data which the coders apply and subsequently will have an adverse effect on our national reporting.

6. Information Governance Manager’s Responsibilities

Reviewing and making necessary changes to the Clinical Coding Policy and Procedure. This policy will be approved by the IM&T/IG Programme Group.

Maintain the Trust’s regular programme of Audit. Implement and action all recommendations from the annual Clinical Coding Information Governance Audit.
Adhere to IG Toolkit standard 516 with regards to training of clinical coders
Ensure that the Trust’s EPR is compatible with the implementation of: OPCS 4.7 (April 2014), ICD-10 and SnoMed CT (ongoing).

7. Training/Awareness

It is a requirement of the IG Toolkit that Clinical Coders who assign ICD10 and OPCS Codes have received approved clinical coding training.

<table>
<thead>
<tr>
<th>Course</th>
<th>For</th>
<th>Renewal Period</th>
<th>Delivery Mode</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCS Clinical Coding Standards Course</td>
<td>New Clinical Coding Staff</td>
<td>24 days</td>
<td></td>
<td>London Clinical Coding Academy</td>
</tr>
<tr>
<td>NCS Coding Refresher Workshop</td>
<td>Experienced Clinical Coders</td>
<td>Every 2-3 years</td>
<td>4 days</td>
<td>London Clinical Coding Academy</td>
</tr>
</tbody>
</table>

8. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of „protected groups“ are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity. Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

RULE

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team. Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.
8. Process for monitoring compliance with this document

<table>
<thead>
<tr>
<th>Action:</th>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor progress against Information Governance Toolkit</td>
<td>Head of Information Management &amp; Compliance</td>
<td>Gather evidence demonstrating compliance</td>
<td>Annually</td>
<td>IM&amp;T/IG Programme Group</td>
</tr>
<tr>
<td>Check Clinical Coding compliance</td>
<td>Head of Information Management &amp; Compliance</td>
<td>Review sample use</td>
<td>Periodically</td>
<td></td>
</tr>
</tbody>
</table>
9. Version Control

**STANDARD**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>July 2011</td>
<td>Information Governance Officer</td>
<td>Superseded</td>
<td>Minor amendments requested by Dr M Mandell &amp; Dr P Simmons Approved by IG&amp;R Group 11th July 2011</td>
</tr>
<tr>
<td>V1.1</td>
<td>July 2011</td>
<td>Information Governance Officer</td>
<td>Superseded</td>
<td>Minor amendments requested by Dr M Mandell &amp; Dr P Simmons Approved by IG&amp;R Group 11th July 2011</td>
</tr>
<tr>
<td>V2</td>
<td>January 2013</td>
<td>Information and Performance Team Leader</td>
<td>Superseded</td>
<td>Full review of existing policy to reflect rules &amp; conventions. Audit recommendations taken into account</td>
</tr>
<tr>
<td>V3</td>
<td>27th May 2014</td>
<td>Information Governance Manager</td>
<td>Current</td>
<td>Full Review</td>
</tr>
<tr>
<td>V3.1</td>
<td>May 2015</td>
<td>Senior Information Governance Analyst</td>
<td>Draft</td>
<td>Annual Review</td>
</tr>
</tbody>
</table>

10. Archiving Arrangements

**STANDARD**

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet.

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

11. Associated Documents

**STANDARD**

This policy is part of the Trust’s Records Management Policy set. The following documents must also be referred to:

- Care Record Management Policy
- Clinical Information Filing Policy
- Data Protection Act 1998 Policy
- Data Protection in relation to Systems Assurance Policy
- Data Quality Policy
- Data Quality & Records Keeping Supervision Guide
12. Comments and Feedback

STANDARD

List of people/groups involved in developing the Policy.

<table>
<thead>
<tr>
<th>Information Governance Clinical Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Information Management and Compliance</td>
</tr>
<tr>
<td>Compliance and Risk Facilitator</td>
</tr>
<tr>
<td>Head of Practice Governance</td>
</tr>
<tr>
<td>E&amp;N SBU Clinical Director</td>
</tr>
<tr>
<td>West SBU Clinical Director</td>
</tr>
<tr>
<td>LD &amp; Forensic Clinical Director</td>
</tr>
<tr>
<td>Clinical Coders</td>
</tr>
<tr>
<td>Senior Information Governance Analyst</td>
</tr>
</tbody>
</table>
Coding Clinic Ref 88 List of Comorbidities

- Abnormal liver function tests (in the absence of an underlying cause)
- Alcohol abuse
- Alzheimer's disease including dementia in Alzheimer's disease
- Anxiety disorders including anxiety
- Asthma
- Autism
- Cerebrovascular diseases
- Chronic bronchitis
- Chronic kidney diseases including chronic tubulo-interstitial nephritis, small kidney(s) and polycystic kidney(s)
- Chronic obstructive pulmonary disease/ Chronic obstructive airways disease
- Congestive cardiac failure
- Current anti-coagulant therapy
- Current smoker
- Dementia including dementia in Alzheimer's disease
- Depressive disorders including depression and bipolar disorder
- Developmental delay including learning difficulties and learning disability
- Diabetes Mellitus
- Drug abuse
- Dysphagia (difficulty in swallowing)
- Dysphasia
- Eating disorders
- Emphysema
- Epilepsy
- Elderly / Geriatric falls
- Heart failure
- Hemiplegia
- Hypertension
- Ischemic heart disease
- Jaundice
- Left ventricular failure
- Living alone
- Mitral valve disease
- Multiple sclerosis
- Personal history of anti-coagulant therapy
- Personal history of self-harm
- Presence of cardiac pacemaker
- Psychosis and psychotic disorders including schizophrenia, schizotypal and delusional disorders
- Registered blind
- Renal failure
- Respiratory failure
- Rheumatoid arthritis
- Severe or profound hearing loss
- Urinary retention
<table>
<thead>
<tr>
<th>Our Values</th>
<th>we are...</th>
<th>you feel...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcoming</td>
<td>☑ Valued as an individual</td>
<td></td>
</tr>
<tr>
<td>Kind</td>
<td>☑ Cared for</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>☑ Supported and included</td>
<td></td>
</tr>
<tr>
<td>Respectful</td>
<td>☑ Listened to and heard</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>☑ Safe and confident</td>
<td></td>
</tr>
</tbody>
</table>