A Guide to Clinical Coding Audit Best Practice
Version 8.0
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1 Introduction

Purpose of Document

This guide provides general principles of the Clinical Coding Audit Methodology used by approved clinical coding auditors and instances of best practice for clinical coding audit. The guide does not provide the full audit methodology or technical worksheets used by an approved clinical coding auditor when conducting audit.

For the purpose of this document, any reference to ‘audit’ or ‘auditor’ throughout this document pertains to clinical coding audit and clinical coding auditor.

The Clinical Coding Auditor Code of Conduct can be found at:
https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=297779#297779
For more details visit:
https://hscic.kahootz.com/connect.ti/t_c_home/groupHome

Audience

The guide is intended for anyone commissioning a clinical coding audit. The ‘commissioner’ of an audit refers to the person who requires or pays for the audit. This could be the coding manager, medical director, clinician, Clinical Commissioning Group etc.

Background

The modernisation of the NHS to provide first-class patient care requires the information exchanged between healthcare professionals, and across NHS organisations, is always of a consistently high quality. To ensure confidence in any information produced as part of the clinical process, the underlying data must be accurate and fit for purpose.

Data quality to support the full spectrum of purposes for which they are needed depends on the quality of the management process surrounding the collection, processing and use of coded clinical data. Good management practice that results in producing good quality data ensures confidence in the information used both within the organisation and outside it.

Information Governance

Information Governance (IG) ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, IG standards for the NHS national IT infrastructure and development of guidance for NHS and partner organisations.

The Information Governance Toolkit¹, a performance tool produced by the Department of Health and hosted by NHS Digital, draws together the legal rules and central guidance and presents them as a set of information governance requirements. NHS and partner organisations in England are required to carry out self-assessments of their compliance against the IG requirements.

The IG Toolkit Requirements 505 and 514 specify assessment of clinical coding based on this audit framework, developed by the Clinical Classifications Service in consultation with

¹ http://systems.hscic.gov.uk/infogov
Department of Health, NHS Digital External Information Governance Delivery Team and NHS health informatics professionals.

When conducting an audit as part of IGT Requirements 505 and 514, the clinical coding auditor will ask to see documents evidencing that this part of the requirement has been met. (See section 4.1.2 for further information.)

The overall accuracy scores must be calculated using the figures from all audits the Trust has submitted as evidence of compliance with IGT 505 or 514 for that financial year. (See full requirements for further information.) The IG final submission assessment scores reported by organisations are used by the Care Quality Commission to risk assess Outcome 21: Records essential standards of quality and safety.²

² http://www.cqc.org.uk/content/essential-standards
2 Quality inspections

This clinical coding audit methodology identifies four key measurement criteria used for judging the quality of coded clinical data:

- Accuracy
- Consistency
- Timeliness
- Completeness.

The methodology can be applied to all clinical coding audits whether general or themed. Regular coding audit will:

- Measure and demonstrate compliance with national clinical coding standards
- Enable users to have confidence in their findings
- Provide necessary information to make relevant changes in order to achieve continuous quality improvements,
  and
- Support validation of trust income relating to clinical activity and best practice.
3 Clinical Coding Audit Principles

It is advisable the following best practice basic principles are considered before completing any clinical coding audit:

- The key resource for audit is a competent auditor. An approved clinical coding auditor must have the appropriate skills, experience and knowledge to complete clinical coding audit. For information on achieving and maintaining approved clinical coding auditor status visit: https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=297779#297779

- Complete probity must be maintained therefore it is recommended best practice that those undertaking the audit should not have been involved in assigning the original clinical codes, or in the training of the clinical coders at the organisation. In addition, for external clinical coding audit, the auditors must be independent of the clinical coding departments at the NHS Trust they are auditing.

- Clinical coding audit should ideally be seen as an objective appraisal, designed to support the organisations and staff in identifying areas where best practice is, or is not, being achieved. The audit should be an open, unbiased assessment that is based on evidence. Any outcome from the audit can be significantly affected by the perceptions of for example the coding team. The aims, objectives and process of the proposed audit should be discussed with the whole departmental team where possible and appropriate to do so.

- The auditors can play an important part in the audit process and an open, communicative attitude towards the departmental team must be maintained throughout the period of the audit.

- Commercial organisations undertaking external coding audits should not be applying their own internal company policies and procedures when conducting audits at other organisations.

- The coded clinical data is only audited against national standards applicable during the period audited. Any coded clinical data that cannot be referenced within the following products must not be pursued:
  - ICD-10 volumes 1, 2 and 3,
  - OPCS-4 volumes I and II,
  - National Clinical Coding Standards OPCS-4 reference book
  - Coding Clinic
  - National Tariff Chemotherapy Regimens List,
  - National Tariff High Cost Drug List,
  - Chemotherapy Regimens Clinical Coding Standards and Guidance OPCS-4,
  - High Cost Drugs Clinical Coding Standards and Guidance OPCS-4,

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3 National Clinical Coding Standards ICD-10 5th Edition and OPCS-4 reference books Clinical Classifications Service

4 https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=298579&exp=e1
Data Set Change Notice (DSCN) or Information Standards Notice or equivalent.

- The auditor(s) must adhere to the Approved Clinical Coding Auditor Code of Conduct throughout the audit. A copy of this document can be downloaded from:
  https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=298579&exp=e1

- A well written and clear report with robust recommendations, underpinned by evidence will support the local organisation in taking forward quality improvements. The auditor must ensure the final report contains all relevant and up-to-date information.

  - A sample size should be agreed that can be considered proportionately indicative for the area to be audited (See also IGT 505 and IGT 514) A sample size of statistical significance would correspond to at least 5% or more of the trust's overall activity, even in small acute Trusts this would almost certainly involve several hundred records. This could prove impossible to audit within the available resource.

  - A suggested indicative sample should be a minimum of 200 Consultant Episodes (CE) depending on the Trust's activity levels. This is likely to meet most business requirements for a clinical coding audit; however, initiatives or other programmes of work may dictate the size and/or specialty of the clinical coding audit.

  - The Trust’s Data Quality Team will need to determine a meaningful number of records to be audited across each of its sites and specialities in order to underpin its data quality programme.
4 Process

The processes outlined are designed to cover all types of clinical coding audit. There will be instances therefore where some sections may not be relevant to local clinical coding audit situations. For example the pre-audit questionnaire and post audit exit interview may not be necessary when the individual undertaking the clinical coding audit is employed at the site being audited.

4.1 Pre-Audit

4.1.1 Request for pre-audit information

Once the audit has been commissioned and auditors secured, the lead auditor will, where necessary, request pre-audit information prior to the pre-audit interview via a pre-audit questionnaire. Availability of electronic information will speed up some of the preliminary work undertaken by the auditor. This information will fulfil a dual purpose:

1. Provide the auditor with essential information to assist in carrying out an accurate and fair audit. It is necessary for the auditor to have a good knowledge of the organisation’s process for the capture of clinical data for input.
2. To allow the commissioner of the audit opportunity to consider if there are any further questions that need to be asked at the pre-audit interview.

On return of the completed questionnaire, the auditor will send confirmation and the audit details to the commissioner of the audit. This correspondence must make clear the auditor’s understanding of the purpose of the audit and, in addition, request specific audit information that should be made available at the pre-audit interview.

4.1.2 Pre-audit meeting

As best practice a pre-audit meeting should be convened with, as a minimum, the lead auditor, a clinical coding representative and commissioner of the audit.

The commissioner of a coding audit may be from a different organisation and the audit might arise from a clause in a contract or a business requirement. It should be expected that a representative of the commissioning organisation is present, and a senior officer within the organisation being audited should be the lead contact for ensuring the audit requirements are met when carrying out the audit.

Input from a clinician/medical director during a pre-audit meeting may be beneficial, as clinicians are becoming more interested in the data generated from their cases, although it is recognised that this may not always be achievable.

A record of the pre-audit meeting must be made by the lead auditor detailing the discussions and any actions agreed, including the issues. For example, the structure and content of the audit report and auditors are clearly defined.

Where a meeting would prove unworkable other forms of communication can be used, for example e-mail, to ensure all necessary information is collected or explained. The lead auditor will keep a record of all associated correspondence. (A record of this correspondence should not be kept longer than is necessary, as indicated in the Data Protection Principles outlined in the Data Protection Act5.)

http://ico.org.uk/for_organisations/data_protection/the_guide/the_principles
It is important to establish the full requirements of the audit and obtain clarification where necessary before the audit starts. As a minimum the lead auditor will:

- Verify the objectives of the audit with the organisation/commissioner.
- Confirm the scope of the audit.
- Confirm the number of consultant episodes to be audited during the agreed period.
- Outline the audit processes surrounding clinical coding audit and methodology that will be used.
- Outline the clinical coding audit authentication mechanism in case any disagreement occurs.
- Confirm if the medical record is not used as the source documentation for clinical coding and confirm the requirement to have access to the source document used by the coders for data extraction in addition to the full medical record. The medical record may include paper case notes or electronic patient records or a mixture of both.
- Confirm that the coding is only measured against clinical classification national standards and is not based on the auditor’s judgement.
- Confirm that data quality issues as a consequence of auditor findings as well as compliance and non-compliance to national coding standards will be reported.
- Secure agreement that (and confirm a copy of) the audit report, be sent to third parties as required.
- Ask the organisation to confirm the attainment level achieved from the past financial year IGT audit(s) by providing a copy of the relevant audit report(s).
- Review the recommendations from the previous IGT audit and any supporting documents that include the status of the recommendations, e.g. action plans, document logs etc.
- Ask the organisation for any supporting documents which evidence the status and progress of recommendations for any other internal/external audits performed at the organisation. Review relevant sections of the clinical coding department’s policy and procedure document.
- Review the organisation’s clinical coding training plan, including any budgets, and evidence of training. This may happen during the pre-audit meeting or during the review of coded clinical data.
- Agree the timetable for completion of the audit.
- Verbally feedback findings based upon the review of the pre-audit information and clarify any issues raised from the pre-audit information.
- Seek confirmation that the source document to be made available to the auditors will be the full medical record (either paper or electronic). The information extracted from the full medical record will be the standard against which data quality will be measured.
- Identify the records for audit.
Security and confidentiality issues regarding patient identifiable data between the organisation and the auditor need to be addressed in line with Data Protection Principles\(^6\) and a written agreement signed at this meeting before the lead auditor identifies the episodes to be audited.

### 4.2 The audit

To conduct the audit the source document made available to the auditors must be the full medical record (either paper or electronic or a combination of both). The information extracted from the full medical record will be the standard against which data quality will be measured.

The coded clinical data will be audited against the national standards. (Please see Section 3 Clinical Coding Audit Principles for the products containing national clinical coding standards.)

#### 4.2.1 Judgemental assignments

Valuable time can be taken up in the audit process trying to reach agreement on a purely judgemental coding assignment.

If, after going through the four step coding process and checking the national clinical coding standards reference products (page 8) a code cannot be found, any selection beyond this point should be deemed as 'judgemental'.

The majority of judgemental code assignments are for terms that cannot be identified within ICD-10/OPCS-4 or their indices.

Judgemental assignments present a challenge for the auditor; any code that cannot be index-trailed, or traced back to a reputable source, must not form the basis for arbitration. Discussion between the relevant parties is more beneficial and a more efficient use of time.

#### 4.2.2 Primary diagnosis

The Health Service Guideline HSG (96)23 mandated the implementation of a standardised primary diagnosis definition for clinical coding which remains the standard:

i) The first diagnosis field(s) of the coded clinical record (the primary diagnosis) will contain the main condition treated or investigated during the relevant episode of healthcare.

ii) Where a definitive diagnosis has not been made by the responsible clinician the main symptom, abnormal findings, or problem should be recorded in the first diagnosis field of the coded clinical record.

#### 4.2.3 Coding conventions

All ICD-10 and OPCS-4 coding conventions must be adhered to.

#### 4.2.4 Potential source of error

There are many potential causes of coded clinical data error and it is vital that the audit identifies the source. The report should not just identify incorrect coding or, when a group of codes does not represent the sequence of events within a finished consultant episode. It should also highlight areas within the clinical coding process that contribute to incorrect code assignment. Errors will continue to occur unless the source is identified and procedures put

in place to prevent reoccurrence. Identification of the source of errors is a key component of the clinical coding audit report.

4.3 Post Audit

4.3.1 Post audit exit interview

This interview takes place before the auditors leave the site and whilst the medical records are still available. Appropriate staff with coding skills and knowledge of local policy and procedures must be present at this interview. As previously documented, it may also be beneficial (where appropriate) for a clinician to be present at the post audit interview. The exit interview should as a minimum cover the following:

a) Review the purpose, objectives and methodology of the audit.

b) Report major coding deficiencies; agree coding errors and sources of errors and sign-off the agreed errors. It should be made clear that once the errors have been agreed at this point, they will not be re-visited.

c) Where site representatives and auditors do not agree on an error, any discrepancies will be referred to the Clinical Classifications Service audit authentication mechanism. (Please see section 4.3.3 Audit Authentication Mechanism).

d) Present any general impressions.

4.3.2 Audit report

The report containing the findings including areas of good practice, analysis of errors and recommendations from the audit should be submitted in draft format initially.

It is an essential component of the audit that the report clearly identifies the findings, conclusions and recommendations and includes comprehensive evidence of the causes of error which are also meaningful to readers unfamiliar with clinical coding/clinical coding audit.

Where appropriate, this should be followed up by both the commissioner of the audit and the lead auditor to clarify any areas of confusion. Once any issues have been discussed, a final version of the findings can be formulated and any recommendations made.

Once the report has been agreed, the lead auditor will ask the commissioner of the audit to formally sign-off the report. (Please see Appendix A for an example of an Audit Report Sign-Off document).

4.3.3 Audit Authentication Mechanism

Where organisation representatives and the clinical coding auditors cannot agree on a clinical coding discrepancy raised at the post-audit meeting, the discrepancy can be referred to the Clinical Classifications Service for resolution. This mechanism can only be used where national standards have been contravened or where clarification of a national standard is required rather than issues of judgement where the views of the organisation and of the auditors differ. The following process must be followed:

1. The auditor must agree to remove the episode(s) from the audit.
2. The auditor should inform the organisation representative of the audit query procedure.

3. The clinical coding audit authentication form must be fully completed by both the organisation and the auditor(s) documenting both the codes and the rationale as appropriate.

4. Anonymised source documentation must be supplied.

5. The audit authentication form (the auditor will provide this) and anonymised case notes must be sent to the Clinical Classifications Service via the Information Standards Helpdesk within ten working days following the post-audit meeting. Any query received after ten working days following the post audit meeting will not be examined.

6. The audit query mechanism must only be used for instances where the organisation and the clinical coding auditors cannot agree on a discrepancy at the time of audit. As previously stated any errors that have been agreed and signed off by the Trust will not be revisited. (Please see 4.3.1 Post-Audit Exit Interview for further information)

The Clinical Classifications Service will inform both the organisation’s representative and the lead auditor of the resolution in writing.
5 Clinical Coding Auditor Log Book

All Approved auditors are required to update and maintain an Approved Clinical Coding Auditor Log Book. The Auditor Log Book will contain details of training undertaken to become an Approved Clinical Coding Auditor and also evidence of the auditor’s continued professional development (CPD).

A commissioner of an audit may ask the auditor for permission to view their Auditor Log Book as evidence of skills, experience and CPD prior to commencement of the audit.

As part of evidencing ongoing CPD the auditor will ask the commissioner of an audit to complete the commissioner evaluation section of the auditor’s Clinical Coding Auditor Log Book. This allows the commissioner to comment upon the auditor’s skills and also allow the auditor to identify what went well and any areas requiring improvement. (Please see Appendix B Evaluation of Clinical Coding Auditor)

For further information about the Clinical Coding Auditor Log Book please refer to section 7.1 of the Clinical Coding Auditor Programme Handbook:

6 For more information

For further information visit our website

https://hscic.kahootz.com/connect.ti/t_c_home/grouphome
## 7 Glossary of Terms

<table>
<thead>
<tr>
<th>Term / Abbreviation</th>
<th>What it stands for</th>
</tr>
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<tbody>
<tr>
<td>Department of Health/DH</td>
<td>Department of Health (DH) is a Government department which exists to improve the health and wellbeing of people in England. It provides health and social care policy, guidance and publications for NHS and social care professionals.</td>
</tr>
<tr>
<td>Health &amp; Social Care Information Centre/HSCIC</td>
<td>The Health and Social Care Information Centre (HSCIC) is an independent public service, established in April 2013 by the Health and Social Care Act 2012 as an executive non-departmental public body of the Department of Health (DH). It is responsible for collecting, transporting, storing, analysing and disseminating the nation’s health and social care data.</td>
</tr>
<tr>
<td>Clinical Classifications Service</td>
<td>The Clinical Classifications Service the Health and Social Care Information Centre and is responsible for the development of ICD-10 for UK implementation.</td>
</tr>
<tr>
<td>OPCS Classification of Interventions and Procedures, /OPCS-4</td>
<td>The OPCS Classification of Interventions and Procedures is a UK classification and is an existing NHS Information Standard.</td>
</tr>
<tr>
<td>NHS Digital</td>
<td>The new trading name of the Health and Social Care Information Centre (HSCIC) effective from 1st August 2016</td>
</tr>
<tr>
<td>Delen</td>
<td>Delen is a new site used by NHS Digital to collaborate with our partners and share information. It contains a library of the national terminology and classifications standards including ICD-10 and OPCS-4.</td>
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8 Appendix A – Sign-off Audit Report

<table>
<thead>
<tr>
<th>Name of Organisation:</th>
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<tbody>
<tr>
<td>Date of audit:</td>
<td></td>
</tr>
<tr>
<td>Date draft report sent:</td>
<td></td>
</tr>
<tr>
<td>Date draft report agreed:</td>
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</tbody>
</table>

Dear

Please find enclosed a copy of the draft clinical coding audit carried out at your organisation. As part of the sign-off process please answer the following questions on the report.

1. **Did the report meet all the requirements agreed at the pre-audit meeting?**
   Yes / No (If no please give details)

2. **Are there any factually inaccurate / incorrect statements that need amending?**
   Yes / No (List any amendments)

If we do not receive a response from you by <DATE> it will be assumed that you are happy with the content and can sign this audit off. A final version of the report will be sent to you by <DATE>.

As discussed at the post-audit meeting completion of Appendix 2 Commissioner Evaluation Form needs to be completed and returned by <DATE>

Yours sincerely
9 Appendix B Evaluation of Clinical Coding Auditor

This form must be fully completed and signed off by the individual who requested the audit for each clinical coding audit undertaken. Examples of requestors could include the Medical Director, Clinical Coding Manager, a Consultant, Director of Information, member of a Clinical Commissioning Group, Finance Manager etc. However, where the organisation has a continual rolling programme of audit it is acceptable that all information is consolidated onto one form and signed-off at the end of the audit programme.

Where the audit is initiated by the auditor themselves, this form can be completed by another Clinical Coding Department representative who can provide the relevant information, e.g. the Clinical Coding Manager, Assistant Clinical Coding Manager, Approved Clinical Coding Trainer, Senior Coder etc.

Audit Commissioner's name:

Job Title:

Dates of audit:

Subject theme of the audit:

1. Did the clinical coding auditor(s) provide you with a current copy of or make you aware of the following, where applicable, prior to undertaking the audit? (delete as appropriate)

- Clinical Coding Auditor Code of Conduct Yes / No / Not Applicable
- Guide to Best Practice Yes / No / Not Applicable
- Clinical Coding Audit Authentication Process Yes / No / Not Applicable

2. How well did the clinical coding auditor interact with the relevant staff throughout the audit process?

3. In what format was the audit feedback provided?

4. Was this format suitable to meet your needs? Yes / No (delete as appropriate)

If not, please explain why:
5. Was the clinical coding auditor clear and confident when presenting the coding audit findings and discussing any issues that had arisen during the audit? **Yes / No** (delete as appropriate)

   If not, please explain why:

6. Did the clinical coding auditor regularly provide you with honest and objective feedback about the issues identified during this audit programme? **Yes / No** (delete as appropriate)

   If not, please explain why:

7. Did the clinical coding auditor demonstrate a clear rationale of how he/she reached a decision about a coding error and evidence on which the decision was based (i.e. coding standards found in any of the following: ICD-10 5th Edition Volumes 1, 2 or 3, the National Clinical Coding Standards ICD-10 5th Edition reference book, OPCS-4 Volumes I or II, National Clinical Coding Standards OPCS-4 reference book, Chemotherapy Regimens List, the High Cost Drugs List and the Chemotherapy and High Cost Drug Clinical Coding Guidance and Coding Clinic)?

   **Yes / No** (delete as appropriate).

   If not, please explain why:

8. Did the audit meet all the objectives agreed prior to the clinical coding audit?

   **Yes / No** (delete as appropriate)

   If not, please explain why.

9. Are you happy for this feedback to be shared with others? **Yes / No** (delete as appropriate)

   **Audit Commissioner’s Signature:**
   
   **Print name:**
   
   **Date:**