A Guide to Clinical Coding Audit Best Practice Version 12.0

Contents

1 Introduction

1.1 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 an 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/t_c_home/view?objectId=16878800

For more details visit:

https://hscic.kahootz.com/connect.ti/t_c_home/groupHome

1.2 Audience

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

1.3 Background

The modernisation of the NHS to provide first-class patient care requires that 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.

1.3.1 Data Security and Protection Toolkit

The Data Security and Protection Toolkit (DSPT) ensures necessary safeguards for, and appropriate use of, patient and personal information. Key areas are information policy for health and social care, Data Security and Protection standards for the NHS national IT infrastructure and development of guidance for NHS and partner organisations.

The Data Security and Protection Toolkit[1], a performance tool supporting the Department of Health and Social Care (DHSC) policy and hosted by NHS Digital, draws together the legal rules and central guidance and presents them as a set of Data Security and Protection standards. NHS and partner organisations in England are required to carry out self-assessments of their compliance against the Data Security and Protection Toolkit standards.

The DSPT National Data Guardian Standard 1, Data Security Standard 1.7.2 and Data Security Standard 1.7.3 ensures necessary safeguards for, and appropriate use of, patient

[1] https://www.dsptoolkit.nhs.uk/

and personal information. It includes confirmation that regular data quality reviews of electronic and manual records must be held to ensure the information continues to be accurate and adequate for the purposes of processing (for which it was collected). This includes the assessment of clinical coding based on this audit framework, developed by the Terminology and Classifications Delivery Service in consultation with Department of Health and Social Care (DHSC), NHS Digital and NHS health informatics professionals.

When conducting an audit as part of Data Security and Protection National Data Guardian Standard 1, 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 used to demonstrate compliance with Data Security and Protection Toolkit National Data Guardian Standard 1 for that financial year. (See full standard for further information.)The Data Security and Protection final scores reported by organisations are used by the Care Quality Commission to risk assess Outcome 21: Records essential standards of quality and safety[2].

Guidance to support clinical coding departments when completing their annual assessment in relation to clinical coding audit can be found by accessing the Data Security and Protection Standard 1 available on Delen.

This guidance includes the reintroduction of levels into the toolkit.

[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 that 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. Only an approved clinical coding auditor is entitled to use the official NHS Digital 'Approved' symbol after their name. For information on achieving and maintaining approved clinical coding auditor status visit:

  https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=14461392#14461392

- 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 department at the organisation 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.
- The approved auditor should communicate any suggested changes and/or recommendations to the coding manager and not make any changes to the coded data without their knowledge and agreement.
- 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 ICD-10 5th Edition reference book[3]
    - National Clinical Coding Standards OPCS-4 reference book [4]
    - *Coding Clinic*[5].

[3] https://hscic.kahootz.com/gf2.ti/f/762498/92815877.1/PDF/-/NCCSICD1020217.pdf

[4]https://hscic.kahootz.com/gf2.ti/f/762498/92815845.2/PDF/-/NCCSOPCS420218.1.pdf

[55] https://hscic.kahootz.com/gf2.ti/f/762498/35472645.1/PDF/-/Coding_Clinic_V8.0.pdf

- National Tariff Chemotherapy Regimens List
- Chemotherapy Regimens Clinical Coding Standards and Guidance OPCS-4
- Data Set Change Notice (DSCN) or Information Standards Notice or equivalent.

N.B. For reference, the following are **not** considered national clinical coding standards reference products and therefore must not be pursued as the source of errors at clinical coding audit:

- Delen Query Resolution Database resolutions
- National clinical coding materials produced by the Terminology and Classifications Delivery Service (whilst the materials are based on the national clinical coding standards reference books, they are not standards themselves, this is the purpose of the reference books)
- National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance (IPG)
- Local clinical coding policies/agreements (unless they contravene national standards)

- 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/t_c_home/view?objectId=16878800

- A well written and clear report with robust SMART[6] 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. 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 organisation's[7] 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 organisation’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.

[6] S=specific, M=measurable, A=achievable, R= realistic, T= timebound/timely.

[7] Organisation in this context is referring to both NHS and non-NHS organisations responsible for the delivery of patient care.

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 increasingly 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 Act[8].)

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(s) achieved from the past financial year's Information Governance Toolkit/Data Security and Protection Toolkit audit(s) by providing a copy of the relevant audit report(s).
- Review the recommendations from the previous Information Governance Toolkit/Data Security and Protection Toolkit audit(s) 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

[8] https://www.gov.uk/data-protection

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 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.

4.2.5 Coding of co-morbidities local policies and clinical coding audit

Additional guidance is provided in the full Clinical Coding Audit Methodology, only available to approved clinical coding auditors, covering the assignment of error keys in this scenario.

The methodology confirms the error keys that an approved clinical coding auditor must assign where a local policy for the coding of conditions/co-morbidities exists and there is **no** evidence of these conditions/co-morbidities having been recorded in the medical record for the spell being audited.

This inclusion in the methodology ensures that error keys are assigned at audit as appropriate, should there be no evidence of the 'co-morbidity/condition' being documented in the full medical record for the current hospital provider spell and where no clinical validation of the codes has taken place.

This guidance must be applied to all clinical coding audits conducted using the current version of the Audit Methodology (v15.0).

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 Terminology and Classifications Delivery 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 Terminology and Classifications Delivery 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 Terminology and Classifications Delivery 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 Terminology and Classifications Delivery Service will inform both the organisation's representative and the lead auditor of the resolution in writing.

5 For more information

For further information visit our website

https://hscic.kahootz.com/connect.ti/t_c_home/grouphome

6 Glossary of Terms

Term / Abbreviation	What it stands for
Department of Health and Social Care/DHSC	Department of Health and Social Care (DHSC) 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.
Health & Social Care Information Centre/HSCIC	The Health and Social Care Information Centre (HSCIC) is an independent public service, established in April 2013 by the by the Health and Social Care Act 2012 as an executive non-departmental public body of the Department of Health and Social Care (DHSC). It is responsible for collecting, transporting, storing, analysing and disseminating the nation's health and social care data.
International Statistical Classification of Diseases and Related Health Problems – Tenth Revision/ICD-10	The World Health Organisation (WHO) International Statistical Classification of Diseases and Related Health Problems – Tenth Revision is an existing NHS Information Standard.
Terminology and Classifications Delivery Service	The Terminology and Classifications Delivery Service is responsible for the development of ICD-10 for UK implementation.
OPCS Classification of Interventions and Procedures, /OPCS-4	The OPCS Classification of Interventions and Procedures is a UK classification and is an existing NHS Information Standard.
NHS Digital	The new trading name of the Health and Social Care Information Centre (HSCIC) effective from 1st August 2016
Delen	Delen is a 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.

7 Appendix A – Sign-off Audit Report

Name of Organisation:	
Date of audit:	
Date draft report sent:	
Date draft report agreed:	

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>.

Yours sincerely