Monitor

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Heart of England NHS Foundation Trust

Payment and Tariff Assurance Framework: end of clinical coding audit report

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Revision History

Revision Date	Revision Number	Author	Summary of Changes	Changes Marked

About CHKS

CHKS, part of Capita plc, is a provider of healthcare intelligence and quality improvement services. In the last 23 years it has worked with 374 healthcare organisations worldwide. With 70 per cent of acute healthcare providers in the UK choosing CHKS to support them on their improvement journey, CHKS has the skills and know-how to boost quality, cost and delivery performance.

Audit information

Trust name	Heart of England NHS Foundation Trust
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Dates of audit	21/4/15 – 23/4/15
Lead auditor	Sharon Molyneux
Second auditor	Ann Jones
Trust representative	Steve Cross – Head of Clinical Coding/Performance Manager
National area for audit (100 FCEs) *Selected to inform the costing audit*	DZ (Thoracic procedures and disorders)
Local area for audit (100 FCEs) *Highlighted through benchmarking of data quality indicators*	LB (Urological and male reproductive system procedures and disorders)

End of audit report

Summary	Finding	Recommendation
Summary		
Causes of price changes	**Area 1 – DZ –** • Two spells with a price change due to the coder omitting a primary diagnosis code. On one occasion the patient with known right middle lobe lung cancer was admitted for a biopsy of the left lung which the histology result confirmed fibrosis. The coder had only coded malignant neoplasm of lung. This caused a price change from £1123 to £1277. On the other occasion the patient had a biopsy and the histology result confirmed pulmonary mycobacterial infection, however the patient had only been coded as having pleural plaque. This caused a price change from £1277 to £2048. • Three spells with a price change due to the coder omitting a secondary diagnosis code. On one occasion the patient had respiratory failure which is a mandatory co-morbidity. This caused a price change from £6380 to £7963. On another occasion the patient had hypertension which is also a mandatory co-morbidity. This caused a price change from £5036 to £6121. On the other occasion the patient was catheterised due to having retention of urine. This is mandatory to code	

	and the omission of the diagnostic code for urinary retention caused a price change from £5063 to £6121. • One spell with a price change due to the coder omitting a secondary procedure code. On one occasion the operation note stated "Damage to the lung at the site of initial port entry" which was repaired. The repair was not coded. This caused a price change from £2889 to £7963. • One spell with a price change due to the primary diagnosis being incorrectly coded at the third character level. The patient had numerous trauma conditions, including traumatic haemopneumothorax, however this had been incorrectly index trailed to unspecified pneumothorax. This caused a price change from £2575 to £3757. • One spell with a price change due to the primary diagnosis being incorrectly sequenced. The patient had been coded as foreign body in bronchus as the main condition with disease of bronchus as a secondary code. However the patient had the granulation tissue of bronchus debrided, therefore is the main condition treated. This caused a price change from £2984 to £1296. • One spell with a price change due to the primary procedure being incorrectly sequenced. The patient had been coded as having endoscopic examination and biopsy of pleura as the main procedure with endoscopic talc pleurodesis as a secondary procedure. However, the rules in the National Clinical Coding Standards state that the therapeutic procedure must be coded in primary position. This caused a price change from £1639 to £2121. • One spell with a price change due to an incorrect primary diagnosis code caused by information not available to the coder in a timely manner. The patient was coded as unspecified disease of bronchus, but the histology result confirmed malignant neoplasm of bronchus. However, the episode was in August and the histology report was not signed off and available until October. This caused a price change from £896 to £750. • One spell with a price change due to a data error. The admission method type for the patient was inputted on the system as a non-elective emergency admission, however the	

	patient was a planned admission. The trust had a new system in July 2014 and had problems with the admission method type. These problems have now been resolved and the trust is currently in the process of reviewing the old admissions and changing if necessary. This caused a price change from £510 to £750. **Area 2 – LB –** • Two spells with a price change due to the primary diagnosis being incorrectly sequenced. On one occasion the patient had been coded as haematuria as the main condition with neoplasm of unknown behaviour of bladder as a secondary code. However the haematuria was caused by the bladder tumour and therefore the bladder tumour should be the main condition with haematuria being an unnecessary code. This caused a price change from £2296 to £4149. On the other occasion the patient had been coded as urinary retention as the main condition with hyperplasia of prostate as a secondary code. However the retention was due to the hyperplasia of prostate and therefore the hyperplasia of prostate should be coded in the primary position. There is also guidance for this in the reference book. This caused a price change from £600 to £657.	
Main issues		
Training	• The department received training from the local academy last year and currently have 3 trainers on site. This year the training will be completed on site from the trusts' trainers.	
Clinician engagement	• The coding department have good clinician relationships in some specialties and the department is currently working on improving clinician engagement across the specialties. • The department have a validation programme and also a clinician engagement programme. • The trust have working group meetings which the coding department are also involved with.	
Source documentation	• The clinical record is the source document. • The clinical coders extract the information for coding purposes on the wards. • The documents in the casenotes were not filed in	

	chronological order, which makes it difficult to navigate through the notes to find the information required for coding/audit purposes. • The Coders have access to additional systems to check diagnostic scans and histology reports, however the histology reports are sometimes not signed off and available until months after the admission.	
Management or clinician specification	• The coding department have an up to date Clinical Coding Policy folder.	
Other contributing factors	• The coding department has recognised the need for more coding staff and have recently submitted a request for the extra staff. The extra coders would also enable the department to hold more training sessions.	
National area (DZ)	• There were inconsistencies around the coding of bronchoscopies. Some coders were coding bronchoscopies in addition to the main procedure, such as lobectomy, when the scope was only used for looking prior to the procedure and therefore is not relevant to code. On occasions where the main procedure was performed on the pleura, bronchoscopies were sometimes omitted when they should be coded. There were also instances where both flexible and rigid bronchoscopies and the coder had only coded one of the scopes. When biopsies had been taken using the bronchoscopy and both rigid and flexible scopes were documented, it was unclear as to which scope had been used to carry out the biopsy. The coders were sometimes omitting the mandatory site and laterality codes for these procedures too, however the site was often not documented in the operation note. • The coders are not always checking histology reports. • The diagnostic versus therapeutic rule for procedures and the main condition treated diagnostic rule are not always being adhered to. • Mandatory and relevant co-morbidities were omitted. • Coders were not always coding VATS (Video Assisted Thoracic Surgery) approach after each procedure.	• Discuss with the clinicians the issues found with the procedures involving bronchoscopies and improve the information in the operation notes to help the coders to assign correct and accurate codes. • Feedback all errors found in this area of the audit to the coders for the issues identified, including reminding coders to follow the four-step coding process when assigning codes. • Discuss and agree the coding of adhesions to ensure uniformity.

	• Adhesions were not being coded consistently. • The coders are not always assigning correct and accurate codes. This is sometimes due to not following the four-step coding process and ensuring that index trails are being correctly used in order to assign the correct code.	
Local Area (LB)	• The coders are sometimes incorrectly assigning Z466 – *Fitting and adjustment of urinary device* in addition to R33X – *Retention of urine* for patients who have been diagnosed with a "Failed TWOC (Trial without Catheter). The guidance in the National Clinical Coding Standards book states ***"...if a TWOC fails, the code describing the condition for which the patient was catheterised is assigned and not code Z466."*** This statement is followed by an example which shows the use of R33X as the only code to be used. • The coders are not always checking histology reports. • Mandatory and relevant co-morbidities were omitted.	• Feedback all errors found in this area of the audit to the coders for the issues identified, including reminding coders to follow the four-step coding process when assigning codes.
Other issues		
National Guidance		
UTA's	• No UTA's found in this audit	
IGT arrangements	• See clinician engagement and training	
Broader data quality	• There were two data quality errors. On one occasion the episode length of stay was incorrect due to the incorrect input of the discharge date. The patient had been discharged at 3pm (15:00 hours) on one day, but had been discharged on the system at 03:00 on the following day. See *Causes of price changes* part of the report for the other occasion and the reason for these errors.	
Good Practice	• The trust have three qualified auditors in post and two trainee auditors. The trust also has three trainers in post. • The coding department have an on-going internal audit programme which include mortality, individual and specialty audits. "Real time" audits also take place where the auditor goes to the wards with the coder and works with the coder to extract correct and accurate	

	codes. • The department have an internal coding review panel which discusses complex coding issues. • The coding department produce newsletters and “Coding Matters” for informative purposes.	
General		