White Paper

Clinical Coding

The path to the adoption of ICD-10 diagnosis coding for the independent sector.

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1.0 Introduction

The absence of comprehensive and accurate diagnosis coding undermines independent healthcare in the UK. Across the NHS, hospitals routinely have Coding Departments and diagnosis coding is at the heart of the public sector's quality and reimbursement model. By contrast, in the private sector, diagnosis coding has historically counted for little more than "getting the bill through".

However, the sector now finds itself under pressure to adopt the ICD-10 standard of diagnosis coding. Why? The simple answer is Quality and Outcomes. Without diagnostic data it is virtually impossible to produce any meaningful clinical metrics or indicators about quality and treatment outcomes and accurately compare them to equivalent performance standards in the NHS.

With healthcare commissioners expected to procure services based on quality, as well as price, it is inconceivable the sector can flourish without providing credible data on which commissioners and patients can base their decisions.

The significance was not lost on the Competition & Markets Authority (CMA) either who, in their final report ("Private healthcare market investigation", 2nd April 2014) explicitly referred to the need for diagnosis coding among the information remedies it recommended for the sector1.

The case for using the globally recognised ICD-10 coding system is clear. Our focus now needs to switch to how we set about the challenge of sector-wide adoption.

[1] 11.571 In order to facilitate the analysis and publication of meaningful performance statistics, we would expect the data provided by the private hospital operators to:
(c) contain diagnostic and procedure coding for each episode in order to allow for risk-adjustment where appropriate—diagnostic coding should include full details of patient co-morbidities;
(d) be fully comparable with that collected by the NHS to allow the information organization to report performance measures for the whole of consultants' practices.

2.0 The ICD-10 Classification Standard

The International Statistical Classification of Diseases (ICD) and Related Health Problems is a comprehensive classification of causes of morbidity and mortality. The ICD-10 refers to the tenth revision.

The World Health Organisation (WHO) is the copyright holder of ICD-10 which is used under license in the United Kingdom. The NHS publishes Clinical Coding Standards which embrace the ICD-10 standards and within the NHS.

While this paper is not aimed at the NHS, it is important to appreciate the demands facing providers serving NHS patients to understand how the private sector should operate.

Within the NHS, all inpatient episodes and attendances that contain diagnoses must be recorded to the mandated version of ICD. For each patient episode, NHS trusts must record: Commissioning Data Sets (CDS) and Hospital Episode Statistics (HES).

In this section we have provided an overview of the important parameters and considerations of ICD-10. For a full technical description of the classification, please refer to the Health and Social Care Information Centre (HSCIC) website[2].

2.1 The Code Structure

The ICD-10 classification consists of 17,872 codes. It is a hierarchical system which enables users to drill down to a very detailed level of information about each disease or condition, such as its cause and the affected part of the body.

Alphanumeric ICD-10 codes are displayed in a four-character format. The first character is always a letter which, with a few exceptions, usually corresponds to a specific chapter in the ICD-10 classification e.g. codes starting with ‘L’ can be found in Chapter XII: diseases of the skin and subcutaneous tissue.

Each chapter is subdivided into blocks of 3-character categories e.g. L20-L30 represents Dermatitis and eczema. Most 3-character categories are then subdivided using a fourth number which appears after a decimal point. This additional level might identify different disease sites, diseases types or individual diseases e.g. L23.2 is the code for allergic contact dermatitis due to cosmetics. If there is no sub-division, it is recommended that the letter X is used to fill the fourth position.

[2] http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/icd10

2.2 Comorbidities

HES and CDS standards allow "as many diagnoses as required" to be recorded against a patient episode. In distinguishing between an apparently infinite number of patient ailments, the most important one is the first: the primary diagnosis. This records the main condition treated or investigated during the relevant episode of healthcare; or where there is no definitive diagnosis, the main symptom, abnormal findings or problem. In CDS this is mandatory and we would suggest that this principle is applied to PHIN[3] records at least.

Additional codes denote secondary conditions or comorbidities (disorders or diseases) for the presenting patient. Examples could include hypertension, lung cancer or diabetes.

Healthcode delivers diagnosis codes recorded by providers to PHIN. The PHIN service currently supports up to fifteen ICD codes (i.e. fourteen comorbidities) although that limit could easily be extended. Given the NHS's published standard it would seem inappropriate for the private sector to adopt a more limited or constrained standard.

Recommendation 1:

Providers and insurers should record a minimum of one (Primary) diagnosis and any number of Secondary diagnoses against any patient episode.

An important final consideration for this section is that it is important to clearly identify the primary diagnosis: Healthcode has introduced a primary indicator into its data structures and we would encourage others to do the same.

2.3 Coding Principles

This paper is not in any way aspiring to substitute as a coding reference but there are key aspects to ICD-10 coding that need to be understood by the sector and handled consistently. For instance, the use of daggers and asterisks to show where an underlying condition is the cause of another disease. If, for example, a type 2 diabetic developed neuropathy then a dagger code would be recorded against the diabetes and an asterisk code against the neuropathy, showing that the diabetes caused the neuropathy.

It is good coding practice to code both as the patient might have been admitted to receive treatment of the asterisk condition. ICD-10 makes it clear that designated dagger codes should not be used on their own and designated asterisk codes are the same and are mainly used in a secondary position to the dagger code.

The classification standards stipulate that the 'main' condition coded should correlate to the main condition treated. This is the case for dagger and asterisk codes where the asterisk denoted condition (manifestation) is the main condition treated, the asterisk code has to come first.

[3] Private Healthcare Information Network (www.phin.org.uk)

Whether we, as an industry moving towards ICD-10 adoption, should support dagger and asterisk combinations depends on how we see the end use of the diagnostic codes.

If we only want to record the patient's main diagnosis against the procedure then it probably wouldn't be necessary to worry about daggers and asterisks. However, from a data quality perspective if we are serious about reporting private sector activity which is comparable with the NHS, then we should really include the use of the dagger and asterisk combinations.

However, as with any coding convention, staff allocating the codes need to understand the convention before applying them[4].

As mentioned at the outset, this paper is not intended to substitute the ICD-10 coding manual and so more technical aspects of coding concerning uniformity, totality and sequencing are not described here.

Recommendation 2:

If we, as a sector, are going to adopt ICD-10 then it is Healthcode's view that it should be used properly - i.e. we adhere to the coding rules and conventions that apply to it and that would include the use of daggers and asterisks.

However any guideline must be in the context of the purpose; daggers and asterisks are not used in determining HRGs (i.e. redundant in grouping and hence payment factoring) and as such should make no material difference to payment considerations in the private sector.

We would therefore propose their adoption is recommended for clinical records but optional for invoice processing.

The conclusion for secondary diagnosis codes is if there are other conditions which are relevant (i.e. are being treated or having some influence on the care of the patient) then those conditions should be coded.

[4] In ICD-10 although there are designated dagger codes, any code in ICD-10 can be used as a dagger code - if a clinician has specified that condition A has caused condition B then condition B must be recorded with an asterisk code (you cannot make a code an asterisk code) and if the condition causing condition B is not a dagger code then it can be designated as one. However, those occasions where the coder gets to this level of detail are extremely rare (from an NHS perspective, let alone private sector) and it would also be a challenge for the software to be able to allow a non-designated code to become a dagger code.

3.0 The Path to ICD-10

Embracing ICD-10 across the private sector presents both operational and technical challenges. The provider market now serves a broad mix of patient types which, while still primarily private funded by insurers also includes significant levels (around a third) of NHS patients as well as a steady stream of self-payers.

It is both undesirable and impractical for providers to work in different “currencies” for different commissioners; if we’re to deploy ICD-10 coding effectively, we need to do so across all patient types. In order to achieve that we need to ensure there are no obstacles preventing such take-up and, for too long now, the insurers have been cited as the major barrier – “we need to code ICD-9 to get the insurers to pay the bill.”

If that ever was the case, it hasn’t been for some time. It is true that some insurers validate invoices against a rather antiquated table of ICD-9 codes. For a number of years now however Healthcode has been able to map ICD-10 codes “down” to ICD-9 for those providers coding ICD-10 at source. Indeed a number of providers have been working this way for years now. Perversely, the insurers are more likely to receive a more accurate ICD-9 code where it was mapped from an ICD-10 than natively coded in ICD-9. The reality is that ICD-9 coding is primarily a function of insurer billing rather than diagnosis recording.

4.0 The Technical Challenge

A fundamental question determining the sector's ability to adopt and adhere to ICD-10 coding standards is whether or not the systems currently used to record and process diagnosis codes can support this more complex standard.

All systems today can record ICD-9 so ICD-10 should be a formality? Not exactly. Data formatting issues aside (it appears routine to ignore the decimal point '.'), there are three main system parameters required to correctly record an ICD-10 code:

- ⇒ the existence of a Primary indicator to allow the identification of the primary diagnosis code
- ⇒ the ability to accommodate sufficient characters available to record any single code, including dagger or asterisk indicators (therefore require six characters) and,
- ⇒ the ability to record a theoretically infinite number of diagnosis codes.

The Healthcode standard data format[5] offers the flexibility to submit valid ICD-10 records. Healthcode supports up to ten characters for a diagnosis code and there is no limit to the number of diagnosis codes that can be used.

Obviously, in order for providers to be able to submit data in this way, they will need to be using the PMIClaimMsg XML format (the legacy 'JEDI' fixed field-length format does not support the extended diagnosis code length) and support the extended code structure.'

For insurers to receive data in this way, they will need to upgrade their format to support the latest Healthcode Output format (version 2.47) and also support the parameters above.

Recommendation 3:

Systems must be able to support a minimum of five character codes, be able to identify the primary code and record multiple secondary diagnoses. Although the latter should theoretically be unlimited, a minimum of fourteen[6] could be considered to be acceptable in practice. As above we think it is important to have the capability to include daggers and asterisks and therefore would propose a system that supports codes with six characters.

[5] PMIClaimsMsg - the file format providers use to submit invoices and spells and insurers use to collect invoices.
[6] The SUS R13 PbR Technical Guidance states the Admitted Patient Care Episodes extract allows for a maximum of twelve instances of secondary diagnosis being recorded. Where these 'repeating groups' exceed the maximum allowed within the main extract, the excess instances are provided via the Supplementary Extract. This guidance is most analogous to that typical for the majority of Private Sector records and as such the fourteen supported within PHIN should more than suffice.

5.0 The Timing Challenge

The discussion so far has been rather academic. However for our collective credibility, speed is of the essence. Looking to the practical nature of coding, the commercial dynamic of the private sector is vastly different to that of the NHS.

Providers understandably will not be prepared to delay invoicing for coding purposes, so the challenge will be to resource and organise coding departments in a way that allows a rapid turnaround. This, more than any other factor, will drive (or constrain) the rate of progress for ICD-10 adoption within the private sector.

Within the NHS, the Payment by Results (PbR) system defines the way funding for secondary care flows around the NHS in England[7]. Accounting for around £30bn of healthcare spend, the PbR process, administered via Secondary Uses Services (SUS) has notoriously long 'freeze' periods whereby PCTs/CCGs do not see, and hence account for, a definitive position on invoices and revenue for months after the patient has been discharged.

By contrast, private sector operators invoice days after the patient has been discharged.

If the ICD-10 code is a core parameter of the reimbursement record (also known as an invoice), as is clearly being proposed, then business processes will need to change. It will not, for example, be feasible for hospitals to send scanned patient records and notes to a centralised coding department that then takes weeks, if not months, to return them.

The task facing providers is how to address the coding challenge in a timely manner without adversely affecting commercial processes. It is clearly unrealistic to expect every private hospital to introduce a fully functional integrated coding department overnight. Each organisation will have a different approach to recruiting or contracting qualified personnel and associated support systems.

Healthcode has an important role to play in this context and, alongside its partners, is introducing systems that will offer a cost-effective implementation path. Our solution includes code mapping from existing classifications and, more importantly, coding reference tools which will boost productivity and efficiency.

However, those alone won't deliver the training and business process changes required for a smooth 'business as usual' operational model and it is important that providers prioritise this.

[7] PbR is the payment system in NHS England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. The two fundamental features of PbR are nationally determined currencies and tariffs. Currencies are the unit of healthcare for which a payment is made, and can take a number of forms covering different time periods from an outpatient attendance or a stay in hospital, to a year of care for a long term condition. Tariffs are the set prices paid for each currency.

6.0 The role of the Consultant

The NHS defines clinical coding as “the translation of medical terminology that describes a patient’s complaint, problem, diagnosis, treatment or other reason for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner”.

Coding therefore is the responsibility of whoever is translating such clinical notes into what will become the health or medical record. In the NHS, this will typically be the coding department although in the private sector coding departments are not yet commonplace across all providers.

While consultants are unlikely to have any direct involvement in coding, their records form the source reference for the clinical coding teams. This must be an accurate record of the encounter between the consultant and the patient as the consultant (or healthcare practitioner) is accountable for the clinical information they provide.

Within the NHS, coders are routinely expected to question consultants where the records do not offer sufficient information for accurate coding. We think it is inevitable that this will become a trend in the private sector too.

Recommendation 4:

Consultants in the independent sector should recognise that their patient records will be used as a basis for coding which will underpin quality and outcomes reporting about their practice and the establishments where they treat patients. If consultants are not already familiar with coding we suggest hospital providers offer training and support so they understand their role in the process.

7.0 Conclusion

The absence of effective diagnosis coding is one area where the private healthcare sector justifiably deserves criticism. In any healthcare economy complete, accurate, consistently and timely recording of clinically coded records is a crucial and fundamental component of the overall healthcare pathway, without which quality and outcomes cannot be measured and compared. That is why PHIN has been capable of receiving and processing ICD-10 codes from the outset.

There should be no more excuses for the private healthcare sector's failure to adopt and embrace the ICD-10 standard across all their patient episodes. While a number of industry figures have questioned whether the sector should potentially delay until the introduction of ICD-11, the WHO has said this will not be released until 2017. The independent sector will be in same place in five years if it considers 'skipping' ICD-10.

The Competition and Markets Authority (CMA) has effectively provided us with a mandate to follow this course. But we should not be dependent on their findings to conclude this is a journey our sector must take.

Consultants and insurers have their parts to play in both encouraging and facilitating the migration but it is the hospitals who must take the lead and drive their individual programmes. These programmes must start now and the sector should set an aggressive target to retire the antiquated set of codes and descriptions the sector currently described as ICD-9. Writing in May 2014 it is perhaps overly aggressive to expect us to complete this by the end of the year, but certainly mid-2015 should be seen as achievable. There is nothing to stop providers coding ICD-10 now, both for billing and clinical records. Healthcode will support any provider who wishes to submit ICD-10 codes for either such purpose and is confident there will be no technical or commercial barriers.

There is still an operational challenge for the providers to ensure appropriately skilled staffing is in place to record diagnoses to the appropriate standard and quality but in many cases such resource exists today, just not across the entire portfolio. Similarly a number of organisations, Healthcode included, are working with providers and across the sector to ensure systems and support services are available to facilitate the transition.

8.0 About Healthcode

Healthcode's goal is to be the knowledge source and most trusted independent expert to deliver interoperable online solutions and define industry standards for private healthcare.

Healthcode is the official UK medical bill clearing company for private healthcare. Since 2001, we have provided encrypted online systems to healthcare professionals and businesses and currently process over £2.5bn of medical invoices annually as well as clinical records for virtually every private patient in the UK.

In addition, we continue to deliver solutions to help streamline administrative processes, connect healthcare organisations and add value. Today Healthcode provides an extensive range of specific products for the private healthcare market, including practice management systems and online billing, patient membership enquiry, secure messaging and clinical coding translation tools.

Our technology is encrypted to Internet banking standards and Healthcode is trusted as the professional choice for most of the UK's private hospitals. Providing the quality tools to help you take direct control of your business and outstanding customer service make Healthcode the natural choice for specialists, medical secretaries, hospitals and insurers.

Healthcode also work closely with PHIN as part of an industry-wide initiative to capture patient level information from private hospitals and process it for benchmarking the independent sector.

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