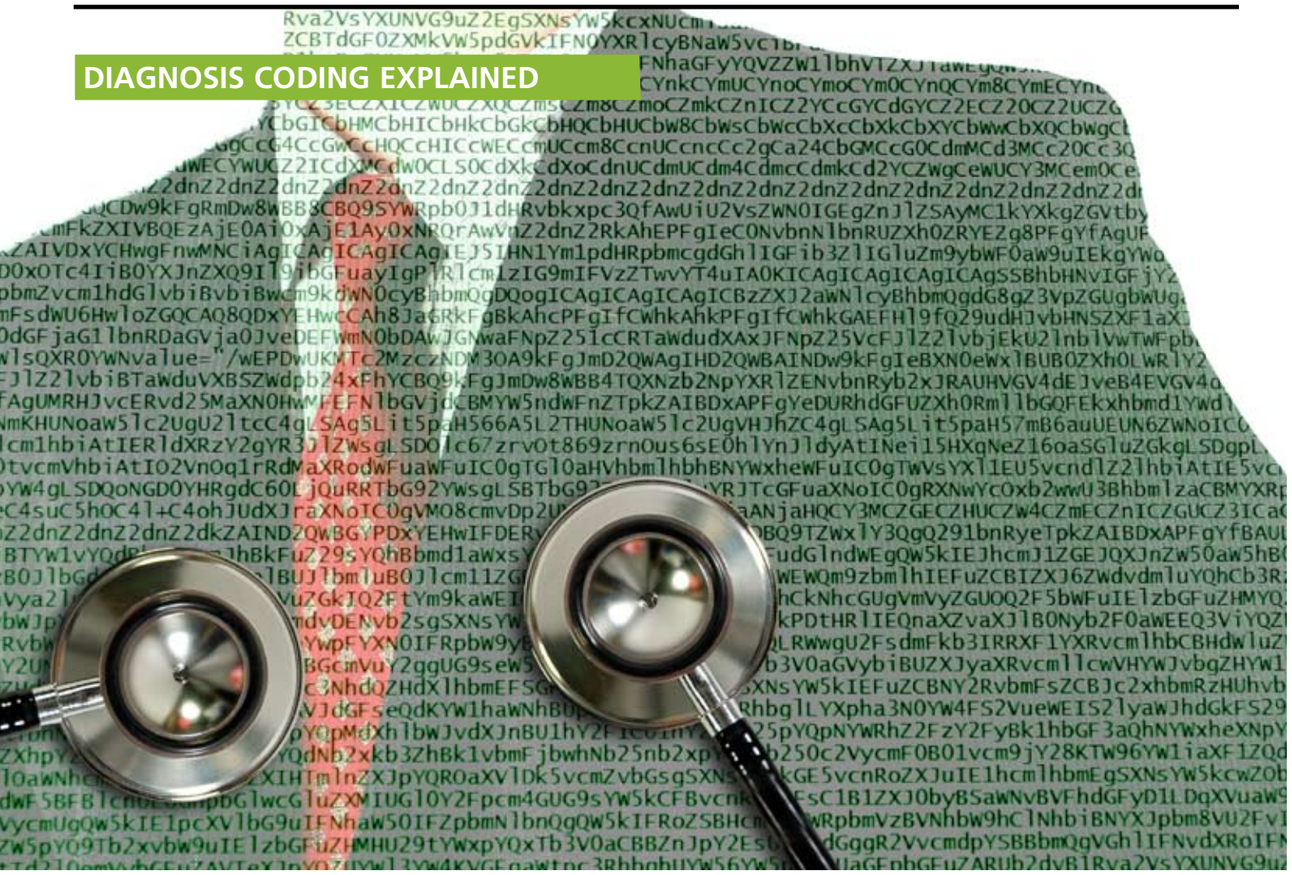

DIAGNOSIS CODING EXPLAINED

CODING starts to get crucial

As a private doctor, you may not have had much to do with diagnosis codes before now, unless you were obliged to provide them when submitting your bills electronically. But here, **Peter Connor** explains why that is about to change

WHEN IT COMES to patient diagnoses, the NHS and the private sector are speaking a completely different coding language. See the box on the opposite page for a basic explanation of the difference.

Within the NHS, hospital trusts refer to the latest incarnation of the World Health Organisation's (WHO) International Classification of Diseases, ICD-101.[1]

All NHS episodes of care are coded and this information is then used to collate Hospital Episode Statistics (HES) for each trust, as well as to ensure trusts are paid correctly for each activity – under Payment By Results – and to support service planning.

Trusts employ teams of coders to translate the clinical information recorded on source documents such as the patient's case notes or discharge summaries.

This must be done within strict time deadlines to meet Department of Health and audit requirements and must pass a threshold of data quality or the trusts risk losing income.

Clinicians are not expected to know the codes but are required to provide complete information about a patient's diagnoses, including co-morbidities, using the NHS's standard clinical terminology, SNOMED CT.

Used when billing private insurers, the private sector's diagnosis code system is based on WHO's earlier ICD-9 classification, which was superseded in 1994 when ICD-10 came into use by WHO member states. But the codes are not clinically maintained and the level of detail available is vastly inferior to that provided by ICD-10 (see box to the right).

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CHARACTER ANALYSIS: NHS AND PRIVATE SECTOR DIAGNOSIS CODES COMPARED

The ICD-10 code set used in the NHS is a hierarchical classification system devised by the WHO 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 eg codes starting with 'L' can be found in Chapter XII: diseases of the skin and subcutaneous tissue.

Each chapter is subdivided into blocks of three-character categories; for example, L20-L30 represents dermatitis and eczema. Most three-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; for example, 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.[4]

By contrast, the ICD-9 code set used in the private sector is a much simplified version of the original WHO classification system.

Codes consist of four significant numbers and a '0', which has no purpose other than to make the codes the standard length for data processing. The original code formatting and descriptions from the WHO version have been abandoned and the fourth character, which could provide additional detail about a patient's condition, is simply not recorded.

For example, one of the most common ICD-9 codes used by private sector orthopaedics specialists is 71940 'joint pain – unspecified'. However, the original ICD-9 WHO code set allowed coders to specify the affected part of the body; for example, 719.41 referred to pain in the shoulder region.

Nor do most independent practitioners have the resources to appoint professional clinical coders to translate discharge summaries into diagnosis and procedure codes, although the main private hospital groups now do so.

With a mountain of bills to submit and limited resources, however, it is understandable that many independent providers simply select from a few summary diagnosis codes which are most applicable for their specialty.

In cases where no detail about the patient's condition is readily available, a summary diagnosis code is often extrapolated from the procedure carried out. The example in the table on page 23 illustrates how a patient's diagnosis might be coded using ICD-10 and ICD-9 code sets.

The patient choice agenda

For as long as diagnosis codes were only used for billing private medical insurers – where detailed diagnostic information simply wasn't necessary – ICD-9 codes served the private sector's needs. But healthcare provision is changing.

The most recent Government reforms envisage a greater role for the private sector in delivering NHS-funded healthcare, but previous reforms designed to give patients greater choice about where they receive their treatment have already made an impact.

In November 2012, a report by the Institute for Fiscal studies, commissioned by the Nuffield Trust,[2] revealed the growth of private provision in the NHS.

For example, by 2010-11, independent-sector treatment centres carried out 17% of hip replacements and 17% of elective unilateral inguinal hernia repairs in England. Meanwhile, according to the official NHS statistics, 345,200 NHS patients received elective treatments such as knee replacements from the private sector in 2011-12, up almost 33,000 (10.5%) in a year.[3]

So if private providers want to treat NHS patients, they cannot afford to ignore diagnosis coding because, as I mentioned above, it is directly linked to remuneration within the public sector.

Under the Payment By Results system, episodes of NHS treatment are given a Healthcare Resource Group (HRG) code, depending on the activity and the type of patient The system used within admitted patient care and outpatients is called HRG4 and includes more than 1,400 types of care.

Risk of non-payment

An elderly patient with diabetes who needs a hip replacement is likely to be more costly to treat than an otherwise healthy 50-year-old who requires the same procedure, so they will be given a different HRG code and reimbursed accordingly.

This means if patients' primary and secondary diagnosis are not accurately recorded and coded, the hospital concerned may not be properly remunerated for the cost of treatment.

It is difficult to see how the current system of private sector diagnosis coding can support the demands of commissioning bodies in the NHS.

Indeed, one of the UK's largest private hospital groups, Ramsay Health Care, which has been commissioned to carry out many thousands of procedures for the NHS, is already using ICD-10 diagnosis codes so can work more efficiently with the NHS and it is likely that other private providers will come to the same conclusion.

It will be interesting to see how insurers respond if providers themselves choose to move to a more sophisticated system.

What next?

The desire to develop close working ties with the NHS is one factor that will raise the profile of clinical coding, but it is not the only one.

As regular readers of *Independent Practitioner Today* will be aware, the Private Healthcare Information Network (PHIN) is about to publish Independent Hospital Episode Statistics, which will be a significant step forward in the drive for greater transparency in quality and outcomes within the private sector.

■ **Next month, in the final article in this series, I will explain the significance of both procedure and diagnosis coding in this project, as well as looking at the limitations of procedure coding in the independent sector and how they can be overcome**

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Peter Connor (pictured below) is managing director of Healthcode

> **For as long as diagnosis codes were only used for billing medical insurers, ICD-9 codes served the private sector's needs. But healthcare provision is changing**

THE VIEW FROM A MAJOR PRIVATE PROVIDER

Jane Cameron, director of clinical services, Ramsay Health Care

'Ramsay Health Care has long used clinical codes when submitting electronic invoices for verification and payment by insurers, but today the codes have other functions, including benchmarking, as well as being critical for our NHS work.

'As the largest private provider of surgical and diagnostics services to the NHS, Ramsay has adopted the ICD-10 diagnosis codes and Healthcare Resource Group codes used in the public sector. This enables us to work seamlessly with our NHS partners and submit invoices under the Payment By Results system.

'To help us code accurately and efficiently, we have appointed our own Clinical Coding Lead who oversees a team of trained coders.

'Of course, clear diagnostic and detailed procedural information ensures coding accuracy, so we expect our clinicians to play their part by providing as much detail as possible about their patients and treatment, including a full clinical history and relevant co-morbidities.'

> **It is difficult to see how the current system of private sector diagnosis coding can support the demands of commissioning bodies in the NHS**

AN EXAMPLE OF DIAGNOSIS CODING

A 55-year-old female patient presented to a consultant orthopaedic surgeon with osteoarthritis in her right hip. The patient had type-1 diabetes – but this was under control – and was also a smoker. The surgeon recommended a hip replacement and she elected to have the operation privately.

■ **Private sector ICD-9 code:**
71500 – 'Osteoarthritis'

■ **Public sector ICD-10 codes:**
Primary diagnosis: M16.9 'Coxarthrosis unspecified' (Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue)
Co-morbidity: E10.9 'Diabetes mellitus without complications' (Chapter 4: Endocrine, Nutritional and Metabolic Diseases)
Z72.0 'Tobacco use' (Chapter 21: Factors Influencing Health Status and Contact with Health Services [Z00-Z99])