

Why coding is important

Prof. PA Gaines FRCP FRCR

Sheffield Vascular Institute

Northern General Hospital

Sheffield S5 7AU

Introduction

The financial viability of hospitals is dependant upon good coding. This brief article explains what coding is and why it is the basis of secure financial income through Payment by Results (PbR). It is necessarily simplistic with the intention of introducing the reader to an important area of hospital practise.

Payment by Results

The 2002 consultation document ‘Reforming NHS Financial Flows: introducing payment by results’ described how hospitals will be reimbursed for their work. Whether it will, as stated, *reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions*’ remains to be seen. PbR will however represent the principal route whereby hospitals, and therefore Radiology Departments, acquire income. Trusts will contract for, and be paid for their activity, on the basis of HRG’s (Healthcare Resource Groups). These groups describe episodes, such as inpatient spells (a period of time spent by a patient from admission to discharge) or out-patient consultations/treatments/investigations that have the same cost implications. In order that an HRG can be generated for the activity undertaken, the coding department must code for what is wrong with the patient and what procedure was undertaken. The HRG generated describes what the hospital undertook on behalf of the patient. Because the HRG’s are iso-resource they can then be associated with a set amount of money - the tariff - that is paid to the hospital.

Coding Systems

The underlying disease process is coded for using ICD 10 which is the international classification of diseases constructed by the World Health Organisation.

There is in addition a requirement to code for the procedure that the patient underwent as a result of the underlying disease process. The NHS department ‘Connecting for Health’ currently has 2 projects underway – OPCS and SNOMED CT.

The OPCS coding system was introduced into the NHS in 1944 as a way of classifying surgical procedures and subsequently matured as a code for all clinical procedures. Unfortunately OPCS 4 had not, until recently, been updated since 1990. Such a failure to keep pace with the rate of medical developments was recognised to have major implications for many specialities, none more so than for Radiology. Over the last 2 years the OPCS 4 codes have undergone major reconstructions into OPCS 4.3. Because the previous codes were so inadequate to code for Interventional Radiology this has seen particular change. To code for every possible technique that can be applied to every possible vessel or organ within the body with sufficient detail to support PbR and future financial and clinical audit would require many thousands of codes if each treatment were to be given its own individual code. A new strategy was therefore developed whereby the coders can code for every current procedure by combining 3 sets of codes that account for the technique, method of access, and target site. Using this construct the number of individual codes required is minimised and the potential for expansion is maximised.

In addition to the OPCS codes Connecting for Health is introducing SNOMED CT as a basic terminology or ‘language’ for use within the NHS. In 1965 the College of American Pathologists developed a Systematized Nomenclature of Pathology (SNOP) as a list of terms to help pathologists store and retrieve data. By 1974 this had been further developed to cover the whole of medicine as SNOMED (Systematized NOmenclature of MEDicine). In 1999 the NHS combined their Clinical terms (READ codes) with SNOMED to produce a SNOMED Clinical Terminology (CT). A clinical terminology is a structured list of terms for use in clinical practise. As such it is a global computerised health language that describes the care and treatment of patients and will therefore facilitate the communication and sharing of health care information.

The implementation of SNOMED CT has major implications for Radiology because of its dependance upon the Radiology Information System (RIS). Were all radiology departments to use their own terms to describe examinations or procedures, or report using local variations on common clinical phraseology there would be no commonality of the data collected and used by the Radiology Information Systems across the country. This confusion would interfere with many processes, for example efficient communication between healthcare workers, research requiring national statistics or collaboration, and health-trend analysis. It would also markedly undermine the value of the patients individual electronic care records. The Royal College of Radiologists took the view that this was unacceptable and instigated a working party to develop SNOMED CT as fit for use in the RIS. The working party has now developed SNOMED CT terms so that it can be used within RIS and as a such will code for all procedures.

This clearly leaves Radiology with a dilemma as there are apparently 2 separate coding structures to be used. Firstly the process requires work to determine that SNOMED CT is fit for purpose. In addition Interventional Radiology has not as yet been effectively included in the process and this needs attention. Secondly, HRG's currently require an OPCS code and not a SNOMED CT term. From October 2006 it is hoped that there will be a mapping process available that will enable SNOMED CT terms to map to the appropriate OPCS code so that an HRG can be generated.

SNOMED CT will support the development of NHS Care Records Service (electronic patient records etc). Because OPCS cannot do this, and because nobody wishes to code twice, it is highly likely that in the future OPCS will eventually be phased out.

What to do now?

For a department to get paid for its activity within PbR an HRG needs to be generated. Attached to this HRG is a tariff. Tariffs are based upon the annual return of reference costs from all Trusts. Unfortunately these reference costs are hopelessly inaccurate and do not reflect the costs of a Radiology Department. So that accurate costs can be acquired the NHS needs to know exactly what activity is occurring and this requires all departments to code as accurately as possible. For those departments that have a RIS utilising SNOMED CT terms then from October 2006 there will be a mapping process that enables all data to be collected in the OPCS format. For those departments with a RIS not utilising SNOMED CT then OPCS 4.3 is available from April 2006. **If Radiology is to be ensured financial viability it is the responsibility of all units to code accurately from now so that we will eventually have accurate**

tariffs that will reimburse us appropriately for our endeavours. How that accurate coding is achieved now and following the introduction of PbR in 2008 will remain the responsibility of each unit.

Prof PA Gaines
Chairman of the Interventional Radiology HRG and OPCS Coding Expert Working Groups.