TIM JONES

On Coding

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About two thirds of hospital income comes from treating outpatients and inpatients, charged under the National Tariff price. How much is charged in each case depends on the way that the clinical episode is coded. This is carried out by hospitals and the perception of some on the commissioning side is that hospitals use this power to inflate their income. It is time for a change.

With all due respect to those who do it, clinical coding is not exciting! However, the excitement is in inverse relationship to its importance.

Just to remind ourselves, clinical coding is the process of translating the complexity of real health care into a standardised language (one for procedures, one for diagnoses) of letters and numbers. A clever piece of software known as the *Spell-Grouper* reads these codes and allocates each one to a pre-determined group which has a tariff price attached to it.

Coding requires training and a skilled interpretation of clinical practice as written in the patient's notes but it is a business process. It contributes nothing (directly) to care or to the quality of the patient experience. It is objective and detachable.

PCTs perceive that 'up-coding' is used to increase hospital funding in three ways:

1. **Mis-coding** - simple procedures coded as more complex ones

2. **Enrichment** - by recording additional health information about the patient the spell grouper can be ‘fooled’ into thinking that the patient has complex needs, leadingto a higher cost code

3. **Enhancement** - by having a patient lie instead of sit the patient becomes an inpatient and so can be charged at a higher tariff

There is little or no benefit for patients and certainly none for the taxpayer as this practice undermines the incentive to become more efficient. It is time to take this vital function out of the hospital and put it on a footing that is objective and transparent.

This would yield benefits:

Objectivity

- Data quality A steady improvement in the quality, accuracy and standardisation of coding leading to better decision-making and better health care
- Capacity - trust and PCTs would be free to argue over other issues, such as all of the care that takes place under archaic block contracts

There are some short-term dis-benefits including:

- Costs of identifying the coding resource
- Need for additional investment to improve quality of coding
- Costs of procurement - procurement of a business process of this type may take £50,000 or more

Even without costing for each of these I confidently predict that this change would pay for itself within two years of operation.

The first step is to draw up a specification and quality schedule. Unusually for the NHS this only needs to be done once. A standard procurement process and contract could follow similar to the method used to purchase Darzi health centers.

This is not a party political issue. It is an essential and long-overdue process change.

It is, in short a no-brainer!

Tim Jones other publications
Jones T and Wood J, Commissioning primary care: a discussion paper (King's Fund forthcoming 2010)
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