How much are coding errors costing us?

Assessing the accuracy of recording of flexible nasendoscopy in ENT outpatient departments.

D Bhasker Specialist Registrar in Otolaryngology
A Coatesworth Consultant ENT Surgeon
York Teaching Hospital NHS Foundation Trust

Funding in the UK National Health Service is allocated based on a ‘payment by results’ system.1 This system involves collection of clinical data or clinical-coding that: (i) allows payment for the work that is carried out and (ii) provides an important audit tool on a local and national basis.2 Thus, the accuracy of clinical coding is of vital importance at financial and clinical levels.

Each patient encounter in hospital is allocated a Healthcare Resource Group (HRG) code based on the details of the encounter. Each HRG code is associated with a national tariff. HRG codes are generated based on a complex system of clinical coding.

Diagnoses are coded based on the International Statistical Classification of Diseases and Other Health Problems (10th edition) (ICD-10) set by the World Health Organization. In addition, procedures are codified using the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS-4). For each patient encounter, diagnoses and procedure codes are entered into a computer system to generate an HRG code.

Coding is undertaken primarily by professionals trained in clinical coding. This can have drawbacks and the potential for inaccuracies in clinical coding, with consequent financial losses.3 However, clinicians are responsible for ensuring the accuracy of coding by recording diagnoses and procedures appropriately (particularly in the outpatient setting).

Flexible nasendoscopy (FNE) is carried out often in ear, nose and throat (ENT) outpatient clinics. Here, we aimed to: (i) ascertain if FNE is recorded appropriately as an outpatient procedure and (ii) calculate the financial implications of inaccurate recording of FNE in the outpatient setting.

METHODS

All patients who underwent FNE in the ENT outpatient department of our hospital in October 2012 were identified based on records for cleaning of flexible nasendoscopes using Trio Wipes (Tristel, Snailwell, UK).

Each outpatient record was identified on the York Core Patient Database (CPD). We noted if the procedure was recorded on the CPD system and, if so, which code was used (eg E368 examination with a flexible endoscope selected from a dropdown list).

We compared the findings with our standard (100% of FNEs should be recorded and coded correctly).

Patients who attended the ENT outpatient department for review but who were hospital inpatients at the time of attendance were excluded from analyses.

RESULTS

A total of 345 outpatients underwent FNE in ENT outpatient clinics during a 23-day period in October 2012. Table 1 shows the numbers recorded on the CPD system.

Seventy-one per cent of FNEs done in outpatient clinics were recorded on the electronic recording system. Several codes were used to record this procedure in the outpatient CPD (Table 2).

Fifty-one per cent of FNEs on the CPD were recorded using the code ‘FLXENDNASO’. Discussion with the clinical coding team revealed that this code is not associated with a tariff because it is not a nationally specified OPCS code: it is used for departmental audit only. Only 46% of recorded FNEs were done using a code associated with an HRG tariff.

For October 2012, the total tariff associated with outpatient FNE recording was £36,474. The potential income generated if all FNEs were coded correctly was calculated to be £43,125; that is, a potential monthly loss of £6,651. Extrapolation revealed an annual income loss to the department of £79,812 from incorrect recording of FNE in the outpatient department alone.

These data were presented at a departmental audit meeting attended by all clinicians in February 2013. Changes were made to the electronic system after discussion.
All procedure codes without an HRG tariff were removed from the electronic recording system. All clinicians were reminded of the importance of coding accuracy and the timely recording of procedures during the presentation at the audit meeting. A re-audit using the same methodology was undertaken in May 2013.

RE-AUDIT

During a 40-day period in April–May 2013, 425 FNEs were carried out in ENT outpatient clinics. An audit of longer duration was used owing to fewer clinics because of staff absence (annual leave and one registrar on long-term leave). Seventy-five per cent (317/425) were recorded using the electronic system, of which 98% (311/317) were coded correctly. Six cases were recorded using the term ‘other’ (which does not generate an associated tariff). Twenty-five per cent (108/425) of procedures were not recorded using the electronic database.

Owing to coding errors and non-recording, the re-audit revealed a shortfall in departmental income for the study period of £4,675.

DISCUSSION

FNE is one of the most commonly undertaken procedures in ENT outpatient clinics and is associated with high tariffs. In our department, coding of outpatient procedures occurs if clinicians record the procedure on the electronic database by entering the procedure into a ‘search’ category and selecting the appropriate procedure from various types of procedure. Correct use of OPCS codes generates an associated HRG tariff. Incorrect or lack of recording by clinicians on the electronic database results in incorrect coding of that outpatient encounter by clinical coders, and leads to a loss in departmental revenue.

We identified an area in which considerable coding errors occurred, thereby leading to a potentially large annual financial shortfall. After implementation of changes, we noted an improvement in the accuracy of FNE recording: 98% of FNEs were recorded using OPCS codes associated with an HRG tariff compared with 46% during the first study. Such improved recording resulted in a saving of £1,976 and, if extrapolated, an annual departmental saving of £23,712.

Despite changes to the electronic recording system and dissemination of information regarding coding of outpatient procedures, the prevalence of FNE recording remained largely unchanged. Seventy-one per cent of FNEs carried out were recorded appropriately during the first study compared with 75% after implementation of changes.

The Royal College of Physicians issued a report with recommendations on improvement in the accuracy of clinical coding based on a study held at a hospital trust: (i) taking a consistent approach to medical documentation; (ii) avoiding duplication of clinical and administrative data; (iii) regular meetings between the clinical coding team and clinicians.
