

Denmark, it is almost nonexistent and all secondary healthcare is specialised. Each country presented an interesting case, ranging from the everyday to the decidedly small print. The case of hantavirus in Finland causing renal failure had us all stumped until the last slide.

The final day was spent at the RCP, where Mervyn Singer delivered the keynote lecture on 'Coping with critical illness', followed much later by renditions of various national anthems. The week was a perfect blend of medicine and strengthening of international relations.

The next ESIM summer school will be held in Turkey in September 2012.

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Clinical coding for electrophysiology and device procedures: why and how to get it right

Introduction

Clinical and nonclinical codes are used to generate nationally agreed tariffs that are charged to the primary care trust for every patient intervention. It is essential that coding is accurate otherwise the provider (secondary or tertiary) might not be reimbursed appropriately.¹ Anecdotal evidence suggested that coding teams were finding it difficult to code electrophysiology (EP) and device procedures correctly because of case complexity. Therefore, we hypothesised that clinical coding for EP and device cases was inaccurate and that this had important implications. We undertook a study to identify the problem, devise a solution and complete the audit loop to determine the effectiveness of our strategy. We agreed that the audit standard would be accurate coding in 80% of cases.

Data collection

A retrospective single-centre analysis of 98 consecutive EP procedures and 62 device

Table 1. Data demonstrating accuracy of coding and the shortfall in the subsequently generated tariff as a result of inaccurate clinical codes.

	EP cases		Device cases	
	Pre-tick sheet	Post-tick sheet	Pre-tick sheet	Post-tick sheet
Coding accuracy	39%	80%	45%	100%
Shortfall in generated tariff (/100 cases)	£1,951	£0	£30,919	£0

cases was undertaken over a 5-month period. A single clinician, blinded to the previously assigned codes, recoded each case appropriately and used national software to generate a corrected tariff to compare with the original tariff assigned by the coder.

Results

Overall, there were large inaccuracies in clinic coding (Table 1), particularly in EP cases using mapping systems (<12% correct) and complex device implants (<25% correct). For EP procedures, this did not greatly influence the overall tariff, principally because 60% of atrial fibrillation ablations were coded as atrial flutter; the latter generating a higher tariff. For devices, there was a significant shortfall in generated tariff as a result of inaccurate coding (approximately £31,000 per 100 cases) driven largely by complex devices (eg implantable defibrillators and resynchronising pacemakers) being miscoded as simple devices. These data confirmed our hypothesis and showed that coding accuracy was well below the acceptable standard. There were two problems; the clinical procedural details were not compatible with the description in the coding manual of the intervention and the coding manual was also ambiguous, with subtle statements reflecting important differences in procedural detail. For example, Code K575 ('...percutaneous transluminal ablation of atrial wall') is the correct code for atrial tachycardia ablation, rather than for atrial fibrillation ablation (K621) or flutter ablation (K622), which themselves have similarly ambiguous code descriptors.

Intervention

The clinicians and coders collaborated on the production of a simple tick-sheet that was an

interface between the clinical procedure, coding manual description of the intervention and clinical code. The clinician would complete this simple pro-forma at the end of the case, which would immediately assign a case code and support the coder's task. Six months later, a re-audit was undertaken

Results of the re-audit

Data from 52 consecutive EP procedures and 24 device cases were analysed. As a result of the tick-sheet, 80% of EP procedures and 100% of device cases were now coded correctly, with marked improvement (elimination) of any shortfall in the subsequently generated tariff (Table 1). The set standards were met and exceeded.

Conclusions

This audit demonstrates how a multidisciplinary approach to clinical coding led to a simple yet powerful tool to improve accuracy and so ensure correct reimbursement.

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Reference

- 1 Department of Health, 2011. *Payment by results*. www.dh.gov.uk/health/category/policy-areas/nhs/resources-for-managers/payment-by-results/ [Accessed 2 February 2012].