ICD-10 Coding Training in England: Greater Access to Education Should Aid US Coders with Transition

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A lack of comprehensive training on ICD-10 and other code sets has contributed to data quality issues in England. US coders, looking ahead to their own transition to the code set, should be encouraged by their access to a strong coding infrastructure.

As professional coders in the US look ahead to the implementation of ICD-10-CM and ICD-10-PCS in 2013, it is helpful to look elsewhere to see how different countries have handled their own ICD-10 training.

Countries such as Canada and Australia can serve as excellent models for training programs, while others such as those in England lack depth and basic educational foundation. That lack is reflected in the results of a national report on coding quality in England, which documented data quality issues and the resulting impact on the country's healthcare initiatives.

The importance of widely available, comprehensive training programs and professional resources to the successful implementation of code sets should encourage US coders as they anticipate their own transition in the coming years.

Lack of an HIM Profession and Documentation Requirements

Contributing to the inadequacy of coder training in England is the fact that, from the inception of the National Health Service (NHS) in England in 1949 until the early 1990s, there was little awareness, understanding, or vision regarding the impact of patient outcomes, resource utilization, or accuracy of patient data on the delivery of healthcare services. Management and policy decisions to determine treatment effectiveness and cost have often been based on unreliable information.

Until the recent introduction of case mix using Healthcare Resource Groups (HRGs), the quality and uniformity of clinical data coding had been undervalued in the NHS. This fairly recent emphasis on data quality has resulted in the creation of training materials for coders, but the NHS training approach has lacked the organization and formalization that is familiar to coders within the US.

In the US, coding training has long been an integral part of the HIM profession, which is recognized and sanctioned by professional bodies. Ever since educational programs were formalized and moved from hospital-based to university-based standardized accredited curricula in the early 1970s, coding has been included as a major foundation for both the two- and four-year degree programs in HIM. More recently, formal coding certificate programs, along with new coding credentials, have been developed to satisfy the increasing demand for quality coders.

In England a similar comprehensive HIM profession does not exist, nor is there an active professional body equivalent to those in the US and other countries. Also lacking are mandatory documentation standards (such as those from accrediting or licensing bodies), and no one is held accountable for the recording of patient data, either clinical or nonclinical.

Even if there were mandates for health record content, there are no HIM professionals with the responsibility to monitor, or the authority to enforce, those requirements. The current push in England to computerize poorly structured paper-based health records, which are often illegible and lacking vital information, has further exacerbated the data quality problem, a dilemma reported in findings from England's Audit Commission.

The impact of these factors is especially felt now that the basic problems of managing patient information are being highlighted in the reporting of inaccurate case-mix and costing data. The importance of the coder's role is only now being recognized due to the effort by England's Department of Health to tie coding to cost through case mix.

This most recent initiative, Payment by Results (PbR), is intended to link the allocation of funds to hospital activity, which is reported through the ICD-10 diagnostic codes and OPCS4 (Office of Population Census and Surveys current version 4.5) procedural codes. PbR is slowly being phased in, but already major problems have arisen due to inaccurate coding and problems with the HRG case-mix tools, which were designed based on unreliable coding practices.

Current State of Coding Quality

The problems were highlighted in a report titled "PbR Data Assurance Framework 2007/2008," which was released by the national Audit Commission in August 2008. In 2007, following the poor results from early implementation trials of PbR, the Department of Health implemented an independent external coding audit program in England managed by the Audit Commission, which is independent from NHS. This analysis of coding quality in all hospitals in England provided the first national look at data quality.

The results showed:

- Payment errors resulting from coding inaccuracies. Coding errors were having an impact on HRG case-mix assignment and, in turn, the accuracy of payments to hospitals. HRG errors in this one year contributed to a gross financial error of almost $5.9 million (£3.5 million).
- Poor quality of the source documentation used for coding data. This was the most common issue that affected the accuracy of clinical coding. Coders in England often code from a variety of sources such as checklists, pro formas, and minimal discharge summaries rather than full patient records.
- Absence of HIM and documentation standards. Coding problems arose from illegible and poorly structured medical records, lack of access to additional information systems, lack of physician involvement and validation, and insufficient information recorded in electronic patient records.
- Inadequate coding training. Coder training and development had more of an impact on quality than did the size of coding staff. There was also a lack of clear national guidance on identifying and coding comorbidities. The Audit Commission concluded that the Department of Health and NHS needed to improve coding training and introduce a wider data quality program to improve information standards and increase confidence in data reliability.

Coding Training in England

Without an HIM professional framework and requirements for health record content, preparation of coders in England largely occurs in a vacuum, without the proper context of how coding fits into the healthcare delivery process. NHS has made strides by developing a good coding training manual to introduce new coders to the coding process.

However, this manual, which serves as a good starting point and could be used as a self-instructional workbook, is closely guarded by NHS and available only to students registered for its Basic Clinical Coding Foundation course. The coding workshops are offered on a limited basis and are relatively expensive, especially compared to training available in the US.

In addition to the course, NHS also offers short specialty workshops throughout the year; however, like the foundation course, these are only recommended. There are currently no mandatory training requirements or prerequisites for coders, even those who wish to sit for the examination for the recently developed Accredited Clinical Coder (ACC) qualification.

Components of the NHS Basic Clinical Coding Foundation Course

This basic course, which only recently has been expanded to an 18-day workshop, has few prerequisites other than to "possess little knowledge on the subject."[1] There are no basic background course requirements and, in 18 days, only two are spent on the key topics of anatomy and physiology and medical terminology. There is no introduction to disease processes and pathophysiology or pharmacology.

The course does not include any kind of formal internship, and coders are left to learn on the job, often supervised by NHS managers who have little or no understanding of the coding process.

The course is divided into four modules delivered over a three-month period. The modules cover the theory and principles of classification systems, medical terminology and anatomy and physiology, ICD-10 diagnostic classifications, and OPCS4

procedural classifications.

The ICD-10 and OPCS4 modules include hands-on activities with answers, using single isolated clinical statements (without the context of real case scenarios). These types of statements, upon which the ACC assessment is also based, are acceptable for learning basic indexing and code assignment skills, but the lack of contextual information provides little room for interpretative differences that a coder may find on the job.

Coders are taught to code from books (rather than using an electronic version as in Canada), and they use the 2000 World Health Organization (WHO) version of ICD-10 without modifications, rather than the current online 2007 version.

The OPCS4 procedural coding training uses a newly revised NHS publication which, in spite of undergoing three revisions in the past three years to accommodate PbR, still is outdated, poorly indexed, and not fit for purpose. Current updates for national coding standards come out in sporadic "Coding Clinic" newsletters that are put online without notification; it is the responsibility of the coder to periodically check the NHS Web site in order to stay current.

Comparing NHS Basic Coding Training

Coders in England have less access to comprehensive coding instruction than do their colleagues in the US, a gap that has contributed to data quality problems that compromise England's National Health Service pay-for-performance initiative. A comparison to an online course in the US highlights the differences.

Training Program	Contact Hours	Length of Program	Time to Complete	Cost for Nonmembers
NHS Clinical Coding Foundation	108 hours	18 days	3 months	$6,000
AHIMA Coding Basics	585 hours	300 days	15 months	$2,000

Comparison of Training Requirements in the US

Basic coding certificate programs in the US can require up to two years to complete and average 45 to 48 credit hours (ranging from 600–700 contact hours of instruction, excluding prerequisite courses). AHIMA's Coding Basics distance education online course is self-directed and requires 41 semester credits (or 585 contact hours). By contrast, the complete NHS Foundation Course of 18 days includes 108 contact hours based on a six-hour training day.

The US college-based programs require, at a minimum, courses in medical terminology, anatomy and physiology, pathophysiology and fundamentals of disease processes, pharmacology, introduction to health information management, diagnostic coding, procedural coding, and a directed practicum under the supervision of a credentialed HIM professional.

In contrast, the NHS Foundation Course includes approximately two days of training in medical terminology and anatomy and physiology and 16 days on coding basics.

AHIMA's online course is covered in four clusters, each lasting 15 weeks at a cost of $2,000. The 18-day NHS course costs between $5,000 and $6,000 depending on NHS membership status. The differences in the AHIMA and NHS training requirements are summarized in the table above.

A curriculum similar to that of the US has recently been accepted as an international standard by the International Federal Health Records Organization through its collaboration with the World Health Organization Family of International Classifications. Countries outside of England have recognized the need for a broader training program than that offered by NHS and are in the process of adopting those training guidelines.

Coder responsibilities in England typically do not go beyond assigning and recording codes. They are not expected or prepared to deal with areas such as coding services structure, coding workflow and organization, revenue cycle, quality control, compliance, or coded data's use in risk adjustment and payment systems.

In addition, they are not directly involved in case mix or release of information or other legal aspects, nor do they understand the broader picture of how the quality of their coding impacts the healthcare system other than meeting varying deadlines for coding discharged patients. This relates back to the problem of coding in a virtual vacuum, in a system where the HIM profession and health record content requirements are not part of healthcare delivery.

US coders, more closely integrated into the healthcare system and with greater access to comprehensive training and professional resources, are positioned for better success in their transition to ICD-10-CM/PCS. They should feel confident, as they approach what may appear a monumental task, that they can minimize disruption and maintain data quality during the conversion.

Note

1. NHS Connecting for Health. "Clinical Coding Foundation Course." Course description. Available online at www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/trainingaccred/schedule08/desc/foundation0809.

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