**Audit on the Coding of Radiological Examinations**

**Descriptor:**

This audit looks at the accuracy in the coding of examinations carried out in the radiology department.

**Background:**

Accurate coding of radiological examinations is critical to the efficient running of a radiology department. It gives a correct reflection of the workload of the department, which can have financial implications for the unit and the trust as a whole in the light of payment by results. It will also prevent the inappropriate repetition of examinations, which can result from incorrect coding. Some of these unnecessary repetitions may have dose penalties for the patient (IRMER).

Patients reasonably expect that the information necessary for their care is available across the health and care community. Delivering high quality health and social care services depends on good information. The right person having the right information at the right time in the appropriate format can make all the difference to the quality and experience of care for an individual and their family and carers. Patients need information to understand their health needs and make decisions about their care; clinicians need it for safe effective delivery of care and treatment; managers, researchers and policy makers need it to innovate, plan and improve services [1].

## The Cycle

**The standard:**

The coding of examinations should be accurate and in keeping with the coding system of the Radiology department.

**Target:**

100% compliance.

## Assess local practice

**Indicators:**

The percentage of completed radiology examinations that have been accurately coded according to locally established guidelines.

**Data items to be collected:**

The request cards for the examinations should be reviewed and the coding on the RIS or CRIS system recorded. The allocated code is then compared with the radiology images on PACS to determine whether the coding was appropriate for the examinations carried out. Various units within the Radiology department such as CT, MRI and Ultrasound can be reviewed independently.

**Suggested number:**

100 examinations is the suggested number for each modality. This will ensure that the data collection gives a good reflection of the coding process in the department over different days.

**Suggestions for change if target not met:**

Re-education of the appointments centre staff about the correct codes reflecting the examinations done. Vetting radiologists and radiographers should be reminded to clearly mention the areas to be examined to ensure correct coding afterwards. The Radiographer/sonographer carrying out the investigation should ensure that the correct code is put in afterwards. The reporting radiologist/radiographer should double-check the coding of the examination before signing it off.

**Resources:**

Resources and assistance were obtained from the radiology department PACS and RIS Teams.

**References:**

1. Everyone Counts: Planning for Patients 2014/15 - 2018/19. (2013). [PDF] NHS England. <https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid.pdf>
2. England, N. (2018). NHS England » The Information Standard Principles. [online] England.nhs.uk.  <https://www.england.nhs.uk/tis/about/the-info-standard/>
3. Implementing standards. <http://systems.hscic.gov.uk/data/learn/implementing>
4. Interim Clinical Imaging Procedure Codes. Webarchive.nationalarchives.gov.uk. (2018). ISB 0148 - Interim Clinical Imaging Procedure Codes - Standards Library - ISB. [online]  [http://webarchive.nationalarchives.gov.uk/+/http://www.isb.nhs.uk/library/standard/125](http://webarchive.nationalarchives.gov.uk/+/http:/www.isb.nhs.uk/library/standard/125)

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