Title: Coding and Documentation for Inpatient Services 1.BR.12

Effective Date: 2/01; Rev. 6/03, 7/05

POLICY: Diagnoses and procedures will be coded utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and/or other classification systems that may be required (such as DSM IV for classification of psychiatric patients). IHS affiliates will follow the Official Guidelines for Coding and Reporting diagnoses and procedures published in AHA Coding Clinic for ICD-9-CM, Second Quarter, 1990 and Fourth Quarter, 1996 or the most current AHA Coding Clinic Guidelines.

SCOPE: IHS system wide. All IHS and affiliate facilities providing inpatient services. For hospital outpatient services, refer to 1.BR.13, Coding Documentation for Hospital Outpatient Services.

BACKGROUND: The purpose of this policy is to improve the accuracy, integrity and quality of patient data, ensure minimal variation in coding practices, and improve the quality of the physician documentation within the body of the medical record to support code assignments.

PROCEDURES:

1. **ICD-9-CM/AHA Coding Clinic.**
   
   1.1 Diagnoses and procedures will be coded utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and/or other classification systems that may be required (such as DSM IV for classification of psychiatric patients).

   1.2 IHS affiliates will follow the Official Guidelines for Coding and Reporting diagnoses and procedures published in AHA Coding Clinic for ICD-9-CM, Second Quarter, 1990 and Fourth Quarter, 1996 or the most current AHA Coding Clinic Guidelines.
2. **UHDDS Definitions.**

2.1 Inpatient diagnoses and procedures shall be coded in accordance with Uniform Hospital Discharge Data Set (UHDDS) definitions for principal and additional diagnoses and procedures as specified in the Official Guidelines for Coding and Reporting.

2.2 The principal diagnosis is defined in the UHDDS as, “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

2.2.1 Coding Clinic provides specific instructions for selecting the principal diagnosis for coding substance dependence, abuse and therapy. IHS facilities providing these services will follow the guidelines published in AHA Coding Clinic, Second Quarter, 1990 or the most current AHA Coding Clinic reference.

2.3 The UHDDS defines additional diagnoses as, “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.” Diagnoses that relate to an earlier episode, which have no bearing on the current hospital stay, are to be excluded.

2.4 In accordance with UHDDS definitions, all significant procedures are to be reported.

2.4.1 A significant procedure is one that is (1) surgical in nature, or (2) carries a procedural risk, or (3) carries an anesthetic risk, or (4) requires specialized training.

2.4.2 When more than one procedure is reported, the principal procedure is to be designated. In determining which of several procedures is principal, the following criteria apply:

2.4.2.1 The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

2.4.2.2 If there appears to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.
3. **Reportable Diagnoses/Procedures.** To achieve consistency in the coding of diagnoses and procedures, all individuals who are authorized to perform coding/claims processing of inpatient services (“Coding Personnel”) must:

3.1 Thoroughly review the entire medical record as part of the coding process in order to assign and report the most appropriate codes.

3.2 Adhere to all official coding guidelines as approved by AHA, AHIMA, CMS and NCHS (“Cooperating Parties”).

3.3 Observe sequencing rules identified by Cooperating Parties.

3.4 Assign and report codes, without physician consultation/query, for diagnoses and procedures that are not listed in the physician’s final diagnostic statement only if those diagnoses and procedures are specifically documented in the body of the medical record by a physician directly participating in the care of the patient, and this documentation is clear and consistent;

3.4.1 Areas of the medical record which contain acceptable physician documentation to support code assignment include the discharge summary, history and physical, emergency room record, physician progress notes, physician orders, physician consultations, operative reports, physician notations of intraoperative occurrences and other ancillary, diagnostic reports signed by physicians (such as anesthesia report, pathology report)

3.4.2 When diagnoses or procedures are stated in other medical record documentation by non-physicians (nurses notes, MDS abstract (SNU’s), pathology report, radiology reports, laboratory reports, EKGs, nutritional evaluation and other ancillary reports), the attending physician must be queried for confirmation of the condition. These conditions must also meet the coding and reporting guidelines outlined in AHA Coding Clinic, 2Q, 1990 page 12.

3.5 Utilize medical record documentation to provide specificity in coding, such as utilizing the radiology report to confirm the fracture site or referring to the EKG to identify the location of an MI.

3.6 Consult the physician for clarification when conflicting or ambiguous documentation is present. Ask the physician to add information to the record before assigning a code that is not supported by documentation.
4. **Query Process.**

4.1 Coding Personnel should query the physician once a diagnosis or procedure has been determined to meet the guidelines for reporting but has not been clearly or completely stated within the medical record by a physician participating in the care of the patient or when ambiguous or conflicting documentation is present.

4.2 Incomplete physician inquiries for coding are included in the record delinquency count.

4.3 All facilities should educate their physicians on the importance of concurrent documentation within the body of the medical record to support complete, accurate and consistent coding.

4.4 Communication should be provided to the medical staff that individuals responsible for coding patient diagnoses or procedures will query physicians when there are questions regarding documentation for code assignment. The physician’s response to the query should be signed by the physician and become part of the medical record. The actual coding query itself shall not be maintained as part of the medical record.

4.5 Administration and medical staff leadership must support this process to ensure its success.

4.6 Coding Personnel must not suggest a code or medical record documentation that is not supported by the patient’s clinical presentation and/or condition. Coding Personnel may relate to physicians what the particular documentation requirements are for specific codes, and the physician can then make the appropriate documentation decision based upon the patient’s clinical presentation and/or condition.

5. **Coding Summary.**

5.1 A coding summary must be placed within the medical record of all inpatient discharges.

5.2 A coding summary should contain all reported ICD-9-CM diagnosis and procedure codes, and their narrative descriptions, patient identification, and admission and discharge dates. The summary may also include discharge disposition, and DRG assignment and description.

5.3 The coding summary should be either a system generated abstract or handwritten codes on the face sheet.
5.4 The summary must be kept as a permanent part of the medical record.

5.5 An electronic coding summary, which is generated through computer interfaces, may be part of the medical record.

6. **Data Quality Application.**

6.1 Coding Personnel must not:

   6.1.1 Add diagnosis codes solely based on test results, unless diagnosis is obtained from physician through the query process outlined in Section 4.

   6.1.2 Misrepresent the patient’s clinical picture through incorrect coding or adding diagnosis/procedures unsupported by the documentation for any reason.

   6.1.3 Report diagnoses and procedures that the physician has specifically indicated he/she does not support.

7. **Facility Coding Reviews.**

7.1 Internal (or external) coding quality reviews must be completed on a regular basis by each facility.

7.2 Reviews should include review of the medical record to determine accurate code assignment with subsequent comparison with the UB-92 claim form to determine accurate billing.

7.3 Findings from these reviews must be utilized to improve coding and medical record documentation practices and for Coding Personnel and physician education, as appropriate.

8. **Unique Payor Requirements.**

8.1 Some payors’ billing and coding procedures are different from those of the Cooperating Parties. “Unique” payor billing requirements should be documented for future reference.

8.2 Bills submitted to these payors should comply with their “unique” billing and coding requirements.

8.3 Coding Personnel should report any “unique” payor requirements that may cause noncompliance with governmental payor billing procedures and coding requirements.
8.4 Coding Personnel should be involved during contract negotiations with third-party payors when coding guidelines are addressed.

8.5 Coding and billing practices should also follow the Medicare/Medicaid 72-Hour Rule regarding billing for services performed prior to admissions. (See Medicare Hospital Manual § 415.6.)

9. **Claim Denials.**

9.1 Written policy and procedures must require that employees responsible for the final code assignments will review all claims denied (in part or total) based on codes assigned.

9.2 Documentation must be maintained on claims denied in part or total due to discrepancies in coding. As areas of exposure or noncompliance are identified, corrective action will be taken.

10. **Business Office/Patient Accounts.**

10.1 Business office or patient accounting may not change/resequence or assign codes without review by Coding Personnel.

11. **Compliance / Monitoring.**

11.1 Compliance with this policy will be monitored as part of the compliance monitoring process outlined in Policy 1.CE.7, Compliance Monitoring.

11.2 Additional internal (or external) coding quality reviews may be completed as appropriate by the facility. Quality reviews should include review of the medical record or available documentation to determine accurate code assignment with subsequent comparison with the UB-92 to determine accurate billing. If applicable, these reviews should incorporate review of any encounter forms in use.

11.3 Employees that have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy should discuss these situations with their immediate supervisor, the affiliate Compliance Officer, or the IHS Compliance Officer.

11.4 All day-to-day operational issues may be handled locally, however, if confidential advice is needed or an employee wishes to report an activity that conflicts with this policy and/or is not comfortable speaking with their supervisor, the employee may discuss the matter with the affiliate Compliance
Officer or the IHS Compliance Officer or may call the Compliance Helpline at 1-800-548-8778.

/s/ Samuel T. Wallace

Samuel T. Wallace
IHS President

REFERENCES: Coding Clinic for ICD-9-CM; Practice Brief on Data Quality, American Health Information Management Association (AHIMA), Chicago, Illinois, February 1996.