Title: Coding Documentation for Hospital Outpatient Services

Effective Date: 3/01; Rev. 5/03, 7/05

POLICY:

1. All IHS affiliates will follow the current guidelines for hospital outpatient diagnosis coding and reporting published in AHA Coding Clinic, 4th quarter, 1995, or the most current AHA Coding Clinic Guidelines.

2. All IHS affiliates will apply the Current Procedural Terminology (CPT) coding conventions and general guidelines as published by the American Medical Association (AMA) for outpatient surgical and diagnostic procedure coding.

3. Insurance carrier and state reporting requirements should be followed when reporting procedure codes from the ICD-9-CM Volume 3 for outpatient diagnostic and surgical procedures.

4. CMS mandates the utilization of Level I (CPT) and Level II (National Medicare) Health Care Financing Administration’s Procedure Coding System (“HCPCS”) codes for outpatient services for Medicare patients.

SCOPE: IHS system wide. All IHS and affiliate facilities including, but not limited to, hospitals, ambulatory surgery centers and all IHS and affiliate departments responsible for performing, supervising or monitoring coding/claims processing of hospital outpatient services.

This policy applies to diagnostic and procedural coding and reporting of outpatient services. Examples of these services include, but are not limited to, outpatient visits and outpatient referrals for laboratory, radiology, cardiology, cardiopulmonary and other diagnostic testing; laboratory testing performed on referred specimens only; observation services; emergency care; and ambulatory outpatient surgery performed in either a freestanding center or a hospital outpatient department. This policy does not apply to physician offices or home
health services. For inpatient services, refer to Policy 1.BR.12, Coding and Documentation for Inpatient Services.

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

**PROCEDURES:** All individuals who are authorized to perform coding/claims processing of outpatient services (“Coding Personnel”) must comply with the following:

1. **Basic Coding for Outpatient Service.**

   1.1 The appropriate code or codes from 001.0 through V84.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting when an established diagnosis has not been diagnosed or confirmed by the physician. The documentation should describe the patient’s condition, using terminology which includes specific diagnoses, or the symptoms, problems or reasons for the encounter.

   1.1.1 Code the diagnosis, condition, problem, symptom, injury or other reason for the encounter or visit which is chiefly responsible for the services provided. This diagnosis is listed first for reporting purposes. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

   1.1.2 Code documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment or management. Diagnoses that were previously treated and no longer exist should not be coded.

   1.1.3 V Codes (V01.0 - V84.8) may be used to code encounters for circumstances other than a disease, symptom, problem or injury. For additional guidance on the use of V Codes, refer to [AHA Coding Clinic, 4th qtr., 1996](https://www.aha.org/). 

   1.1.4 Codes must be reported using the maximum number of digits required for that code. Three or four digit codes may be used when they are not further subdivided.

   1.1.5 Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” or “working diagnosis.”
1.1.5.1 Code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, or other reason for the visit.

1.1.6 When only diagnostic services are provided during an encounter or visit, sequence first the symptom, sign, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit.

1.1.6.1 Codes for other diagnoses (e.g. chronic conditions) may be sequenced as additional diagnoses. Example: Complete blood count, liver profile for patient on methotrexate for rheumatoid arthritis. V58.69, 714.0

1.1.7 When only therapeutic services are provided during an encounter or visit, sequence first the diagnosis, condition, problem or other reason for encounter/visit shown in the medical record.

1.1.7.1 The only exception is that the appropriate V code is used for patients receiving chemotherapy, radiation therapy or rehabilitation services.

1.1.8 For patients receiving preoperative evaluations only, sequence a code from category V72.8X to describe the pre-op services and code the reason for the surgery as an additional diagnosis.

1.1.9 For routine and administrative examinations, (general check-up, school exam, child check, etc.) list first the appropriate V code for the examination.

1.1.10 For outpatient or ambulatory surgery cases, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, code the postoperative diagnosis, with the exception of screenings, which require that the preoperative diagnosis be reported.

1.1.11 For cases in which the patient is admitted to inpatient services following outpatient surgery, apply UHDDS guidelines for principal diagnosis. Also code the reason for the outpatient surgery and the outpatient surgery procedure.
1.2 IHS affiliates recognize that there are unique payor coding and billing requirements. These requirements are addressed in section 4 of this policy.

2. Query Process.

2.1 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.

2.2 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.

2.3 It is necessary to include a chart that requires a physician response to a coding query in the incomplete and delinquent record count.

2.4 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.

2.5 Communication should be provided to the physicians 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.

2.6 Administration and physician leadership must support this process to ensure its success.

2.7 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.

3. Documentation Requirements.

3.1 Outpatient Referrals to IHS Facilities.

3.1.1 Documentation must include the following, as appropriate to the service:
3.1.1 An authenticated physician order for services (i.e., order signed by manual signature (including initials), signature stamp, or electronic signature).

3.1.2 A diagnosis or reason the service was ordered

3.1.3 Test result or the results of the treatment provided

3.1.4 Demographic information

3.1.5 Signed consent for services (if required)

3.1.2 Referred Specimens: Documentation for laboratory tests on referred specimens only, where there is no patient contact with the laboratory, should include the following, as appropriate to the service:

3.1.2.1 An authenticated physician order for testing

3.1.2.2 Date and time of specimen collection

3.1.2.3 A diagnosis or reason for ordering each test

3.1.2.4 Demographic information (if required)

3.1.3 Each facility must establish a system for retention of the required documentation, including documentation necessary to substantiate coding/billing of the service. This may be maintained either in a centralized location such as the Medical Records Department or in a de-centralized location such as the laboratory. Refer to Policy 1.AD.3, Record Retention.

3.2 Outpatient Visits.

3.2.1 Documentation maintained must include, as appropriate to the service, an outpatient medical record that includes the following:

3.2.1.1 An authenticated physician order for services (an order is not required for screening mammograms)

3.2.1.2 Clinician visit notes

3.2.1.3 A diagnosis
3.2.1.4 Test results
3.2.1.5 Therapies
3.2.1.6 A problem list
3.2.1.7 Medication list
3.2.1.8 Demographic information
3.2.1.9 Required consents

3.2.2 Coding of the diagnosis may be completed using the medical record or encounter form which is completed by the provider at the point of service.

3.2.3 Documentation in the medical record must support the diagnosis and CPT codes marked on the test requisition/order form or encounter form.

3.2.3.1 It is important to review and update the ICD-9-CM and CPT codes on these forms at least annually. (Note: ICD-9-CM is updated each October, while CPT is updated each January. Additionally, these codes may be updated throughout the year).

3.2.4 The documentation or source document referred to by the coder should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems or reasons for the service. Coding Personnel may assign diagnosis codes based on the reason for the referral. A specific diagnosis based on test results usually is not available and may not be available until after subsequent evaluations or physician visits.

3.3 Emergency Visits.

3.3.1 Documentation maintained must include, as appropriate to the service, an emergency medical record that includes the following:

3.3.1.1 Encounter form
3.3.1.2 Required consents
3.3.1.3 Physicians’ emergency documentation
3.3.1.4 Nursing notes

3.3.1.5 Test results

3.3.1.6 Demographic information

3.3.1.7 Treatment

3.3.1.8 Pre-hospital information, when available (i.e., ambulance records)

3.3.2 Diagnosis and CPT surgical procedure codes (if applicable) shall be assigned by the coder based on the diagnosis and procedures recorded by the treating physician in the emergency room record.

3.3.3 The physician’s emergency medical record documentation and test results shall be reviewed to assist in code assignment.

3.4 Observation Visits.

3.4.1 Documentation must include the following:

3.4.1.1 A history and physical

3.4.1.2 Written progress notes

3.4.1.3 Physician orders for admission to observation and for treatment

3.4.1.4 Physician orders for discharge from observation

3.4.1.5 Clinical observations

3.4.1.6 Final progress note or summary that includes the diagnosis and any procedures performed and treatment rendered

3.4.2 The observation unit medical record is reviewed by the coder to assist in the code assignment process.

3.5. Ambulatory (Outpatient) Surgical or Diagnostic Procedural Services.

3.5.1 As applicable, documentation maintained must include an ambulatory medical record that includes the following:
3.5.1.1 A history and physical examination (as required by hospital policy or Medical Staff Rules and Regulations)

3.5.1.2 Results of previous diagnostic tests as related to this encounter

3.5.1.3 Operative/procedure report

3.5.1.4 Pathology report

3.5.1.5 Medication list

3.5.1.6 Demographic information

3.5.1.7 Signed consent(s) for services

3.5.2 ICD-9-CM diagnosis codes and CPT or ICD-9-CM surgical procedure codes must be assigned by the coder based on the diagnosis and treatment recorded by the physician in the ambulatory medical record.

3.5.3 The physician’s dictated operative report, including review of the post operative diagnosis, and any pathology report should be reviewed to assist in accurate code assignment.

4. Unique Payor Requirements.

4.1 It is recognized that payors in various states may utilize coding guidelines that do not comply with those issued by the parties that formulate the AHA Coding Clinic. “Unique” payor billing requirements should be documented for future reference.

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

4.3 Coding Personnel will be oriented about and aware of individual payor contracts that contain specific coding and reporting requirements.

4.4 Coding Personnel should be involved during contract negotiations with third-party payors when coding guidelines are addressed.

4.5 A payor may have special or different coding guidelines for certain procedures/tests. For example, Medicare has special coding guidelines for Pap tests.
4.6 Coding and billing practices should also follow the Medicare/Medicaid 72-Hour Rule regarding billing for services performed prior to admission. (See Medicaid Hospital Manual § 415.6).

4.7 If coding conflicts with payors are identified, the issue will be forwarded to the individual/department who performed the coding for resolution. If that individual/department determines that recoding is appropriate, they should update the codes and inform the central billing office or other appropriate billing office to rebill the claim.

5. **Review of Denials.**

5.1 Employees responsible for code assignments will review all claims denied (in part or total) based on the codes assigned. As areas of exposure or noncompliance are identified, corrective action will be taken.

5.2 Documentation should be maintained on claims denied in part or total due to discrepancies in coding.

6. **Payor Coverage/Medical Necessity For Services.**

6.1 ICD-9-CM diagnosis and CPT procedure codes must be correctly submitted and will not be modified or misrepresented in order to be covered and paid.

6.2 Certain payors, specifically Medicare, have issued requirements for “certain cardiopulmonary, radiology and laboratory tests” which must have specific diagnoses for the service to be covered. Payment may be made only for services it determines to be “reasonable and necessary.” Routine exams or screenings, tests for investigative or research use only, and other services may not be covered.

6.3 Each facility should have a process in place to identify appropriateness of services and/or inform the patient of coverage issues before service is rendered.

7. **Patient Accounting.**

Business office or patient accounting may not change or resequence codes without review by Coding Personnel. Billing records will be corrected accordingly.
8. **Chargemaster/Encounter Form Maintenance.**

8.1 Each facility has responsibility for maintaining and updating the chargemaster and encounter forms on an annual basis to include new and/or revised codes.

8.2 Each facility also has responsibility for implementing internal billing controls to assure correct use of chargemaster, encounter form codes and accurate billing practices.

9. **Compliance / Monitoring.**

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

9.2 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 or CMS 1500 claim form to determine accurate billing. If applicable, these reviews should incorporate review of any encounter forms in use.

9.3 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.

9.4 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:**

The Physician’s Current Procedural Terminology, Fourth Edition (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures
performed by physicians. This system of terminology provides a uniform medical language to accurately describe medical, surgical, and diagnostic services. It should be noted that inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy. Coding guidelines for CPT procedural coding are included in both the CPT manual and published in the AMA CPT-Assistant.

International Classification of Diseases - 9th revision- Clinical Modification (ICD-9-CM) is a coding classification of diseases, injuries and procedures, which are grouped into appropriate chapters, sections, categories and subcategories. Volumes 1 and 2 include the disease classification and Volume 3 is the procedure classification.

ICD-9-CM is based on the ninth revision of the World Health Organization’s ICD-9. The clinical modification adopted by the U.S. expands codes to facilitate more precise coding of morbidity. The uses of this classification in this country are for vital statistics reporting, mortality reporting, and for many third party reimbursement systems, including Medicare.

AHA Coding Clinic - Coding Clinic is the official publication of ICD-9-CM coding guidelines and advice as designated by four cooperating parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), Centers for Medicare & Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

Policy 1.AD.3, Record Retention

Medicare Part B Policy Manual