HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	***Quality Through Compliance***	**Policy No.:** **PAT 1006** **Revision No.:** N/A
	Issued by: Corporate Compliance Committee	**Effective Date:** September 15, 2000
Subject: ***Medical Records: Skilled Nursing Facilities/Units***	**Approved by:** Thomas M. Driskill, Jr. President & CEO	**Supersedes Policy:** N/A **Page:** 1 of 5

I. PURPOSE: 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.

II. 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 if applicable). Hawaii Health Systems Corporation (HHSC) 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*.

III. PROCEDURE:

A. ICD-9-CM/AHA Coding Clinic: 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).

HHSC 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*.

B. UHDDS Definitions: Skilled nursing 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. The principal diagnosis is defined as follows:

1. The admitting diagnosis is defined as the condition for which the patient was admitted to the SNF, to receive skilled nursing services, and should be one of the conditions for which the patient received hospital care in the qualifying hospital stay. (Reference*: Medicare Manual*, Section 560, Completion of HCFA-1450 (UB-92), definition of principal diagnosis.)

2. 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 skilled nursing unit/facility stay are to be excluded.

C. Reportable Diagnoses/Procedures: To achieve consistency in the coding of diagnoses and procedures, coders must:

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

2. Adhere to all official coding guidelines as stated in this policy.

3. Assign and report codes, without physician consultation/query, for diagnoses that are not listed in the physician's final diagnostic statement only if those diagnoses 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.

    a. Areas of the medical record which contain acceptable physician documentation to support code assignment include the discharge summary, history and physical, physician progress notes, physician orders, and physician consultations.

    b. When diagnoses or procedures are stated in other medical record documentation (nurses notes, MDS abstracts (SNUs), pathology reports, radiology reports, laboratory reports, EKGs, nutritional evaluations 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*.

4. 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.

D. Query Process: Query the physician after the patient leaves or expires or as needed on an ad hoc basis 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.

1. The documentation of the coder's query to the physician must comply with one of the following formats:

    a. The physician can add an addendum to the medical record. The addendum must be dated and signed.

    b. The query can be documented on a separate query form.

2. This documentation must be kept as a permanent part of the medical record and must include the patient's name, the patient's medical record number, the name of

the individual submitting the query, the date the query was submitted, a statement of the issue in the form of a question, and the physician's response to the query. It must be signed and dated by the physician.

3. If the query process is documented in this format, a second signature is not required on the coding summary.

    a. The query process can be documented on the coding summary.

    b. This documentation must be kept as a permanent part of the medical record and must include the name of the individual submitting the query, the date the query was submitted, a statement of the issue in the form of a question, and the physician's response to the query. The query must be signed and dated by the physician.

    c. A statement "I have reviewed the narrative descriptions of the diagnosis and procedure codes listed above and agree they accurately reflect the clinical picture of this episode of care." indicating physician agreement with the diagnoses and procedures reported must be included as part of the coding summary.

    d. A notation that this form will be included as a permanent part of the medical record should also be included.

4. The query process is performed on a retrospective basis only. It is not necessary to maintain the concurrent query for diagnoses or procedures, which the physician includes in the body of the medical record. If, however, the physician does not update the medical record documentation, this query must be maintained as a permanent part of the medical record to support code assignments.

5. The retention of the query documentation is related to codes reported at the time of final billing.

6. 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.

    a. Communication should be provided to the medical staff that coders will query physicians when there are questions regarding documentation for code assignment. This query will be documented and will require physician signature. This is done on a case by case basis.

    b. Administration and medical staff leadership must support this process to ensure its success. Our outside consultant that performs chart reviews is providing training to the physicians; however, the attendance is low because the sessions are not mandatory.

E. Coding Summary: A coding summary must be placed within the medical record of all skilled nursing discharges.

1. A coding summary must 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.

2. The coding summary should be either a system generated abstract or handwritten codes on the face sheet.

3. The summary must be kept as a permanent part of the medical record.

F. Data Quality Application: Coders must not:

1. Add diagnosis codes solely based on test results;

2. Misrepresent the patient's clinical picture through incorrect coding or adding diagnosis/procedures unsupported by the documentation for any reason. Each facility must have a process in place to identify appropriateness of services and/or coverage issues before the service is rendered.

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

G. Minimum Data Set (MDS) Completion: The Long Term Care Head Nurse should establish a protocol for completing Section I.3 of the MDS. This information must be forwarded to the Medical Records Director to provide coding documentation. It is the responsibility of the Medical Records coding staff to assign ICD-9-CM codes for completion of Section I.3. Use the following references when completing Section I.3:

1. HCFA's RAI Version 2.0 Manual, Chapter 3; MDS Items, Section I: Disease Diagnoses

2. HHSC's SNF PPS and Consolidated Billing Transition Manual.

H. MDS/RAP Documentation Requirements: Each electronically submitted Minimum Data Set (MDS) must be printed and maintained as a permanent part of the patient's medical record. In addition, all caregivers involved in the completion of each MDS must sign the printed paper MDS. This includes any Medical Records individuals who participated in assigning codes on the MDS. Confirmation of each electronic MDS submission should be maintained as part of the facility's business records. These do not have to be a permanent part of the patient's medical record but can be maintained with the medical record if desired. When applicable, any Resident Assessment Protocol (RAP) generated must also be maintained as a permanent part of the medical record.

I. Facility Coding Reviews: Internal (or external) coding quality reviews must be completed on a regular basis by each facility.

1. 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.

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

J. Claim Denials: 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. Documentation must be maintained on claims denied in part or total due to discrepancies in coding.

K. Business Office/Patient Accounts: *A written policy* has been developed with the business office and patient accounting which prohibits changing/resequencing of codes by patient accounting personnel without review by the coder.

L. Policy Compliance Monitoring:

1. It is the responsibility of each facility's administration to ensure that this policy is applied by all individuals involved in coding/claims processing of skilled nursing services.

2. Employees who 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 to resolve the situation.