I. PURPOSE: To establish guidelines to maintain the accuracy, integrity, and quality of patient data with minimal variation in coding practices, and to improve the quality of the documentation within the body of the medical record to support code assignment. Complete and accurate diagnostic and procedural coded data is necessary for statistical analysis, financial and strategic planning, reimbursement, and evaluation of quality of care. Clinical documentation is the foundation for accurate coding. Collaboration between clinicians and coders through queries supports the reporting of quality information.


CMS mandates the utilization of Level I (CPT) and Level II (National Medicare) HCPCS codes for Medicare patients. Level III HCPCS codes are created and maintained by the local Medicare carriers. *Note* that Level III HCPCS codes may override Level I or Level II codes; therefore, it is critical to follow local carrier coding policies and procedures. Procedure HIM 1002B shall be followed in coding outpatient records.

III. APPLICABILITY: All HHSC operations in all HHSC facilities.

IV. AUTHORITY: All applicable federal and state statutes and regulations that pertain to coding and health care reimbursement. Third party payor contracts, as applicable.

V. ATTACHMENT: HHSC Procedure HIM 1002B