	Department:	Procedure No.:
HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Quality Healthcare For All"*	**Administration**	**HIM 1002B**
		Revision No.:
PROCEDURE	Issued by: Finance and Information Systems Committee	Effective Date: October 25, 2018
Subject: *Medical Records: Coding and Documentation for Outpatient Services*	Approved by: Linda Rosen By: Linda Rosen, MD Its: HHSC CEO	Supersedes Policy: PAT 1002B
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Last Review: August 14, 2018; Next Review: August 14, 2021

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 are 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.

II. **PROCEDURE**: All individuals performing coding/claims processing of outpatient services shall comply with the following:

   A. **Basic Coding for Outpatient Service:** The appropriate code or codes 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 that includes specific diagnoses or the symptoms, problems, or reasons for the encounter.

   1. The Diagnosis, Condition, Problem, Symptom, Injury, or Other Reason for the Encounter or Visit that 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).

   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."* These represent additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures or increased nursing care and/or monitoring.

   Codes must be reported using the maximum number of characters required for that code.

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

    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. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

3. 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. The only exception is that the appropriate Z code is used for patients receiving chemotherapy and radiation therapy. For care involving the use of rehabilitation services, assign the appropriate code for the condition for which the rehabilitation service is being performed (e.g. aphasia, hemiparesis, other neurological deficits). If the condition for which the rehabilitation service is being provided is no longer present, assign the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis.

4. For patients receiving preoperative evaluations only, sequence Z code to describe the pre-op services and code the reason for the surgery as an additional diagnosis. Code also any findings related to the preoperative evaluation.

5. For routine and administrative examinations (general check-up, school exam, child check, etc.) first list, the appropriate Z code for the examination. If a diagnosis or condition is discovered, it should be coded as an additional code.

6. For 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.

7. 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.

8. For "History of" diagnoses documented by physician, code pertinent chronic conditions as current if being treated on an ongoing basis and affecting management of patient that require additional monitoring, medications, require additional evaluation and assessment and/or treatment by a specialist(s), which may include additional diagnostic tests such as lab and x-rays. Diagnoses may include, but are not limited to, history of hypertension, diabetes, seizure disorder, old MI, history of stroke, Parkinson's disease, COPD.

9. All other "history of" diagnoses that are no longer being treated with medications, diagnostic testing or being monitored will be coded to "history of" (which are typically Z-codes).

B. Minimal Documentation Requirements for Coding Purposes:

1. Outpatient Referrals:

   a. Documentation must include, as appropriate to the service:

   (1) An authenticated physician order for services;
   (2) A diagnosis or reason the service was ordered;
   (3) Test result, demographic information; and
   (4) Signed consent for services (if required).

   b. Each facility must establish a system for retention of the required documentation, including documentation necessary to substantiate coding/billing of the service.

   c. Referred Specimens - documentation for laboratory tests on referred specimens only, where there is no patient contact with the laboratory, should include, as appropriate to the service:

   (1) An authenticated physician order for testing;
   (2) Date and time of specimen collection;
   (3) A diagnosis or reason for ordering each test; and
   (4) Demographic information (if required).

   This documentation may be kept in a decentralized location such as the laboratory.

2. Outpatient Visits:

   a. Documentation maintained may include, as appropriate to the service, an outpatient medical record that includes:

   (1) An authenticated physician order for services (an order is not required for screening mammograms);
   (2) Clinician visit notes;
   (3) A diagnosis or the reason the service was ordered;
   (4) Test results;
   (5) Therapies;
   (6) A problem list;
   (7) Medication list;
   (8) Demographic information; and
   (9) Required consents.

   b. 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.

c. Documentation in the medical record must support the diagnosis and CPT codes indicated on the order. When paper forms are utilized, it is important to review and update ICD-10-CM and CPT codes on these forms at least annually.

d. 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. Coders 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. Emergency Visits:

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

      (1) Required consents;
      (2) Physicians emergency documentation;
      (3) Nursing notes;
      (4) Test results;
      (5) Demographic information;
      (6) Treatment; and
      (7) Any other facility specific review items.

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

   c. The physician's emergency medical record documentation and test results are reviewed to assist in code assignment.

4. Observation Visits:

   a. Documentation must include, but should not be limited to:

      (1) A history and physical;
      (2) Written progress notes;
      (3) Physician orders for admission to observation and for treatment;
      (4) Clinical observations;
      (5) Final progress note or summary that includes the diagnosis and any procedures performed and treatment rendered.

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

5. Ambulatory Surgical or Diagnostic Procedural Services:

   a. As applicable, documentation maintained must include an ambulatory medical record that includes, but should not be limited to:

(1) A history and physical examination;
(2) Results of previous diagnostic tests as related to this encounter;
(3) Operative/procedure report;
(4) Pathology report;
(5) Medication list;
(6) Demographic information;
(7) Signed consent(s) for services;
(8) Any other facility specific focus review items.

b. ICD-10-CM diagnosis codes and CPT or surgical procedure codes must be assigned by the coder based on the diagnosis and treatment recorded by the physician in the ambulatory medical record.

c. 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.

C. Query Process:

1. 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. Refer to the Query Policy (HIM 1010A) and Query Procedure (HIM 1010B) for established guidelines and procedures.

D. Quality of Outpatient Coded Data:

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

2. Quality reviews shall include review of the medical record or available documentation to determine accurate code assignment with subsequent comparison with the UB-04 or HCFA 1500 claim form to determine accurate billing. If applicable, these reviews should incorporate review of any encounter forms in use.

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

F. Payer Coverage/Medical Necessity For Services: ICD-10-CM diagnosis and CPT procedure codes must be correctly submitted and will not be modified or misrepresented in order to be covered and paid.

1. 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.

2. Medicare also maintains a listing of approved procedures that may be performed in an ASC setting.

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

G. **Patient Accounts:** Each facility must develop a written policy that prohibits changing of codes by patient accounts office personnel without review by the coder.

H. **Chargemaster/Encounter Form Maintenance:**

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.

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

I. **Compliance:**

1. It is the responsibility of each facility's administration to ensure that the Coding and Documentation for Outpatient Services Policy (HIM 1002A) and Coding and Documentation for Outpatient Services Procedure (HIM 1002B) are complied with and followed by all individuals involved in coding/claims processing of outpatient services.

2. All appropriate staff members who have questions about a decision based on the Coding and Documentation for Outpatient Services Policy (HIM 1002A) or Coding and Documentation for Outpatient Services Procedure (HIM 1002B), or both, or wish to discuss an activity observed related to application of the Coding and Documentation for Outpatient Services Policy (HIM 1002A) or Coding and Documentation for Outpatient Services Procedure (HIM 1002B), or both shall discuss these situations with their immediate supervisor to resolve the situation.

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 payors contracts, as applicable.

V. **ATTACHMENT:** HHSC Policy HIM 1002A.