HAWAII HEALTH SYSTEMS CORPORATION *"Quality Healthcare For All"* **PROCEDURE**	Department: ***Administration***	**Procedure No.:** **HIM 1003B**
		Revision No.:
	Issued by: Finance & Information Systems Committee	**Effective Date:** October 25, 2018
Subject: ***Medical Records: Coding and Documentation for Inpatient Services***	**Approved by:** By: Linda Rosen, MD Its: HHSC CEO	**Supersedes Policy:** PAT 1003B
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Last Review: August 14, 2018; Next Review: August 14, 2021

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. Complete and accurate diagnostic and procedural coded data are necessary for statistical analysis, financial and strategic planning, reimbursement, evaluation of quality of care. Clinical documentation is the foundation for accurate coding. Collaboration between clinicians and coders through queries support the reporting of quality information.

II. **PROCEDURE:**

A. **ICD-10-CM and PCS/AHA Coding Clinic**:

1. Diagnoses and procedures shall be coded utilizing the *International Classification of Diseases*, Tenth Revision, *Clinical Modification* (ICD-10-CM, ICD-10-PCS) , and/or other classification systems that may be required (such as *DSM IV)*

2. HHSC shall follow the official guidelines for coding and reporting diagnoses and procedures published in the most *current AHA Coding Clinic Guidelines.*

B. **UHDDS Definitions:** 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.

1. 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.*" C*oding Clinic* provides specific instructions for selecting the principal diagnosis for coding substance dependence, abuse and therapy. HHSC facilities providing these services will follow the guidelines published *in AHA Coding Clinic.*

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."

Diagnoses that relate to an earlier episode that have no bearing on the current skilled nursing unit/facility stay shall be excluded.

The definition of principal diagnosis does not supersede the guidance related to long term care as published in the most current AHA Coding Clinic. There may be instances when the reason for services may not be the same as the reason the resident is in the facility.

2. In accordance with UHDDS definitions, all significant procedures shall be reported. A significant procedure is one that: (1) is surgical in nature, or (2) carries a procedural risk, or (3) carries an anesthetic risk, or (4) requires specialized training. 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: 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. 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.

C. Reportable Diagnoses/Procedures:

1. To achieve consistency in the coding of diagnoses and procedures, coders must:

   a. Thoroughly review the entire medical record as part of the coding process in order to assign and report the most appropriate codes;
   b. Adhere to all official coding guidelines as stated in this policy;
   c. 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.

2. Areas of the medical record that contain acceptable physician documentation to support code assignment include the discharge summary, history and physical, operative report, pathology report, physician progress notes, physician orders, and physician consultations.

3. When diagnoses or procedures are stated in other medical record documentation (nurses notes, Minimum Data Set (MDS) abstracts Skilled Nursing Units (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 and specificity. These conditions must also meet the coding and reporting guidelines outlined in *AHA Coding Clinic guidelines.*

D. Present on Admission (POA):

1. All inpatient admissions are subject to regulation mandating collection of present on admission information.
2. POA is defined as the condition/diagnosis present at the time the order for the inpatient order is written.
3. POA indicator is assigned to the principal and secondary diagnoses and the external cause of injury codes.
4. Issues related to the POA assignment shall be resolved with the physician.
5. Options for reporting include:
   a. Yes
   b. No
   c. Unknown
   d. Clinically undetermined
6. Conditions exempt from reporting the indicator are published in the AHA Coding Clinic guidelines.

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

F. Coding Summary:

1. A coding summary shall be placed within the medical record of all inpatient discharges.
2. A coding summary must contain all reported ICD-10-CM/PCS 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.
3. The coding summary should be either a system generated abstract or handwritten codes on the face sheet.
4. The summary must be kept as a permanent part of the medical record.

G. 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.

H. Facility Coding Reviews:

1. Internal (or external) coding quality reviews must be completed on a regular basis by each facility.
2. Reviews shall include review of the medical record to determine accurate code assignment with subsequent comparison with the UB-04 claim form to determine accurate billing.
3. Findings from these reviews must be utilized to improve coding and medical record documentation practices and for coder and physician education, as appropriate.

I. Claim Denials: Policy and procedures shall require that employees responsible for the final code assignments will review all claims denied (in part or total) based on codes assigned. Written documentation must be maintained on claims denied in part or total due to discrepancies in coding.

J. Patient Accounts: A written policy must be developed with the patient accounting office that prohibits changing/resequencing of codes by patient accounting personnel without review by the coder.

K. Policy Compliance Monitoring: Each facility's administration shall ensure that this policy is applied by all individuals involved in coding/claims processing of inpatient services. Employees who have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy shall discuss these situations with their immediate supervisor to resolve the situation.

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

IV. AUTHORITY: Federal rules on coding health care provider bills; contract with thirty party payors.

V. REFERENCES:

- CMS ICD -10 Official Coding Guidelines for Coding and Reporting
- American Health Information Management Association Standards of Ethical Coding
- AHIMA's Long Term Care Health Information Practice & Documentation Guidelines
- AHA Coding Clinic for ICD-10-CM Guidelines (most current guidelines)
- CMS memorandum to the Peer Review Organization entitled "Use of the Physician Query Forms", January 22, 2001

VI. ATTACHMENT:

- HHSC Policy HIM 1003A