ICD-9-CM Reporting: Complications of Care

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Practical Tools for Seminar Learning

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Faculty

Judith Anderson, BA, CCS

Ms. Anderson as Certified Coding Specialist (CCS) with a Bachelor of Arts (BA) degree in the management of human resources and over 20 years of experience in the health information management (HIM) profession. Judith currently is Corporate Manager of Coding HIM Compliance for Catholic Healthcare West (CHW) and is responsible for coding and compliance activities for seven CHW California hospitals on the central coast. Judith works with the director and staff of the CHW Corporate Coding HIM Compliance Department to provide internal coding compliance auditing and on-going continuing education for the CHW coding and charging staff.

Ms. Anderson’s recent experience includes work as a Senior Associate for a major healthcare accounting firm, Director of Coding Services for a HIM Coding consulting company based in the west, and Medicaid Auditor for the Oregon Medical Assistance Program (OMAP). She has provided educational articles for the RMC Newsletter and workshops for the AHIMA Coding Roundtables. Judith has worked extensively as a consultant throughout the United States and has been responsible for inpatient, outpatient, and professional coding reviews and educational presentations for coders, administrators, and physicians. In addition, she has worked as an expert witness for the Medicaid Fraud Control Unit in Oregon and for the United States Attorney.

Gloryanne Bryant, BS, RHIA, CCS

Ms. Bryant has over 27 years of experience in the health information management profession. Gloryanne currently is the Corporate Director of Coding/HIM Compliance for Catholic Healthcare West (CHW), located in San Francisco, California. In this role Gloryanne has responsibility for the coding and documentation compliance of 40 acute care facilities and a variety of other non-hospital based healthcare entities (outpatient settings) in three states. Gloryanne has the charge of developing, implementing/setting and maintaining SystemWide coding policies, and creating an internal coding compliance auditing and monitoring team and process. She is also responsible for maintaining on-going continuing education to the CHW coding and charging staff, and providing specific documentation related education to physicians, case management, and other ancillary clinicians. In addition, she works closely with Senior Management and those involved with the CDM (Charge Description Master) and is a driving-force for regulatory updates and communication.

Gloryanne serves as a volunteer leader for the California Health Information Association (CHIA) as a Director to the state board and has served several national positions for AHIMA (American Health Information Management Association). Gloryanne has served as a Director and Past-Chair for the Society for Clinical Coding (SCC), and served two years on the AHIMA Compliance Task Force. As a Health Information Management Practitioner in the HIM/Coding arena, she was on the AHA Editorial Advisory Board (EAB) on ICD-9-CM for Coding Clinic for two years and completed serving a three-year term on the Council on Accreditation for AHIMA. She continues to publish articles and agrees to be interviewed for national publications like “For the Record”, “Medical Record Briefing”, “CHIA Journal”, “AHIMA Journal” and “Advance” magazines for HIM.

In June 2000, Gloryanne received the “CHIA Literary Award”, from the California Health Information Association (CHIA) for her many articles and writings related to clinical documentation improvement, compliance, data quality and coding and in 2003 she received the CHIA award for “Distinguished Member”. In August 2005, Gloryanne was appointed to the HHS CMS (Centers for Medicare and Medicaid Services) APC Advisory Panel to work on OPPS policy, coding and reimbursement issues. She was recently (11/06) appointed to the RAND Technical Expert Panel on Severity DRGs. Gloryanne is a sought-after national speaker and author on healthcare compliance, reimbursement, clinical documentation, coding regulations (ICD-9-CM and CPT) and serves as a catalyst for change and improvement in healthcare.
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Goals/ Objectives

• Review some Documentation and Coding rules
• How to use the Alpha and Tabular Index for Complication Coding
• Illustrate Best Practices - case examples
• Future Coding Complications of Care - concerns
• Summary key points
• Look at Action Items and next steps
• Questions

Background - Documentation

• Justifies treatment, supports the diagnosis
  • Advances Regulatory Compliance
  • Patient safety
  • Increases accuracy of publicly reported Patient Care Outcomes
  • Captures patient severity and acuity
  • Kicks off the revenue cycle and Improves Reimbursement
**Background - Why is the Clinical Documentation so Important**

- Legal Ramifications
  - Disciplinary action by licensing body for unprofessional conduct
  - Criminal prosecution by the DA or AG
  - Altering medical records or creating false medical data is a misdemeanor
  - Loss of accreditation from various agencies
  - Loss of funding/reimbursement for the care provided
  - Patient/client loses benefits they are otherwise entitled to
  - Adverse impact on defense in malpractice case

**New Legal Ramifications**

*“Never Events”*

- When an event occurs during a hospital encounter or stay that was not expected, should the event result in additional revenue to the provider?
- CMS believes this impacts quality of care
- Proposed IPPS rule will address this...

*(more on this later)*
What is Coding Clinic?

- It is published *quarterly* by the Central Office on ICD-9-CM of the American Hospital Association (AHA).
  - Four cooperating parties
- This is the official source of advice and clarification regarding the “how” and “why” ICD-9-CM diagnosis and procedure codes should be applied.
- This is a “must” publication for any ICD-9-CM coder in any setting.

Diagnosis Related Groups - DRG

- Inpatient Prospective Payment System (IPPS), the hospital is paid an amount for the expected cost of treatment for a given DRG or a Diagnostic Related Group, not based on the actual costs.
- DRG Relative Weight (RW) = numeric figure (number) to reflect the relative “resource consumption” associated with the specific DRG.
- The higher the relative weight, the greater the resources utilized, the greater the reimbursement.
- A computer software called “grouper” is used to compute (group) the DRG via the submitted data and program algorithms.
  - Software program “encoder”
**Definition of Principal Diagnosis - Inpatient**

- The condition found (established) after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
  - Uniform Hospital Discharge Data Set (UHDDS) reporting

- The HIM coding staff reviews all physician documentation to determine which condition meets this definition.

For Inpatient Discharged records...

**DRG Definition of Complication or Comorbidity**

- A condition that arises during the hospital stay that prolongs the length of stay at least one day in approximately 75% of the cases.
- A pre-existing condition that will, because of its presence with a specific diagnosis, cause an increase in length of stay by at least one day in approximately 75% of the cases.

UHDDS Standard definition used/applied across all hospitals.

Having a complication and/or comorbid condition is called a “CC”
Complications and Comorbidities

- The presence or absence of a comorbid/ complication or “CC” can have significant impact on the DRG assignment, RW and payment.

- Physician documentation is essential to capture patient comorbid/ complications
  - Resource consumption

Polling Question #1

Have you looked at your Internet scorecard on quality?

* 1 Yes
* 2 No
* 3 Don’t Know
**Relationship Between Clinical Documentation and Public Reporting**

- Physician clinical documentation is used to code principal and secondary diagnoses (ICD-9-CM) for both inpatient and outpatient records.
- Clinical documentation is used to generate billing - administrative data.
- Administrative data is used by a wide array of entities that publish cost and quality reports.

**Defining Quality Aims for Healthcare**

Care that is

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

"98,000 Preventable Deaths a Year" . . .
So is clinical documentation a link to quality?
Documentation for Diagnosis Coding

- All diagnoses should be supported by physician documentation.
  - Documentation is not limited to the face sheet, must use also the discharge summary, progress notes, history and physical, or other reports designed to capture diagnostic information.
  - This advice refers only to inpatient coding.
  - For outpatient coding be sure to reference ancillary reports as the guidelines state.

Yes you will find that 'coding rules' are 'counter-intuitive' to how Physicians practice medicine.
But this information will help you understand the coding world better.
Coding the Diagnosis - Many Rules to Follow

- Starting in 1984 and now we have revised and updated guidelines October/November 2006
- You can’t just pick up a coding book and be assured of accuracy
- Index changes . . .

- Thus... complication coding is difficult also!

Documentation and Coding

- When the documentation in the medical record is clear and consistent, coders may assign and report codes.
- If there is evidence of a diagnosis within the medical record, and the coder is uncertain whether it is a valid diagnosis because the documentation is incomplete, vague, or contradictory, it is the coder’s responsibility to query the attending physician to determine if this diagnosis should be included.
ICD-9-CM Coding Complication of Care

- Within ICD-9-CM, code Categories 996 through 999 are provided capturing complications of medical and surgical care that are not classified elsewhere in ICD-9-CM.
- Note that the term “complication” as used in ICD-9-CM does not imply that improper or inadequate care is responsible for the problem.

Coding Complication of Medical Care

The alphabetic index should be used to locate the complication code(s)

The coder should first refer to the main term for the condition and look for a subterm indicating a postoperative or other iatrogenic condition. For example:

Adhesion(s) . . .

- postoperative (gastrointestinal tract) . . . 568.0
  - eyelid 997.9 . . .
  - urethra 598.2
Coding Complication of Medical Care

- If there is no entry that can be found under the main term for the condition, go to the main term “Complications” and look for an appropriate subterm, such as one of the following:
  - Nature of complication, such as foreign body, accidental puncture, or hemorrhage
  - Type of procedure, such as colostomy, dialysis, or shunt
  - Anatomical site or body system affected, such as respiratory system
  - General terms such as mechanical, infection, or graft

Indexing the Term(s)
Complication is the Key......

- Alpha - “Complications”
  - each condition (specific) is listed alphabetically
  - open your ICD-9-CM coding book

- Alpha - “postoperative” see also condition
  - confusion state 293.9
  - psychosis 293.9
  - status NEC (see also Status (post)) V45.89

- Tabular - provides you with “includes” and “excludes” instructional notes to be followed.

- Tabular
  - review the “includes” and “excludes” instructional notes.
There must be more than a routinely expected condition or occurrence.

- For example, a major amount of bleeding is expected with joint replacement surgery; hemorrhage should not be considered a complication unless such bleeding is particularly excessive.

- Physician documentation is very important and must be specific.
ICD-9-CM – Coding Complications of Care

- In addition, there must be a cause-and-effect relationship between the care provided and the condition, and some indication that it is a complication, not a postoperative condition in which no complication is present, such as an artificial opening status or absence of an extremity.

- In some cases, this is implicit, as in a complication due to the presence of an internal device, an implant or graft, or a transplant. In other situations, the fact that the problem is a complication due to a procedure must be documented by the physician; the coder cannot make this determination.

ICD-9-CM – Coding Complications of Care

- Time Limit?

- No time limit is defined for the development of a complication. It may occur during the hospital episode in which the care was provided, shortly thereafter, or even years later. When it occurs during the episode in which the operation or other care was given, it is assigned as an additional code.
Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)

• General Rules for Obstetric Cases
  1) Codes from chapter 11 and sequencing priority
     - Obstetric cases require codes from chapter 11, codes in the range 630-677, Complications of Pregnancy, Childbirth, and the Puerperium. Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code V22.2 should be used in place of any chapter 11 codes.
     - It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.

Keep in Mind

• The alpha and tabular index take precedence over Coding Clinic, so watch.
  • See new Coding Guidelines of 10/2006
ICD-9-CM - Postoperative

♦ Postoperative - see also condition
♦ Ileus...

| Ileus (epigastric) (lacerated) (obstructed) (intestinal) (neurogenic) (paralytic) | 560.1 |
| due to gallstone (in intestine) | 580.81 |
| duodenal, chronic | 597.6 |
| following gastrointestinal surgery | 597.4 |
| gallstone | 580.81 |
| mechanical (paralytic obstruction intestine) | 580.9 |
| necrotic | 777.1 |
| due to colic fibers | 777.4 |
| myeloblast | 594.69 |
| postoperative | 992.4 |
| ileus, newborn | 777.4 |

What does postoperative mean to the physician? It is a timeframe, simply meaning… after surgery

Dorland’s says……

Postoperative - occurring after a surgical operation.

Clinical Knowledge - Postoperative Ileus

As with hemorrhage, triggers for ileus can have different relationships to the procedure:
♦ Exist before a procedure and unrelated
  ♦ Exist before a procedure and due to the disease
♦ Start after the procedure due to the disease
♦ Start after the procedure due to a complication that occurred during the operation
♦ POI is one of the of the most common causes of a prolonged hospital stay.
Clinical Knowledge - Ileus

Clinical Definition:
- Ileus can be mechanical, as obstruction of the bowel - intrinsic or extrinsic
- Ileus can be reflexic due to inflammation or as response to handling
- Ileus can be intrinsic due to neurologic or muscular dysfunction (diabetes, Ogilvie’s syndrome, etc.)

Treatment & documentation will be key, while applying the coding guidelines of reportable diagnoses.

Clinical Knowledge - Postoperative Anemia

Anemia that occurs in relation to an operation can have four perspectives:
- It was present prior to the surgery and has no relation to the surgery at all
- It was present due to the disease process that led to the surgery with minimal blood loss at the operation (check documentation)
- It resulted because of the character of the operation and occurs in virtually every similar case
- It occurred because of an event that happened during the surgery that led to excessive blood loss, such as tear of a vein or spleen
- Watch the hgb/ hct before and after surgery
Clinical Knowledge - Postoperative Wound Infection

Frequently in abdominal or orthopedic surgery - post trauma or infection
Redness at/ around the wound site, swelling, warm to touch, increased pain at surgical site, fever, also can include increased WBCs
MAY NEED TO QUERY THE PHYSICIAN FOR CLARIFICATION

Dehiscence: separation of wound edges that had been closed - may be superficial (skin and subq) or deep to or through fascia
Evisceration: dehiscence through fascia so that deep structures (lung, intestine) are exposed
Either may be due to infection but are usually due to suturing technique or failure

996.x Complications peculiar to certain specified procedures

- In ICD-9-CM 996.x classifies conditions that occur only because an internal device, implant, or graft is present. Complications of this type are classified first according to whether they are mechanical or nonmechanical in nature.
- A mechanical complication is one that results from a failure of the device, implant, or graft, such as displacement or malfunction.
Dislodged Joint Prosthesis (dislocation) - Coding

- Alpha look under “dislodged” - not there
- Then look under “device/implant” or “orthopedic” - not there
- Try “dislocation” in the alpha, Go down to - prosthesis, internal - see complications, mechanical
- Go to “device”, then to “prosthetic”, down to “joint” then “dislocation”
- 996.42 Dislocation prosthetic joint
- Tabular .............Mechanical complications of internal orthopedic devices, impact , and graft
  - Dislocation of prosthetic joint 996.42
    - Instability of prosthetic joint
    - Subluxation of prosthetic joint
Complications of a Transplant

- Assign 996.8x when:
  - The transplant organ is being rejected by the recipient
  - There are other complications or diseases of the transplanted organ
  - A pre-existing condition effects the function of the transplanted organ
  - A post-transplant medical condition affects the function of the transplanted organ

- Reference AHA Coding Clinic guidance:
  - 1998 - 3 Qtr, pgs 3-7
  - 2003 - 1 Qtr, pgs 10-11
  - 2006 - 4 Qtr, pgs 180-200

997.x Complications affecting specified body systems, not elsewhere classified

- ICD-9-CM Category 997, Complications affecting specified body systems, not elsewhere classified, are general in nature and offer little specificity.
- These codes are not assigned when the Alphabetic Index provides another code, and they should not be assigned without specific documentation by the physician that the condition is a complication of the surgery.
Postoperative CVA - Coding

- Alpha go to “postoperative CVA”
- Caution - MD documentation really must state that the condition is due to the procedure

See: Coding Clinic 1st Qtr 2005, pg 48-49

997.02 Iatrogenic cerebrovascular infarction or hemorrhage

- Sometimes instructions to use an additional code to the 997.x, check the index carefully
998.x Other complications of surgery, not elsewhere classified

Codes in the 998.x series are used/assigned to classify a miscellaneous group of postoperative complications.

Often additional codes are not required because the complication code itself provides sufficient specificity.

Note that if the infection is due to a device, the 998 code is primary or principal diagnosis always, unless it occurs after admission.
ICD-9-CM Postoperative Anemia

• Postoperative anemia is rarely considered to be a complication of surgery.
• When the physician documents postoperative anemia, without specification of acute blood loss, assign 285.9 code Only assign 285.1, Acute posthemorrhagic anemia, when it is documented as due to blood
• No complication code is assigned unless the physician documents excessive bleeding as a complication.
• The fact that blood is administered during a surgical procedure does not indicate a postoperative anemia. Transfusions are sometimes given as a prophylactic replacement in order to avoid postoperative anemia. Anemia is not assigned solely because the patient received a transfusion; the physician must document the condition. (Source: Faye Brown)

ICD-9-CM Postoperative Anemia (con't)

• Code 998.11 Hemorrhage complicating a procedure, and add 285.1 if documented as a complication
• Must state it’s due to blood loss or the code is 285.9
• Revisions were made in the alpha index in 2004...
Indexing the Term …

“Anemia Postoperative” In the Alpha......Anemia 285.9

• There is the term in the alpha index for “Anemia postoperative”
  • However, “Posthemorrhagic Anemia” is listed also
   - posthemorrhagic (chronic) 280.0
     • in the tabular: secondary to blood loss anemia NOS = 280.0
   - acute 285.1
   - newborn 776.5
   - Postoperative
     due to blood loss 285.1
     other 285.9

• There needs to be a documentation “link” to the due to blood loss

• The coder would need to query the physician for clarification of
  the diagnosis, if no further documentation is present

999.x Complications of medical care

Complications of medical care in the 999.x series is used to capture a number
of specific conditions that may occur following almost any type of procedure.
Transfusion Reaction

- “Post blood transfusion reaction with hives”
- Alpha go to -Transfusion... reaction or complication see complication transfusion
  - Complication transfusion 999.8
  - Look in tabular under 999.8
  - = 999.8 Transfusion Reaction
- Add a code for the specific reaction ie. Hives = 708.9 (Hives NOS)
Definition for Reporting/Documenting Secondary or Other Diagnosis

- Conditions that affected patient care in terms of requiring:
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended the length of stay; or
  - increased nursing care and/or monitoring

- Document all conditions/diagnoses

Also: Coding guidelines state “... all conditions that coexist at the of admission, that develops 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 hospital stay are to be excluded”

IF IT’S NOT DOCUMENTED, WE CANNOT CODE IT!

- Acidosis
- Alcoholism
- Anemia due to blood loss
- Angina
- Atelectasis
- Atrial Fibrillation
- Atrial Flutter
- Cachexia
- Convulsions
- CHF
- COPD
- Decubitus Ulcers
- Dehydration
- Diabetes, out of control
- Drug Use, Abuse, Dependency
- Epilepsy
- Hematemesis
- Hennaturia
- Hypernatremia
- Hyponatremia
- Ileus
- Malnutrition
- Mela
- Metastasis (specify site)
- Pancreatitis
- Paroxysmal Supraventricular Tachycardia
- Paroxysmal Ventricular Tachycardia
- Pathological Fractures
- Phlebitis
- Pleural Effusion
- Pneumonia
- Pneumothorax
- Renal Failure (acute/chronic)
- Renal Insufficiency (acute/chronic)
- Thrombophlebitis
- Urinary Obstruction
- Urinary Retention
- Urinary Tract Infection
- Ventricular Fibrillation
- Ventricular Flutter

Thank you for your help!
Polling Question #2

Are you aware that CMS will be implementing at least two ICD-9-CM diagnosis codes within POA reporting and these could impact your DRG reimbursement?

* 1 Yes
* 2 No
* 3 Don’t Know

Data Collection via POA

• POA was approved due to the increased concern with healthcare quality and payment being increased (via DRGs) when a complication occurred that the hospital was responsible for.
  • Better tracking of hospital acquired infections, accidents and adverse events
• A patient is admitted to the hospital for a coronary artery bypass surgery. Postoperatively he developed a pulmonary embolism.
  • Assign “N” on the POA field for the pulmonary embolism. This is an acute condition that was not present on admission
Present On Admission Indicator Definitions

- **Y = Yes**
  Condition is present at the time of inpatient admission
- **N = No**
  Condition not present at the time of inpatient admission
- **U = Unknown**
  Documentation is insufficient to determine if the condition is present on admission
- **W = Clinically Undetermined**
  The provider is unable to clinically determine whether condition was present on admission or not
- **Unreported/ Not Used – Exempt from POA reporting**
  This option is the only circumstance in which the POA field is left blank. The condition needs to be on the list of ICD-9-CM codes for which this field is not applicable.

Case Example #1

What is the correct ICD-9-CM diagnosis code(s) for the diagnosis of postoperative Ileus?

A. 997.4 Digestive System Complication, NOS
B. 997.4 Digestive System Complication, NOS and 560.1 Paralytic Ileus
C. 560.1 Paralytic Ileus
D. None of the above
Case Example #2

What is the correct ICD-9-CM diagnosis code for bone marrow transplant complication?

A. 996.84  
B. 996.89  
C. 997.2  
D. 996.85  
E. A and B

Case Example #3

What is the correct ICD-9-CM diagnosis code for sepsis due to a Foley catheter?

A. 038.9, 995.90  
B. 038.9 and 997.2  
C. 998.59  
D. 998.59 and 038.9  
E. none of the above
Case Example #4

What is the correct ICD-9-CM diagnosis code for Hematoma following breast biopsy?

A. 922.0  
B. 998.12  
C. 998.11  
D. 996.70  
E. 998.12 and 996.70

Don’t be Encoder Dependent

- Coders need to review carefully the final code that the encoder software is providing
- Use your ICD-9-CM code book
  - Alpha and Tabular
- Documentation must be supported for the assignment of the code.
- Coding from memory is dangerous
  - Coding guidelines change - Quarterly Coding Clinic
ICD-9-CM Reporting: Complications of Care

Never Events – IPPS and POA Impact

1. CMS releases proposed inpatient rule

The Centers for Medicare & Medicaid Services late this afternoon put on display its hospital inpatient prospective payment system proposed rule for fiscal year 2008. In the rule, CMS announced the mandated full market basket update of 3.3% for hospitals that report quality data. CMS also proposes creating 746 new Medicare Severity diagnosis-related groups to replace the current 538 DRGs and lowering the outlier threshold from $23,015 to $24,465 in FY 2007. In addition, the proposed rule includes a 2.4% cut in both FY 2008 and 2009 to eliminate what they claim will be the effect of coding or classification changes that the agency claims do not reflect real changes in case mix. AHA Senior Vice President for Federal Relations Tom Nickels said, "The AHA is opposed to this nearly $5 billion reduction in payments, which we do not believe is warranted." The rule also proposes eliminating the capital update for urban hospitals and the large urban add-on to capital payments. CMS also is considering discontinuing the teaching and disproportionate share hospital adjustments to capital payments. Comments on the proposed rule will be accepted until June 12, and a final rule, which will take effect on October 1, will be published later this summer. The AHA is reviewing the proposed rule and will send members a Special Bulletin summarizing the specifics of the rule on Monday.

"Never Events" – IPPS and POA Impact

- The CMS IPPS 13 proposed conditions (and their ICD-9-CM codes) include:
  - Catheter-associated urinary tract infection (996.64 and various urinary tract infection codes)
  - Pressure sores (707.00-707.09)
  - Object left in surgery (998.4)
  - Air embolism (999.1)
  - Delivery of ABO-incompatible blood products (999.1)
  - Staphylococcus aureus septicemia (038.11)
  - Ventilator-associated pneumonia (999.9 + pneumonia code)
  - Vascular catheter-associated infection (996.62)
  - Clostridium difficile-associated disease (008.45)
  - Methicillin-resistant staphylococcus aureus infection (V09.0)
  - Surgical site infections (998.59)
  - Surgery on wrong body part, patient, or wrong surgery (E876.5)
  - Patient falls (no code)

CMS is seeking public comment to determine which of these measures (at least two) to implement for 2008.
Summary

- Regulations require healthcare providers to capture all clinical data with new emphasis on complication “never events”
- Clinical documentation is at the center
- Linkage of documentation to the coding and payment systems continues
- There is a linkage to Quality measures and scorecards of performance from documentation and coding
- Coding rules and guidelines

Next Steps

- Additional education - specific and one-on-one?
- Shadowing while on rounds?
- Reaudit documentation and coding
  - Audit POA reporting
- Use your books!
- Review current documentation forms - make revisions and improvement (capture clinical data)
- Talk with your HIM Coding staff
- Have a Discussion with Physicians
  - Increase your clinical knowledge
References and Resources

- Medicare Hospital Manual
- Federal Register, CMS, HHS
- Medicare Customer Service Department 1-877-567-3094
- AHA Coding Clinic
- 3M Encoder
- Faye Brown ICD-9-CM Handbook
- Web Med (eMedicine)

Audience Questions
Appendix - Competencies

A. DATA IDENTIFICATION

1. Read and interpret health record documentation to identify all diagnoses and procedures that affect the current inpatient stay/outpatient encounter visit.
2. Assess the adequacy of health record documentation to ensure that it supports all diagnoses and procedures to which codes are assigned.
3. Apply knowledge of anatomy and physiology, clinical disease processes, pharmacology, and diagnostic and procedural terminology to assign accurate codes to diagnoses and procedures.
4. Apply knowledge of disease processes and surgical procedures to assign nonindexed medical terms to the appropriate class in the classification/nomenclature system.

B. CODING GUIDELINES

1. Apply knowledge of current approved ICD-9-CM Coding Guidelines* to assign and sequence the correct diagnosis and procedure codes for hospital inpatient services.
2. Apply knowledge of current Diagnostic Coding and Reporting Guidelines for Outpatient Services.*
3. Apply knowledge of CPT format, guidelines, and notes to locate the correct codes for all services and procedures performed during the encounter/visit and sequence them correctly.
4. Apply knowledge of procedural terminology to recognize when an unlisted procedure code must be used in CPT.

C. REGULATORY GUIDELINES

1. Apply Uniform Hospital Discharge Data Set (UHDDS) definitions to select the principal diagnosis, principal procedure, complications, comorbid conditions, other diagnoses, and significant procedures which require coding.
2. Select the appropriate principal diagnosis for episodes of care in which determination of principal diagnosis is not clear because the patient has multiple problems.
3. Apply knowledge of the Prospective Payment System to confirm DRG assignment which ensures optimal reimbursement.
4. Refuse to fraudulently maximize reimbursement by assigning codes that do not conform to approved coding principles/guidelines.
5. Refuse to unfairly maximize reimbursement by unbundling services and codes that do not conform to CPT basic coding principles.
6. Apply knowledge of the Ambulatory Surgery Center Payment Groups to confirm ASC assignment, which ensures optimal reimbursement.
7. Apply policies and procedures on health record documentation, coding and claims processing, and appeal.
8. Use the HCFA Common Procedural Coding System (HCPCS) to appropriately assign HCPCS codes for outpatient Medicare.
Appendix - Competencies

D. CODING
1. Exclude from coding diagnoses, conditions, problems, and procedures related to an earlier episode of care that have no bearing on the current episode of care.
2. Exclude from coding ICD-9-CM nonsurgical, noninvasive procedures which carry no operative or anesthetic risk.
3. Exclude from coding information such as symptoms or signs characteristic of the diagnosis, findings from diagnostic studies, or localized conditions, which have no bearing on the current management of the patient.
4. Apply knowledge of ICD-9-CM instructional notations and conventions to locate and assign the correct diagnostic and procedural codes and sequence them correctly.
5. Facilitate data retrieval by recognizing when more than one code is required to adequately classify a given condition.

Exclude from coding those procedures that are component parts of an already assigned CPT procedure code.

E. DATA QUALITY
1. Clarify conflicting, ambiguous, or nonspecific information appearing in a health record by consulting the appropriate physician.
2. Participate in quality assessment to ensure continuous improvement in ICD-9-CM and CPT coding and collection of quality health data.
3. Demonstrate ability to recognize potential coding quality issues from an array of data.
4. Apply policies and procedures on health record documentation and coding that are consistent with Official Coding Guidelines.*
5. Contribute to development of facility specific coding policies and procedures.

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  • June 14, 2007
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