


Reporting Accurate Codes
In the Era of Recovery Audit Contractor Reviews
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The Official Guidelines for coding and reporting using ICD-9-CM


- A set of rules that have been developed to accompany and complement the official conventions and instructions provided within ICD-9-CM itself
- Adherence to the Guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under HIPAA
- The guidelines for diagnosis coding have been adopted under HIPAA for all healthcare settings



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The Official Guidelines for coding and reporting using ICD-9-CM

- Volume 3 procedure codes have been adopted for inpatient reporting by hospitals by HIPAA
- The Guidelines have been approved by the 4 organizations that make up the cooperating parties:
 - AHA
 - AHIMA
 - CMS
 - NCHS (National Center for Health Statistics)



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The Official Guidelines for coding and reporting using ICD-9-CM

- The Official Guidelines are the first line of justification to support code assignment, along with official conventions and instructions within ICD-9-CM
- Make it a practice to review the Alphabetical and Tabular lists on a regular basis. (i.e. don't always assign codes from memory or the encoder)
- Review the "excludes" notes frequently



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Principal Diagnosis code assignment

- Definition of the Principal Diagnosis:
 - "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the (inpatient) hospital for care"
 - The circumstances of admission, the diagnostic approach, and the treatment rendered factor into the principal diagnosis selection
 - ICD-9-CM sequencing rules prevail



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Reporting Other Diagnoses

- Reporting "other diagnoses" that affect patient care in terms of requiring:
 - Clinical evaluation; or
 - Therapeutic treatment; or
 - Diagnostic procedures; or
 - Extended length of hospital stay; or
 - Increased nursing care and/or monitoring
 - Has implications for future healthcare needs (newborns only)



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Definition of Other Diagnoses

- The UHDDS defines "other 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 hospital stay are to be excluded."



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Reporting Other Diagnoses

- The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-9-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.



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Reporting Previous Conditions

- **Previous conditions**
 - If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.



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Reporting Previous Conditions

- However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
- Status post codes may also be assigned if hospital policy is established.



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Uncertain diagnoses

■ C. Uncertain Diagnosis

- If the diagnosis documented **at the time of discharge** is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The basis for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

- **Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals**



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Coding Abnormal Findings

- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported **unless the provider indicates their clinical significance.** If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

- **Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider**



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Coding Abnormal Findings

- Diagnoses on Pathology reports should be substantiated by the Attending Physician
- There are many “incidental diagnoses” noted on Pathology reports (i.e. chronic cervicitis) which are typically not pertinent
- Request an addendum to Discharge Summaries to note significant pathologic diagnoses



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AHA Coding Clinic for ICD-9-CM

- Coding Clinic is recognized by CMS as an official source of coding guidance.
- During the RAC demonstration project there were many denials overturned when the documentation from Coding Clinic was provided with the appeal.
- Published on a quarterly basis – be sure to review each edition for issues pertinent to your facility.



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Coding Abnormal Findings

- From Coding Clinic Third Quarter 2008
- Abnormal findings on the pathology report are not coded and reported unless the provider indicates their clinical significance. “This ensures that the documentation and the codes reported are consistent with the attending physician's interpretation since he or she is responsible for the clinical management of the case. It is the responsibility of the attending physician to gather and collate all of the findings from the consultants and other providers involved in the care of the patient.”



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Coding Chronic Conditions

- Coding Clinic, 3rd Quarter, 2007 – Chronic conditions
 - Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization.



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Coding Chronic Conditions

- What may be challenged in coding chronic conditions will be the Past Medical History diagnoses documentation without indication of the current status of those conditions
- Coders typically “match up” diagnoses with current medications.



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Coding Chronic Conditions

From Coding Clinic, Third Quarter 2008

- Question:
 - Upon review of the patient's past medical history, we noted that the patient occasionally uses a medication. No diagnosis or condition is documented related to this medication and the patient does not receive this medication during the hospital stay. Is it appropriate to query the physician to determine the diagnosis for which the medication has been prescribed? For example, the patient is on Viagra, can we query the physician for autonomic neuropathy?



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Coding Chronic Conditions

■ Answer:

- “No, the fact that a patient has used a particular medication in the past should not trigger a query in the absence of other information in the medical record indicating the clinical significance of the underlying diagnosis. It would not be appropriate to query on the basis of a medication that has been taken in the past, but is not taken during the hospitalization.”



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Coding Chronic Conditions

- “All coded diagnoses should be based on the provider’s documentation and should meet the definition of a reportable additional diagnosis as outlined in the Official Guidelines for Coding and Reporting.

A condition that does not meet this definition should not be reported. **On the other hand, if the patient has been receiving a medication for some time and continues to receive this treatment during the hospital stay/encounter, it may be appropriate to query the provider for clarification.** “



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Short stays

- Short stays should be reviewed on a regular basis for:

- Medical Necessity
- Appropriateness of the right service (i.e. IP versus Observation)
- Thoroughness of provider documentation
- Coding accuracy



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Short stays

- Provider documentation and the subsequent assigned codes must reflect the medical necessity of the admission.
- Code all pertinent diagnosis, including indications for any diagnostic studies which are performed.
- CT ordered and performed for abdominal pain.
 - If the study is negative, assign an abdominal pain code.
 - If the study has positive findings, make sure the provider has documented a diagnosis and a code assigned.



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Provider Documentation

- If there are diagnoses that are not supported in the medical record -
 - Query the provider for further documentation when:
 - i.e. Final Diagnosis of Dehydration
 - H&P does not document poor skin turgor, dry mucous membranes, or decreased intake/output
 - Electrolyte levels are normal
 - Progress notes are not well documented



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Provider Documentation

- If your providers are difficult to approach on clinical documentation issues, enlist the support of the Utilization Review nurse or Quality Improvement nursing personnel.
- Share coding guidelines and Coding Clinic advice with the providers to support the need for further documentation to assign codes.



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Provider Documentation

- Obtain copies of clinic notes and diagnostic tests performed pertinent to the circumstances of this admission (i.e. clinic visit which resulted in admission to the hospital).



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Provider Documentation

- Assure all tests are ordered and present on the record
- Positive test results should be addressed by the provider
- Records should not be coded until all pertinent test results are available to provide the most accurately assigned codes
- Query the provider to note the abnormal test results and provide a diagnosis if pertinent



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Outpatient Coding

- May be the arena with the highest scrutiny by the Recovery Audit Contractor in the Critical Access Hospitals.
- High utilization of expensive testing in the Emergency Department and outpatient tests may be noticed in the statistical analysis of your facility.



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CPT®

- CPT® is a billing based coding system
- The procedure performed should match the description of the code exactly
- Use unlisted codes when there is not a code available to accurately describe the procedure performed



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CPT®

- CPT® has been adopted for outpatient procedure reporting by hospitals and physicians by HIPAA.
- *CPT Assistant* is accepted as the official coding guidelines for outpatient procedure reporting.



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Modifier -59

- The Office of Inspector General (OIG) has identified errors in billing involving modifier -59. Use of this modifier is widespread and, in their study, 40% of the services billed with the modifier did not meet program requirements. It is therefore important for providers to be knowledgeable about these requirements so that services are billed appropriately by the provider and paid correctly by the MAC.



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Modifier -59

- According to the CPT® book, Appendix A, modifier -59 represents a distinct procedural service.
- Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.



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Modifier -59

- This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.



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Modifier -59

- Per the *Medicare Claims Processing Manual*, when correct coding edits indicate a modifier may be utilized, "the secondary, additional, or lesser procedure(s) or service(s)" (the code in the second column in the edits) "must be identified by adding the modifier '-59'."



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Modifier -59

- Per Section 1833(e) of the Social Security Act, providers must furnish "such information as may be necessary in order to determine the amounts due" to receive Medicare payment. Documentation is a very important part of the use of modifier -59.



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Outpatient Coding

- Assure an accurate order and diagnosis are present for all outpatient tests prior to the test performance.
- Is medical necessity present?
- If not, contact the provider for documentation to be forwarded to the hospital and filed in the medical record to document medical necessity.



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Outpatient Coding

- Outpatient ICD-9-CM coding guidelines allow codes to be assigned from physician interpretation (i.e. pathologist, radiologist) of the diagnostic test.



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Outpatient Coding

- “For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses. “



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Outpatient Coding

- **Uncertain diagnosis**
- Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
- **Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.**



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Outpatient Surgery

- When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.
- The Pathologists interpretation may be coded as long as it is clear and concise.



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Observation

- There must be a dated and timed provider order which specifically states “admit to observation care.”
- Nursing documentation must support the need for continued observation.
- The provider discharge order must be dated and timed.



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Infusions in Observation

- Codes for infusions and injections may be assigned during the observation care period.
- Only one “initial” infusion or injection may be assigned for the entire outpatient encounter.
 - If the patient is admitted through the Emergency Department, the encounter includes the Emergency Department through the discharge from Observation.



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Infusions

- If two separate IV sites are medically reasonable and necessary (use modifier 59).
- If the patient returns for separate and medically reasonable and necessary visit (encounter) on the same day, another initial code may be billed for that visit with modifier 59.



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Infusions

- Many payers and “experts” state only infusions with medications or therapeutic substances added should be assigned the infusion codes.
- All other IV infusions should be assigned hydration codes.



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Infusions in Observation

- Units of service are billed on a daily basis
 - Additional hours of hydration billed each day with the appropriate number of units to reflect the hours.
 - If you have billed additional hours of hydration greater than 8 hours and your claims have been RTPd with reason code 31715 (medically unlikely edit) attempt to rebill, as these hours were denied in error.



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Interrupted Observation

- From the Medicare Claims Processing Manual, Chapter 4, Section 290, subsections dealing with Observation Services
 - “Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).”



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Interrupted Observation

- “In situations where such a procedure interrupts observation services, hospitals would record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378.”



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Interrupted Observation

- It has been noted in reviews which have already taken place, a RAC has interpreted this statement to include infusion services; i.e. the hours of infusion should be carved out of the number of observation hours reported.



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Physician Queries

- Physicians should be queried whenever there is conflicting, ambiguous, or incomplete information in the medical record regarding any significant reportable condition or procedure.
- Do not query on insignificant or irrelevant findings – you will only annoy them!



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Physician Queries

- Use such terminology as:
- *Please clarify in your progress notes or discharge summary if there is a link between the acute gastrointestinal bleed and the new anemia (hemoglobin drop from 14 to 8.9). This will help us to assign a code that will properly reflect the underlying cause of the anemia.*



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Physician Queries

- Only query when the condition meets the criteria of a reportable diagnosis – i.e. it was treated, monitored, increased nursing resources, or prolonged the patient's stay.
- The provider must update the patient record to reflect their response to the query.
- To Keep or Not to Keep (the query form). It may be filed at the back of the record. The record however, needs to stand alone.



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Questions?

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