

AHIMA THOUGHT LEADERSHIP SERIES

Defining the Core Clinical Documentation Set

for Coding Compliance

It is time to examine coding compliance policy and test it against the upcoming challenges in clinical documentation and associated coding the health information management (HIM) professional staff in your organization will face in 2013 and 2014. Whether your medical record is paper-based, electronic, or hybrid, a high-integrity coding compliance policy should be written and updated at least once per year as part of an information governance framework. This paper offers guidance on identifying key source documents and clinical documentation that make up the core designated clinical documentation set. A core designated clinical documentation set for coding should be used as the key constant source of clinical documentation by coding professionals as they conduct all the medical coding for an organization.

An AHIMA position statement on the consistency of healthcare diagnostic and procedure coding notes, “The collection of accurate and complete coded data is critical to healthcare delivery, research, public reporting, reimbursement, and policy-making. The integrity of coded data and the ability to turn it into functional information requires all users to consistently apply the same official coding rules, conventions, guidelines, and definitions (the basis of coding standards). Use of uniform coding standards reduces administrative costs, enhances data quality and integrity, and improves decision-making—all of which leads to quality healthcare delivery and information. For the United States to maintain quality data and information, coding standards must be consistently required, promoted, and uniformly applied across sites of service. AHIMA coding professionals are educated and certified to ethically apply and utilize national uniform coding standards to support these data quality, analysis, and maintenance functions. Complete, clear, and accurate health record documentation is the foundation for complete and accurate coding. Therefore, this documentation, whether electronic or paper-based, must be clear, accurate, complete, and timely in order to produce quality coded data.”¹

To meet the spirit of the position statement, all HIM coding professionals must understand and adhere to the principle of reporting only the codes that are clearly and consistently supported by authenticated clinical documentation in accordance with code set rules and guidelines. Organizations using diagnosis and procedure codes to report healthcare services must have formal policies and corresponding procedures in place that provide instruction on the entire process—from the point of service to the billing statement or claim form. Coding compliance policies serve as a guide to performing coding and billing functions and provide documentation of the organization’s intent to correctly report services.

According to AHIMA’s updated practice brief on developing a coding compliance policy document, a coding compliance plan should include the following:

- » General policy statement about the commitment of the organization to correctly assign and report codes
- » The source of the official coding guidelines used to direct code selection
- » The parties delegated with responsibility for code assignment
- » The procedure to follow when the clinical information is not clear enough to assign the correct code
- » Specification of the policies and procedures that apply to specific locations and care settings. Official coding guidelines for inpatient reporting and outpatient or physician reporting are different. This means an organization that is developing a facility-specific coding guideline for emergency department services should designate that the coding rules or guidelines that apply only in this setting.
- » Applicable reporting requirements required by specific agencies. The document should include where instructions on payer-specific requirements may be accessed.

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- » Procedures for correction of inaccurate code assignments in the clinical database and to the agencies where the codes have been reported
- » Areas of risk that have been identified through audits or monitoring. Each organization should have a defined audit plan for code accuracy and consistency review, and corrective actions should be outlined for problems that are identified.
- » Identification of essential coding resources available to and used by coding professionals
- » A process for coding new procedures or unusual diagnoses
- » A procedure to identify any optional codes gathered for statistical purposes by the facility and clarification of the appropriate use of E codes
- » Appropriate methods for resolving coding or documentation disputes with physicians
- » A procedure for processing claim rejections
- » A statement clarifying that codes will not be assigned, modified, or excluded solely for the purpose of maximizing reimbursement or avoiding reduced payment. Clinical codes will not be changed or amended merely because of either physicians' or patients' request to have the service in question covered by insurance. If the initial code assignment did not reflect the actual services, codes may be revised on the basis of supporting documentation.
- » The use of and reliance on encoders within the organization. Coding staff cannot rely solely on computerized encoders. Current coding manuals must be readily accessible, and the staff must be educated appropriately to detect inappropriate logic or errors in encoding software. When errors in logic or code crosswalks are discovered, they are reported to the vendor immediately by the coding supervisor.
- » Medical records are analyzed and codes selected only with complete and appropriate physician documentation available. According to coding guidelines, codes are not assigned without supporting documentation from the provider. The guidelines also state that the entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.²

What has never been clearly and uniformly defined are the actual core medical record documents or clinical documentation that should be used as the core designated record and clinical documentation set for coding. Your coding compliance policy must identify medical record documents and clinical documentation that require a mandatory review by your coding staff or the outsourcing providers of coding for your organization.

All coders should review the following clinical documentation (specify the location in the paper medical record, hybrid, or EHRs) to identify all diagnoses and procedures requiring coding and to increase the accuracy and specificity of coding. There should be specific guidelines and tips for the coders to follow to be in compliance with your policy.

INPATIENT CODING

1. Face sheet (may be referred to by another name in your organization) code diagnoses and complications appearing on the face sheet. Patient face sheets in an EHR are easier to use now to get the information you need for coding. A face sheet in an EHR is one convenient location to see both chronic and acute diagnoses, prescriptions, and drug allergies for each patient.
2. Progress notes: to detect complications and/or secondary diagnoses for which the patient was treated and/or procedures performed
3. History and Physical: to identify any additional conditions, such as history of cancer or a pacemaker in situ. These conditions should be coded.
4. Discharge summary: read if available and compare listed diagnoses with face sheet. Code diagnoses and procedures are listed on discharge summary but not specified on face sheet.



5. Consultation report: to detect additional diagnoses or complications for which the patient was treated
6. Operative reports: scan to identify additional procedures requiring coding
7. Pathology reports: review to confirm or obtain more detail (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical documentation with the attending physician).
8. Laboratory: use reports as guides to identify diagnoses (for example types of infections) or more detail (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical documentation with the attending physician).
9. Radiology: use reports as guides to identify diagnoses or more detail (for example type of fracture) (note: coder must continue to verify and obtain confirmation of any diagnoses from this clinical documentation with the attending physician).
10. Physician's orders: to detect treatment for unlisted diagnoses, the administration of insulin, antibiotics, sulfonamides (may indicate treatment of diabetes), and respiratory or urinary infections that should be confirmed by the coder
11. Nutritional assessments

OUTPATIENT CODING

For accurate reporting of ICD-9-CM diagnosis codes today and for ICD-10 in the future, the clinical documentation should describe the patient's condition, using terminology that includes specific diagnoses as well as symptoms, problems, or reasons for the encounter, an authenticated physician order for services, reason the service was ordered, and test results.

The clinical documentation or source document/documentation referred to by the coder should describe the patient's condition using terminology that includes specific diagnoses, as well as symptoms, problems, or reasons for the service.

Examples of clinical documentation to consider including in your outpatient coding compliance policy include:

1. An authenticated physician order for services
2. Clinician visit notes
3. A diagnosis or the reason the service was ordered
4. Test results (note: coders should not be coding from all test results in the outpatient setting; they are allowed to code from test reports that have a physician interpretation and are authenticated by the attending physician.)
5. Therapies
6. A problem list
7. Medication list

Outpatient Diagnostic Services: For patients receiving diagnostic services only during an encounter/visit, coders are reviewing the documentation for the diagnosis, 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. These should be found in the encounter and diagnostic documents and physician interpretation reports and there should be specific guidelines and tips for the coders to follow to be in compliance with your policy.

Outpatient Therapeutic Services: For patients receiving therapeutic services only during an encounter/visit, the coder is reviewing the medical record for the diagnosis, condition, problem, or other reason for encounter/visit documented in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. As with outpatient diagnostic services, there should be specific guidelines and tips for the coders to follow to be in compliance with your policy.



OUTPATIENT OR AMBULATORY SURGERY

For ambulatory surgery, coders review the authenticated clinical documentation for 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, the coders must review the history and physical examination, pre-operative report, operative report, anesthesia record, progress notes, face sheet, and encounter summary. There should be specific guidelines and tips for the coders to follow to be in compliance with your policy.

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

OBSERVATION RECORD

Coders must review, but should not be limited to, the following authenticated clinical documentation in the medical record:

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

EMERGENCY DEPARTMENT CODING

Coders must review, but should not be limited to, the following authenticated clinical documentation information in the emergency department medical record:

1. Emergency department report
2. Initial encounter physician documentation, including incident event description, chief complaint, clinical history, and physical examination
3. Diagnostic interventions
4. Treatment interventions
5. Nursing notes
6. Physician's orders
7. Progress notes with principal diagnosis

COMPUTER-ASSISTED CODING

AHIMA defines CAC as "...the use of computer software that automatically generates a set of medical codes for review, validation, and use based upon clinical documentation provided by healthcare practitioners."³ Computer-assisted coding (CAC) is a term most hospital executives and HIM professionals are exploring, but it continues to be an unknown technology.

Among the many long-term benefits promised by a well-planned and well-executed CAC solution are improved coder productivity, coding accuracy, data integrity, coding compliance, physician relations, and coder retention.

Identifying your core designated clinical documentation or record set for is essential not only for coding compliance; it is key to building your roadmap to the transition to a technology-enabled coding process or CAC. In a CAC environment, the encounter or



inpatient discharge case has initial codes available to review, even when all the core designated clinical documentation or documents required for quality code assignment are not yet available. With CAC systems, coding professionals can set a flag that holds a record for a specific document or clinical documentation (that is, pathology report is missing). When the appropriate clinical documentation is available and entered in the system, an alert is sent to the coding professional for final review and approval.

The critical success factor with building efficiency and accuracy into your CAC is creating your core coding designated clinical documentation or record set. Regardless of the CAC vendor, the HIM team must create and designate the data sources required for a coding compliance program. It is the HIM professional who advises the vendor as to which documents or clinical documentation are to be used in the CAC for accurate and compliant discharge clinical coding. With its inherent ability to improve data capture and integrity, CAC represents an exciting future for enhancing clinical coding compliance. The challenge now is to ensure your organization is asking the right questions and putting the right technology in place to support and leverage the long-term benefits.

SUMMARY

A coding compliance policy is essential to your organization's overall compliance program. The four key areas where you will rely on your coding compliance policy are:

1. Coding: Organizations using diagnosis and procedure codes to report healthcare services must have formal policies and corresponding procedures in place that provide instruction on the entire process—from the point of service to the billing statement or claim form.
2. Coding audits: Coding compliance policies serve as a guide to performing coding and billing functions and provide documentation of the organization's intent to correctly report services.
3. Outsourcing coding work: Policies should include facility-specific documentation requirements, payer regulations and policies, and contractual arrangements for coding consultants and outsourcing services. The outsourcing vendor does not tell you what documents they will use to code your encounters; you, the HIM professional, are in charge of this process and should have your outsourcing partner follow your best practice or coding compliance policy.
4. Computer-assisted coding: In selecting a business partner to build a technology enabled coding process, use and provide your coding compliance policy for your vendor to create a customized and trained CAC solution for you. You do not need to load your entire EHR into a CAC system when you have already identified your core designated clinical documentation or record set that is the foundation of your clinical coding compliance.

NOTES

1. "Statement on Consistency of Healthcare Diagnostic and Procedural Coding." AHIMA Position Statement, December 2007. Available in the HIM Body of Knowledge at ahima.org.
2. AHIMA. "Developing a Coding Compliance Policy Document (Updated)." *Journal of AHIMA* (Updated March 2010). Available at ahima.org.
3. AHIMA e-HIM Work Group on Computer-assisted Coding. "Delving into Computer-assisted Coding." *Journal of AHIMA* 75, no. 10 (Nov–Dec. 2004): 48A–H. Available at www.ahima.org.

“It is the HIM professional who advises the vendor as to which documents or clinical documentation are to be used in the CAC for accurate and compliant discharge clinical coding.”



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