HAWAII HEALTH SYSTEMS C O R P O R A T I O N *"Touching Lives Everyday"* **Policies and Procedures**	***Quality Through Compliance***	**Policy No.:** **PAT 1002** **Revision No.:** N/A
	Issued by: Corporate Compliance Committee	**Effective Date:** September 15, 2000
Subject: ***Medical Records: Coding and Documentation for Outpatient Services***	**Approved by:** Thomas M. Driskill, Jr. President & CEO	**Supersedes Policy:** N/A **Page:** 1 of 6

I. PURPOSE: 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.

II. POLICY: Hawaii Health Systems Corporation (HHSC) will follow the current guidelines for outpatient/physician diagnosis coding and reporting published in *AHA Coding Clinic*, 4th quarter, 1995, or the most current *AHA Coding Clinic Guidelines, and CPT Assistance*, as well as ICD-9 for diagnosis.

HHSC will apply the *Current Procedural Terminology* (CPT) coding conventions and general guidelines as published by the AMA for surgical and diagnostic procedure coding.

HCFA mandates the utilization of Level I (CPT) and Level II (National Medicare) HCPCS codes for Medicare patients. Level III HCPCS codes are created and maintained by the local Medicare carriers. It should be noted that Level III HCPCS codes may override Level I or Level II codes; therefore, it is critical to follow local carrier coding policies and procedures.

III. PROCEDURE: All individuals performing coding/claims processing of outpatient services must 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 which includes specific diagnoses or the symptoms, problems, or reasons for the encounter.

1. <u>The Diagnosis, Condition, Problem, Symptom, Injury, or Other Reason for the Encounter or Visit which is Chiefly Responsible for the Services Provided:</u>
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).

2. Documented Conditions that Coexist at the Time of the Encounter/Visit and Require or Affect Patient Care, Treatment or Management:
   Diagnoses that were previously treated and no longer exist should not be coded.

3. V Codes (V01.0-V82.9) may be used to code encounters for circumstances other than a disease, symptom, problem, or injury. For additional guidance on the use of V Codes, refer to *AHA Coding Clinic*, 4th qtr., 1996 as well as ICD-9.

4. Codes must be reported using the maximum number of digits required for that code. Three or four digit codes may be used only when they are not further subdivided.

5. Do not code diagnoses documented 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.

6. 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. Example: Complete blood count, liver profile for patient on methotrexate for rheumatoid arthritis; assign codes V 58.69, 714.0.

7. 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 V code is used for patients receiving chemotherapy, radiation therapy, or rehabilitation services followed by the problem or the diagnosis.

8. For patients receiving preoperative evaluations only, sequence a V code 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.

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

10. 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.

11. 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.

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 marked on the test requisition/order form or encounter form. It is important to review and update the ICD-9-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) Encounter form;
      (2) Required consents;
      (3) Physicians emergency documentation;
      (4) Nursing notes;
      (5) Test results;
      (6) Demographic information;
      (7) Treatment; and
      (8) 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-9-CM diagnosis codes and CPT or ICD-9-CM 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. Quality of Outpatient Coded Data:

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

2. Quality reviews should include review of the medical record or available documentation to determine accurate code assignment with subsequent comparison with the UB-92 or HCFA 1500 claim form to determine accurate billing. If applicable, these reviews should incorporate review of any encounter forms in use.

D. Review of Denials: Documentation should be maintained on claims denied in part or total due to discrepancies in coding.

E. Payer Coverage/Medical Necessity For Services: ICD-9-CM diagnosis and procedure codes 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. Currently, these procedures are included in the eight ASC payment groups.

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

F. Patient Accounting: A written policy must be developed with patient accounting which prohibits changing of codes by patient accounting personnel without review by the coder.

G. 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.

H. Compliance:

1. It is the responsibility of each facility's administration to ensure that this policy is applied by all individuals involved in coding/claims processing of outpatient services.

2. Employees that have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy should discuss these situations with their immediate supervisor to resolve the situation.