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Owner	Melissa Gomez: Director Clinical Coding/Record Quality Management
Area	Health Information Management
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References	HIM-034

Inpatient & Outpatient Coding Compliance Policy

I. Policy Purpose, Statement of Policy, and Policy Goals:

The purpose of this policy is to affirm the commitment of Erie County Medical Center Corporation (ECMCC) to coding practices that are consistent with the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting (the Official Coding Guidelines), advance the prevention of fraud and abuse, and further the mission of providing quality care to our patients. ECMCC is dedicated to providing health information that is complete and accurate and that reflects reasonable and necessary services performed by appropriately licensed medical professionals.

ECMCC must follow the most current and relevant official guidelines for coding and reporting diagnoses and procedures published in the Official Coding Guidelines and, where appropriate, the relevant guidelines published in the American Hospital Association (AHA) Coding Clinic for ICD-10-CM, and ICD-10 PCS (the AHA Coding Clinic). Diagnoses and procedures will be coded utilizing the International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification (ICD-10-CM & PCS), and/or other classification systems that may be required or updated thereafter (such as DSM IV for classification of psychiatric patients).

II. DEFINITIONS:

A. **"AHIMA"** means the American Health Information Management Association. AHIMA is the national organization for HIM professionals. In addition, AHIMA is one of the four "Cooperating

Parties for ICD-10-CM" along with CMS, NCHS and the AHA. The parties are responsible for establishing national ICD-10-CM/PCS guidelines (or principles).

B. **AHA Coding Clinic for ICD-10-CM & PCS (the AHA Coding Clinic)**: provides supplementary advice to the Official Coding Guidelines. It is approved by the four Cooperating Parties.

C. **Affected Individual** are individuals who are covered by ECMCC's Compliance program requirements. This includes employees, senior administrators, managers, contractors, governing body, volunteers, students and corporate officers.

D. **"HIM Coding"** means short-term or long-term acute hospital or ambulatory surgery center (ASC) based coding and abstracting of services for ECMCC, Terrace View, and all associated onsite and offsite locations for the purpose of claim submission. The Hospital/ASC HIM coding function includes assignment of any ICD-10-CM diagnosis (including the Present on Admission (POA) Indicator) or ICD-10-PCS procedure code, assignment of any CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding designated codes in this range approved by Coding Compliance to be placed in the Charge Description Master), designated HCPCS Level II Codes, designated HCPCS Modifiers, and designated CPT Category III codes.

E. **HIM Coder" or "Coder"** means a Hospital, ASC, market, regional, or Home Office Employee, contractor, subcontractor, agent, or other person who performs Hospital or ASC HIM coding. It also includes those employees or contractors involved indirectly, such as in a supervising or monitoring role, with the HIM coding.

F. **"Clinical Documentation Improvement" or "CDI"** means the entity-based process of reviewing patient records at the point of care and, as needed, working with treating physicians to assure that the clinical documentation in the legal health record most accurately reflects the patient's clinical condition and treatment provided.

G. **"Clinical Documentation Specialist" or "CDS"** means a Hospital, ASC, market, regional, or Home Office Employee, contractor, subcontractor, agent or other person who performs clinical documentation improvement duties. It also includes those employees or contractors involved indirectly, such as in a supervising, assisting or monitoring role, with clinical documentation improvement.

H. **CPT Assistant:** allows users to access archived issues of coding-related newsletters issued by the American Medical Association (AMA) from 1990 onward to help answer daily coding questions, stay apprised of changes and trends, train staff and validate coding to external sources.

I. **Current Procedural Terminology (CPT):** is a set of codes, descriptions and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code.

J. **Health Care Procedure Coding System (HCPCS)**: is the standard for hospital reporting of outpatient procedures and physician reporting.

K. **ICD-10-CM & ICD-10-PCS Official Guidelines for Coding and Reporting (the Official Coding Guidelines)**: are a set of rules that have been developed and approved by the four Cooperating Parties to accompany and complement the official conventions and instructions provided within the ICD-10- CM & ICD-10-PCS itself. These guidelines are based on the coding and sequencing instructions in ICD-10-CM for Hospitals and the ICD-10-PCS coding books, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM &

ICD-10-PCS, diagnoses and procedure codes is required under the Health Insurance Portability and Accountability Act. The four Cooperating Parties are the AHA, the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

L. **"Outpatient Procedure"** as used in this policy means any account with an HIM-assigned CPT procedure code to represent the "technical component" between 10020 and 69990 (excluding designated codes in this range approved by Coding Compliance to be placed in the Charge Description Master), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes. Note: accounts in this category are not limited to those procedures performed in the operating room.

III. POLICY:

A. **Coding Resources**

1. Coding resources are available to the appropriate coding staff, including the following: the Official Coding Guidelines, the AHA Coding Clinic, CPT Assistant and updated encoder software, including the appropriate version of all DRGs, including MS-DRG, APR-DRG and the APC grouper software, which includes CPT4 and NCCI edits. Updated ICD-10-CM & PCS, CPT4, and HCPCS Level II code books are used by all coding professionals.
2. ECMCC Coding Department must maintain a minimum set of required coding references and tools and make them available to coding staff to facilitate complete, consistent and accurate coding. Coding Managers must review these materials on an annual basis and, if necessary, update them.
3. Documentation of coding guidelines or coding requirements documentation are available to coding staff. Communication sign off to ensure all coders have received information. In addition, a resource folder is available to all coding staff on the G:Drive.
4. Coding Roundtable meetings held monthly.

B. **General Coding and Reporting Policies**

1. Any individual involved in HIM Coding must at all times adhere to the AHIMA Standards of Ethical Coding, Official Coding Guidelines as well as applicable Policies, and Coding Compliance Procedures, Processes, and Guidelines.
2. The Coder is expected to have and maintain specific expertise and demonstrate proficiency in the patient types and classifications system for which she/he is responsible.
3. The Coder is expected to receive and maintain certified coding credentials through an accrediting body. Maintenance of credentials is to be obtained through continuing education unit (CEU) programs to ensure coding professionals are current and up to date with reporting and coding changes, education and the health care industry. The number of CEUs required is based upon the type and number of certifications an individual has earned. A copy of updated certification is to be kept in the HR file for validation of the requirements.

4. The Coder must not report codes from previous encounters/coding summary sheets, non-physician or allied health practitioner documentation. The Coder must not report diagnosis based on previous discharge/visits, charges, registration lists, system generated reports, face sheets, electronic medical record nursing problem lists, or similar non-physician generated information. Documentation for each encounter must stand alone to justify medical necessity for services rendered for the encounter specific dates of service. To report a diagnosis the documentation within the legal health record must reflect all current diagnosis and treatments for that encounter dates of service.
5. The Coder must not report an abnormal finding unless the provider indicates its clinical significance. The Coder must continue to verify and obtain confirmation of any diagnosis from a Pathology or Radiology report with the attending physician.
6. The Coder must not interpret an abnormal finding on an ancillary report or non-invasive diagnostic test as a diagnostic statement.
7. The Coder must not report a diagnosis based on an up/down or other symbol that does not directly and unambiguously correlate to a narrative ICD-10-CM code description. If indicated, the Coder should report such findings to the Clinical Documentation Team for clarification regarding the clinical significance of the finding and/or meaning of the symbol.
8. All findings, problems or diagnosed must be tested, treated, or clinically evaluated to be a reportable condition.

IV. Procedure:

General Coding Procedures are as follows:

1. **Review of record** – Information regarding the patient's diagnosis and treatment is extracted from the patient record by clinical coding staff. Source documents for the purpose of coding include: discharge summary, history and physical, clinical progress notes, physician orders, operative report(s), consultation(s), ancillary reports/test results (radiology and laboratory), nutritional assessments, and other clinical related documentation. The Coder must undertake a thorough review of all applicable documentation to assess the quality of clinical documentation to determine the appropriate diagnosis and/or codes to be reported, in conjunction with all applicable Official Guidelines.
2. **Code Assignment Responsibility**
    1. For Part A records and outpatient records, coding staff is responsible for the assignment of the correct ICD-10-CM , ICD-10-PCS codes and CPT (when required) codes based on the source documentation in the medical record in accordance with the Official Coding Guidelines. For Part B records, providers are responsible for the assignment of the correct ICD-10-CM codes and CPT codes based on the source documentation in the medical record in accordance with the Official Coding Guidelines.
        a. This information is then translated into the appropriate ICD-10-CM diagnosis and procedures codes through the use of the hospital encoder and/or coding books.

a. The Coder acknowledges that electronic documents interfaced to a computer-assisted coding software system are facsimile representations only.

1. The Coder should validate final code reporting against source documents in the official legal health record to validate code assignment.
2. Any discrepancy potentially affecting code assignment regarding documentation should be reported to the Clinical Documentation Team for review.

3. **Present on Admission "POA"**

1. Coders must assign the Present on Admission (POA) indicators to all diagnoses that have been coded, subsequent to the assignment of the ICD-10-CM codes. The POA regulation applies only to inpatient records. Outpatient claims are excluded from submitting POA indicators.

4. **Specific Inpatient Reporting Policies**

1. For Inpatient reporting, the coder must at all times follow the Uniform Hospital Discharge Date Set (UHDDS) definitions for Principal Diagnosis, Additional Diagnosis and Principal Procedure. The Coder must specifically refer to Sections II and III of the ICD-10-CM Official Coding Guidelines for Coding and Reporting for additional information for Official guidance on the selection of Principal and Secondary Diagnosis.

a. 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."

b. Additional Diagnosis is defined by UHDDS 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.

c. An Inpatient Coder must not report abnormal findings, and/or interpret abnormal findings unless the provider indicates its clinical significance through documentation confirmation. Pathology reports are utilized by the Inpatient coder and reviewed to confirm or obtain more detail; the attending physician must verify and confirm the report findings in the legal health record to be considered a reportable condition. Laboratory and Radiology reports are utilized by the Inpatient Coder as guides to identify diagnoses and provide more detail; the attending physician must verify and confirm the findings in the legal health record to be considered a reportable condition.

d. Principal Procedure is defined by UHDDS as follows: "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 two procedures appear to meet the definition, then the one most related to the principal diagnosis should be selected as the principal procedure."

e. For inpatient records, if the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely" "questionable", "possible" or "still to be ruled out", etc., code the condition as if it existed or was established.

f. When coding an Inpatient account, the Coder must not report a diagnosis documented solely by the Emergency Department physician unless confirmed by the attending or other physician involved with the care following the inpatient admission. If there is evidence of a condition tested, treated, or clinically evaluated, the Coder or CDS may generate an appropriately constructed physician query. An **exception** is permitted by Coding Clinic Q3 2012, page 22, when the patient expires immediately after admission and there is limited documentation from other physicians. In this unique circumstance the Coder may use the ED physician's documentation to substantiate code assignment.

g. When coding an Inpatient account, the Coder must not report a diagnosis documented solely by the Emergency Department (ED) physician unless confirmed by the attending or other physician involved in the care following the Inpatient admission. If there is evidence of a condition tested, treated, or clinically evaluated, the Coder or CDS may generate an appropriately constructed physician query. An exception is permitted by Coding Clinic Q3 2012, page 22, when the patient expires immediately after admission and there is limited documentation from other physicians. In this unique circumstance the Coder may use the ED physician's documentation to substantiate code assignment.

h. Procedures performed in the Emergency Department may be reported on the inpatient claim.

5. **Specific Outpatient Reporting Policies**

    1. The term "First-listed" is used for outpatient reporting, in lieu of "Principal Diagnoses." The Outpatient Coder must specifically refer to Section IV of the ICD-10-CM Official Guidelines for Coding and Reporting for specific outpatient reporting guidance.
    2. For an outpatient visit, the Coder must sequence and report first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for the encounter that is chiefly responsible for the service provided, as documented in the patient's legal health record. The Coder is then to report additional codes that describe any co-existing conditions.
    3. Uncertain diagnosis are **not** coded in an Outpatient setting. Instead code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs or abnormal test results,

6. **Outpatient Diagnostic/Ancillary Accounts-** Coders must have a valid order/requisition

indicating the reason for the test/service prior to coding and releasing for billing. Refer to Regulatory Compliance policies COMP-RCC 5.01 Orders for Outpatient Tests and Services and COMP-RCC 5.02 Outpatient Laboratory Requisitions for additional information, specific requirements and exceptions.

7. **Outpatient NCCI Modifiers**- The Coder is to assign applicable modifiers on outpatient services for all procedural codes that require a modifier based on CMS edits in the encoder software. Code modifiers help further to describe a procedure code without changing the definition of the codes. Modifiers can be found in the CPT and HCPCS code books.
8. **Physician Queries and Clinical Documentation Improvement**
    a. The Coder and/or CDS is expected to engage in an appropriate physician query process when there is evidence of a diagnosis or condition within the medical record and the Coder/CDS is uncertain whether that diagnosis is valid because the documentation is vague, incomplete, or contradictory, or when documentation is unclear regarding the appropriate Present on Admission (POA) indicator for established diagnosis.
    b. The appropriate providers should be queried in situations including, but not limited to, the following: when there are clinical indicators of an undocumented condition in the medical record; when ambiguous or conflicting documentation is present in the medical record; when documentation is unclear for POA indicator assignment; when there is a need to clarify a potential cause and effect relationship; and when there is a need for further specificity or information regarding the degree of severity of a documented condition. Standard protocols for the addition of documentation to a record must be followed, in accordance with ECMCC medical record completion requirements, the Joint Commission on Accreditation of Healthcare Organizations and applicable state law.
    c. Physician queries, whether initiated concurrently or retrospectively, and regardless of the credential(s) held by the one issuing the query, are to be compliant with Official Guidelines and ECMCC policies and procedures.
        a. Any affected individual engaged in generating concurrent or retrospective physician queries must use only query forms and processes approved by ECMCC.
    d. Any affected individual engaged in generating physician queries is to strictly adhere to the AHIMA Ethical Standards for Clinical Documentation Improvement Professionals and the ACDIS Code of Ethics.
9. **Record abstraction** – Once all diagnostic and procedural codes have been assigned, the coder must enter this and other pertinent patient information into the hospital abstracting system in order to assign the appropriate reimbursement for inpatient (DRGs) and outpatient (APCs/APGs/ASC groups) records. This information is also entered to comply with the federal and state reporting regulations.
10. **Monitoring to Detect and Prevent Coding Discrepancies**
11. 1. HIM Director or designee will perform periodic monitoring to ensure the accuracy of clinical documentation and code assignments. This monitoring will be designed to provide reliable assessments of current coding practice and to encompass both

inpatient and outpatient services. Monitoring must be implemented to track key indicators of patient mix and coding practices.

a. Ongoing monthly audits being conducted by CDS/Coding:

i. H&P

ii. Medication reconciliation

iii. Abbreviations

iv. Discharge Disposition

v. Mechanical Ventilation

vi. DRG 558

vii. Malnutrition

viii. CERT top 10 DRGs (high risk)

2. HIM Director or designee will be responsible for designing and conducting monthly chart reviews for coding quality and accuracy. All cases in which coding revisions result in a lower or higher weighted DRG assignment must be identified and correctly re-billed and/or refunded to the payor, as applicable, within 60 days of identification. The HIM Director or designee must maintain written documentation of all such revisions.
3. Whenever a coding discrepancy is identified (from any internal or external source), HIM and in collaboration with Corporate Compliance if applicable, must undertake the appropriate investigation to determine the root cause(s) of the variance and immediately work to correct any adverse result of the variance.
4. Any affected individual must report identification of material trends or variations to the Office of Corporate Compliance upon identification. The Office of Corporate Compliance will investigate such material trends or variations and, if applicable, work with the appropriate department(s) to resolve the issue. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education and training sessions.
5. All overpayments must be refunded and appropriately reported to the applicable federal and state payors within 60 days after identification or within such additional time period as may be agreed to by the payor. The corrective action will include correcting the underlying cause of the overpayment and taking remedial action to prevent the overpayment from recurring.
6. Professional fee monitoring is performed annually for billing by employed providers (including PAs and NPs). Reviews are performed pre-billing. Any discrepancies will be revised and billed appropriately.

12. **Auditing to Detect and Prevent Coding Discrepancies**

1. The Outside Auditor provides feedback to the coding staff on coding errors. The Outside Auditor provides follow-up education, references to the applicable AHA about correct coding of these conditions, where appropriate, and the process to be used to correct the deficiency. Each coding professional will comply with mandatory annual coding education.

2. Outside audits of the coding processes on a regular basis to monitor compliance with coding policies and all applicable federal and state laws, as well as to identify and monitor risk areas. At the conclusion of each such audit, the HIM and Office of Corporate Compliance will investigate the root causes of any coding discrepancies, discuss the audit and investigation findings with the appropriate department(s) and, if necessary, work with the appropriate departments to resolve any identified issues. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education and training sessions regarding trends identified, if any.

13. **Coder Coding Training Requirements**
    1. Employees are expected to share the responsibility for upholding company standards as well as coding standards. All coders are required to take a skill competency test prior to employment. Upon employment and on a regular basis thereafter, all coding staff must complete additional education on applicable coding topics and meet coding continuing education requirements.
    2. All coders contracted with ECMCC to provide coding services must follow the coding compliance guidelines and meet all applicable ECMCC coding education and training requirements.

14. **Reporting and Enforcement**
    1. All violations of this policy shall be reported to the appropriate manager/supervisor/director or to the Office of Corporate Compliance (716-898-6439) for appropriate resolution of the matter. The Compliance & HIPAA Hotline is available 24 hours a day, seven days a week at (855) 222-0758 is accessible to all individuals and allows for questions regarding compliance issues to be asked and for compliance issues to be reported. Reports of potential fraud, waste and abuse and compliance issues also may be made directly to the Corporate Compliance Officer or designee in person, in writing, via email, mobile device or by telephone. All reports received by the Office of Corporate Compliance are investigated and resolved to the fullest extent possible. The confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by Medicaid Fraud Control Unit, Office of Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the required provider's policy for non-intimidation and non-retaliation. Violations of this policy will be subject to disciplinary action as outlined in Compliance Discipline Policy and in the Bylaws, Rules and Regulations of the Medical Staff.

Reference:

IM.04.01.01, Official ICD10-CM Coding Guidelines for coding and reporting
AHIMA Standards of Ethical Coding, American Health Information Management Association (AHIMA) House of Delegates, Chicago, Illinois, September, 2008
CDI Toolkit, American Health Information Management Association (AHIMA), Chicago,2016"

"Guidelines for Achieving a Compliant Query Practice (2019 Update)"

“AHIMA Query Tool Kit AHIMA, 233 N. Michigan Ave., 21st Fl., Chicago, IL, 2017” Transmittal 1240 (POA)

Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 1 -General Billing Requirements and Chapter 3 – Inpatient Hospital Billing
AHA Coding Clinic for ICD-10-CM and AHA Coding Clinic for HCPCS

OMIG Compliance Program Guidance, Title 18 NYCRR § 521 – Fraud, Waste and Abuse Prevention (March 28, 2023)

ECMCC has developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations from these policies and procedures may be warranted in actual practice based upon individual patient characteristics and clinical judgment in unique care circumstances.

Approval Signatures

Step Description	Approver	Date
	Melissa Gomez: Director Clinical Coding/Record Quality Management	Pending

Applicability

Erie County Medical Center