(A) Policy Statement

The assignment of codes shall be based entirely on the physician documentation in the medical record with the utilization of official coding resources available to all coding staff.

(B) Purpose of Policy

To ensure our commitment to practice ethical, accurate and consistent coding, as stated in our Standard of Ethical Coding, at all times and for all patient types.

(C) Procedure

The objectives described below shall be followed while performing the coding function:

1. The sequencing of codes for inpatient accounts shall be performed utilizing the Official Coding Guidelines and the UHDDS guidelines.

2. The reporting of Other (Additional) diagnoses shall be performed utilizing the Official Coding Guidelines and the UHDDS guidelines. Please see policy 3364-105-507.

3. The reporting of the principal procedure and other significant procedures shall be performed utilizing the UHDDS guidelines.

4. All reported ICD-9-CM and/or CPT codes that appear on the UB-92 shall be supported by documentation in the medical record.

5. The following items shall be read and reviewed in order to obtain sufficient documentation:
   A. Transcribed Discharge Summary and the Multi-disciplinary Discharge Form.
   B. ER Record, (HEC)
   C. Transcribed or hand-written History and Physical.
   D. Admit Note.
   E. All Progress Notes.
   F. Diagnostic Test Results (these shall not be used for diagnostic coding purposes but for physician querying only.)
   G. Procedures performed (this shall include the anesthesia report (MAC), dictated OP report, pathology report, and all operative documents (HSM).)
   H. Physician’s Orders.
   I. Medication Sheets (these shall not be used for diagnostic coding purposes but for physician querying only.)
   J. Nursing Notes (HED)(these shall not be used for diagnostic coding purposes but for physician querying only).
   K. Any additional information needed by the physician shall be obtained by following Policy 3364-105-506 Physician Query Form.
6. The coding team member shall retrieve all transcribed operative reports, clinic progress notes, diagnostic procedure reports, laboratory results, radiology reports, pathology reports, cardiology reports and discharge summaries from Horizon Patient Folder (HPF). The coding staff has access to all essential coding resources through the 3M Reimbursement system. This includes the ICD-9 CM and CPT Coding manuals, Coding Clinic, Physician Coder Desk Reference, CPT Assistant and Pharmacology References. It will be the responsibility of the hospital to annually renew all updates to the computer software.

7. Primarily, the coding department shall code using the 3M Coding and Reimbursement System.

8. A coding team member who exhibits any form of noncompliance with this policy shall be disciplined in accordance with Policy 3364-105-504.

Approved by:

Paula F. Kessler, MEd, RHIA
Director, Health Information Management

Scott Scarborough, Ph.D, CPA, CHFP
Vice President & Executive Director

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It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.