(A) Policy Statement

The reporting of codes for other additional diagnoses shall be based on hospital data purposes; on conditions that affect the whole body system; on any diagnoses that place a bearing on the management of the patient; on any conditions that are not associated with the integral disease process; and on any physician documentation of abnormal findings that are of clinical significance to the patient’s care.

(B) Purpose of Policy

To ensure our commitment to practice the ethical, accurate and consistent reporting of codes for other additional diagnoses.

(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, ICD-10-CM/PCS and/or CPT codes that appear on the UB-04 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. Physician Addendum submitted for additional supporting documentation.
   J. Medication Sheets (HED)(these shall not be used for diagnostic coding purposes but for physician querying only.)
   K. Nursing Notes (HED)(these shall not be used for diagnostic coding purposes but for physician querying only).
L. Any additional information needed will be followed up with a physician query.

6. The coding staff has access to all essential coding resources through the 3M Reimbursement system. This includes the ICD-9-CM, ICD-10-CM/PCS and CPT coding manuals, a medical dictionary, an anatomy and physiology reference, the Physician Desk Reference, AMA’s CPT Assistant and the AHA’s Coding Clinic. All listed resources shall be updated annually. The AMA’s CPT Assistant and the AHA’s Coding Clinic shall be utilized as our official coding resource for coding.

7. The hospital will furnish the coder with current editions of the ICD-9-CM, ICD-10-CM/PCS and CPT coding manuals electronically through the 3M coding references. The manuals will be utilized for coding during downtime procedures and to verify the appropriateness of any questionable code or edit that has been generated from the 3M Coding and Reimbursement System. It will be the responsibility of the hospital to annually renew all updates to the manuals and computer software.

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

9. 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, RHIA, MEd
Director, Health Information Management
Date
8/28/15

Carl Sirio, M.D.
Chief Operating & Clinical Officer
Date
8/1/2015

Review/Revision Completed By:
Health Information Management

Policies Superseded by This Policy: 8-01

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