CCS Coding Competencies--ICD-9-CM and CPT/HCPCS Procedural Coding

For Further Reference

The Cooperating Parties (AHIMA, American Hospital Association, Health Care Financing Administration, National Center for Health Statistics) publish official guidelines in the *Coding Clinic for ICD-9-CM*, available from the American Hospital Association. See also *ICD-9-CM Official Guidelines for Coding and Reporting*, published by AHIMA in 1994, and "Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-based and Physician Offices)" published in *Coding Clinic for ICD-9-CM* 12, no. 4, 1995. The *CPT Assistant Newsletter*, published by the American Medical Association, is also considered a coding resource for the CCS exam.

Data Identification

1. Read and interpret health record documentation to identify all diagnoses and procedures that affect the current inpatient stay or outpatient encounter visit
2. Assess the adequacy of health record documentation to ensure that it supports all diagnoses and procedures to which codes are assigned
3. Apply knowledge of anatomy and physiology, clinical disease processes, pharmacology, and diagnostic and procedural terminology to assign accurate codes to diagnoses and procedures
4. Apply knowledge of disease processes and surgical procedures to assign nonindexed medical terms to the appropriate class in the classification/nomenclature system

Coding Guidelines

1. Apply knowledge of current approved ICD-9-CM coding guidelines to assign and sequence the correct diagnosis and procedure codes for hospital inpatient services
2. Apply knowledge of current diagnostic coding and reporting guidelines for outpatient services
3. Apply knowledge of CPT format, guidelines, and notes to locate the correct codes for all services and procedures performed during the encounter/visit and sequence them correctly
4. Apply knowledge of procedural terminology to recognize when an unlisted procedure code must be used in CPT

Regulatory Guidelines

1. Apply Uniform Hospital Discharge Data Set definitions to select the principal diagnosis, principal procedure, complications and comorbid conditions, other diagnoses, and significant procedures which require coding
2. Select the appropriate principal diagnosis for episodes of care in which determination of principal diagnosis is not clear because the patient has multiple problems
3. Apply knowledge of the Prospective Payment System to confirm DRG assignment which ensures optimal reimbursement
4. Refuse to fraudulently maximize reimbursement by assigning codes that do not conform to approved coding principles/guidelines
5. Refuse to unfairly maximize reimbursement by unbundling services and codes that do not conform to CPT basic coding principles
6. Apply knowledge of the Ambulatory Surgery Center Payment Groups to confirm ASC assignment which ensures optimal reimbursement
7. Apply policies and procedures on health record documentation, coding and claims processing, and appeal
8. Use the HCFA Common Procedural Coding System (HCPCS) to appropriately assign HCPCS codes for outpatient Medicare reimbursement

Coding

1. Exclude from coding diagnoses, conditions, problems, and procedures related to an earlier episode of care which have no bearing on the current episode of care
2. Exclude from coding ICD-9-CM nonsurgical, noninvasive procedures which carry no operative or anesthetic risk
3. Exclude from coding information such as symptoms or signs characteristic of the diagnosis, findings from diagnostic studies, or localized conditions which have no bearing on the current management of the patient
4. Apply knowledge of ICD-9-CM instructional notations and conventions to locate and assign the correct diagnostic and procedural codes and sequence them correctly
5. Facilitate data retrieval by recognizing when more than one code is required to adequately classify a given condition
6. Exclude from coding procedures that are component parts of an already assigned CPT procedure code

Data Quality

1. Clarify conflicting, ambiguous, or nonspecific information appearing in a health record by consulting the appropriate physician
2. Participate in quality assessment to ensure continuous improvement in ICD-9-CM and CPT coding and collection of quality health data
3. Demonstrate ability to recognize potential coding quality issues from an array of data
4. Apply policies and procedures on health record documentation and coding that are consistent with official coding guidelines
5. Contribute to development of facility-specific coding policies and procedures

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