Data Quality (1996) - Retired

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Background

Complete and accurate diagnostic and procedural coded data is necessary for research, epidemiology, outcomes and statistical analyses, financial and strategic planning, reimbursement, evaluation of quality of care, and communication to support the patient's treatment. Upon the implementation of an inpatient prospective payment system, Medicare and several other payers required physicians to attest to the accuracy of the diagnoses and procedures being reported on inpatient claims prior to billing. The administrative burden of this requirement was recently deemed far greater than its success in preventing fraud and abuse, and thus the attestation requirement was eliminated. However, the loss of this requirement does not mean the need for accurate coded data has diminished. To the contrary, the quality of healthcare data is more critical than ever before. Adherence to approved coding principles that generate coded data of the highest quality remains important.

In this new era of clinical data management, health information professionals must continue to meet the challenges of maintaining an accurate and meaningful database reflective of patient mix and resource use. As long as diagnostic and procedural coding serves as the basis for payment methodologies, the ethics of clinical coders will be challenged. Assuring accuracy of coded data is a shared responsibility between health information management professionals and clinicians. The HIM professional continues to have the unique responsibility of assessing and coding clinical data. Within their organizations, health information management professionals translate clinical information into coded data and then evaluate, analyze, and maintain its accuracy, validity, and meaningfulness. Health information professionals are responsible for the achievement and maintenance of data of the highest quality.

Clinical Collaboration

The Joint Commission on Accreditation of Healthcare Organizations and the Medicare Conditions of Participation require final diagnoses and procedures to be recorded in the medical record and authenticated by the responsible practitioner. Physician documentation, in its entirety, is the cornerstone of accurate coding. Meaningful diagnostic and procedural coded data originate from the collaboration between clinicians with extensive clinical experience and coding professionals with comprehensive classification systems expertise.

Elimination of the attestation requirement does not mean the end to this collaboration, but rather a continued opportunity for dialogue and communication. Clinical documentation from which the coded data is derived continues to rely on information provided by healthcare practitioners. More than ever before, healthcare providers rely on coded clinical data for financial viability. Thus, the need for collaboration, cooperation, and communication between clinicians and coders continues to grow.

Clinical Database Evaluation

Ongoing evaluation of the clinical database may assure that ethical reporting of clinical information occurs. Regular evaluation of the quality of the database provides evidence that the clinical data remains consistent with standards of ethical coding practice.

Evaluation can be conducted by diagnosis-related group (DRG), pertinent clinical issues, high dollar cases, high volume DRGs, or particular diagnoses or procedures. The diagnosis and procedure codes should be reviewed to ensure the accuracy of coding, appropriate sequencing, and clinical pertinence. Reporting review results to administration and the medical staff increases their awareness of coded data quality issues within the facility.

Recommendations

The Coding Professional Should:

- Thoroughly review the entire medical record as part of the coding process in order to assign and report the most appropriate codes
- Adhere to all official coding guidelines as approved by the Cooperating Parties[1]
- Observe sequencing rules identified by the Cooperating Parties[1]
- Select the principal diagnosis and procedure according to UHDDS definitions[2]
- Assign and report codes, without physician consultation, to diagnoses and procedures not stated in the physician's final diagnosis only if these diagnoses and procedures are specifically documented by the physician in the body of the medical record and this documentation is clear and consistent
- Utilize medical record documentation to provide coding specificity without obtaining physician concurrence (such as utilizing the radiology report to identify the fracture site)
- Maintain a positive working relationship with physicians through ongoing communication and open dialogue

The Coding Professional Should Not:

- Add diagnosis codes solely based on test results
- Misrepresent the patient's clinical picture through incorrect coding or add diagnoses/procedures unsupported by the documentation in order to maximize reimbursement or meet insurance policy coverage requirements
- Report diagnoses and procedures that the physician has specifically indicated he/she does not support

As the need for coded data of the highest quality continues to grow, HIM professionals need to build and develop their role as clinical data managers. In order to achieve this end, coder education in the areas of anatomy and physiology, medical terminology, disease pathology, pharmacology, and laboratory studies, as well as classification and reimbursement systems, should be encouraged. Dialogue between health information professionals and clinicians should also be encouraged, as it improves coder clinical competency and educates the clinician on documentation practice issues.

Additional Recommendations in the Absence of Physician Attestation

The Coding Professional Should:

- Assess physician documentation to assure that it supports the diagnosis and procedure codes selected
- Consult the physician for clarification when conflicting or ambiguous documentation is present; ask the physician to add information to the record before assigning a code that is not supported by documentation
- Provide the physician the opportunity to review reported diagnoses and procedures on pre- or post-bill submission, via mechanisms such as:
    - providing a copy (via mail, fax, or electronic transmission) of the sequenced codes and their narrative descriptions
    - placing the diagnostic and procedural listing within the record and bringing it to the physician's attention
- Revise the codes if the physician disagrees with code selection

- Offer coding and classification system education to any and all clinicians (e.g., provide pertinent official coding guidelines)

- Develop institutional coding policies in the absence of official guidelines

Notes

1. American Hospital Association; American Health Information Management Association; Health Care Financing Administration; National Center for Health Statistics

2. Uniform Data Discharge Set

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Issued: February 1996
