Developing a Coding Compliance Policy Document (2001)

Save to myBoK

This practice brief has been updated. See the latest version here. This version is made available for historical purposes only.

Organizations using diagnosis and procedure codes for reporting healthcare services must have formal policies and corresponding procedures in place that provide instruction on the entire process-from the point of service to the billing statement or claim form. Coding compliance policies serve as a guide to performing coding and billing functions and provide documentation of the organization's intent to correctly report services. The policies should include facility-specific documentation requirements, payer regulations and policies, and contractual arrangements for coding consultants and outsourcing services. This information may be covered in payer/provider contracts or found in Medicare and Medicaid manuals and bulletins.

Following are selected tenets that address the process of code selection and reporting. These tenets may be referred to as coding protocols, a coding compliance program, organizational coding guidelines, or a similar name. These tenets are an important part

of any organization's compliance plan and the key to preventing coding errors and resulting reimbursement problems. Examples are taken from both outpatient and inpatient coding processes for illustration purposes only. This document cannot serve as a complete coding compliance plan, but will be useful as a guide for creating a more comprehensive resource to meet individual organizational needs.

A coding compliance plan should include the following components:

- A general policy statement about the commitment of the organization to correctly assign and report codes

Example: Memorial Medical Center is committed to establishing and maintaining clinical coding and insurance claims processing procedures to ensure that reported codes reflect actual services provided, through accurate information system entries.

- The source of the official coding guidelines used to direct code selection

Example: ICD-9-CM code selection follows the Official Guidelines for Coding and Reporting, developed by the cooperating parties and documented in Coding Clinic for ICD-9-CM, published by the American Hospital Association.

Example: CPT code selection follows the guidelines set forth in the CPT manual and in CPT Assistant, published by the American Medical Association.

- The parties responsible for code assignment. The ultimate responsibility for code assignment lies with the physician (provider). However, policies and procedures may document instances where codes may be selected or modified by authorized individuals

Example: For inpatient records, medical record analyst I staff are responsible for analysis of records and assignment of the correct ICD-9-CM codes based on documentation by the attending physician.

Example: Emergency department evaluation and management levels for physician services will be selected by the physician and validated by outpatient record analysts using the HCFA/AMA documentation guidelines. When a variance occurs, the following steps are taken for resolution (The actual document should follow with procedure details).

- The procedure to follow when the clinical information is not clear enough to assign the correct code

Example: When the documentation used to assign codes is ambiguous or incomplete, the physician must be contacted to clarify the information and complete/amend the record, if necessary. (The actual document should follow with details of how the

medical staff would like this to occur, e.g., by phone call, by note on the record, etc.). Standard protocols for adding documentation to a record must be followed, in accordance with the applicable laws and regulations.

- Specify the policies and procedures that apply to specific locations and care settings. Official coding guidelines for inpatient reporting and outpatient/physician reporting are different. This means that if you are developing a facility-specific coding guideline for emergency department services, designate that the coding rules or guidelines only apply in this setting

Example: When reporting an injection of a drug provided in the emergency department to a Medicare beneficiary, the appropriate CPT code for the administration of the injection is reported in addition to the evaluation and management service code and drug code. CPT codes are reported whether a physician provides the injection personally or a nurse is carrying out a physician's order. This instruction does not always apply for reporting of professional services in the clinics, because administration of medication is considered bundled with the corresponding evaluation and management service for Medicare patients.

Example: Diagnoses that are documented as "probable," "suspected," "questionable," "rule-out," or "working diagnosis" are not to have a code assigned as a confirmed diagnosis. Instead, the code for the condition established at the close of the encounter should be assigned, such as a symptom, sign, abnormal test result, or clinical finding. This guideline applies only to outpatient services.

- Applicable reporting requirements required by specific agencies. The document should include where instructions on payer-specific requirements may be accessed

Example: For patients with XYZ care plan, report code S0800 for patients having a LASIK procedure rather than an unlisted CPT code.

Example: For Medicare patients receiving a wound closure by tissue adhesive only, report HCPCS Level II code G0168 rather than a CPT code.

Many of these procedures will be put into software databases and would not be written as a specific policy. This is true with most billing software, whether for physician services or through the charge description master used by many hospitals.

- Procedures for correction of inaccurate code assignments in the clinical database and to the agencies where the codes have been reported

Example: When an error in code assignment is discovered after bill release and the claim has already been submitted, this is the process required to update and correct the information system and facilitate claim amendment or correction (The actual document should follow with appropriate details).

- Areas of risk that have been identified through audits or monitoring. Each organization should have a defined audit plan for code accuracy and consistency review and corrective actions should be outlined for problems that are identified

Example: A hospital might identify that acute respiratory failure is being assigned as the principal diagnosis with congestive heart failure as a secondary diagnosis. The specific reference to Coding Clinic could be listed with instructions about correct coding of these conditions and the process to be used to correct the deficiency.

- Identification of essential coding resources available to and used by the coding professionals

Example: Updated ICD-9-CM, CPT, and HCPCS Level II code books are used by all coding professionals. Even if the hospital uses automated encoding software, at least one printed copy of the coding manuals should be available for reference.

Example: Updated encoder software, including the appropriate version of the NCCI edits and DRG and APC grouper software, is available to the appropriate personnel.

Example: Coding Clinic and CPT Assistant are available to all coding professionals.

- A process for coding new procedures or unusual diagnoses

Example: When the coding professional encounters an unusual diagnosis, the coding supervisor or the attending physician is consulted. If, after research, a code cannot be identified, the documentation is submitted to the AHA for clarification.

- A procedure to identify any optional codes gathered for statistical purposes by the facility and clarification of the appropriate use of E codes

Example: All ICD-9-CM procedure codes in the surgical range (ICD-9-CM Volume III codes 01.01-86.99) shall be reported for inpatients. In addition, codes reported from the non-surgical section include the following (Completed document should list the actual codes to be reported).

Example: All appropriate E codes for adverse effects of drugs must be reported. In addition, this facility reports all E codes, including the place of injury for poisonings, all cases of abuse, and all accidents on the initial visit for both inpatient and outpatient services.

- Appropriate methods for resolving coding or documentation disputes with physicians

Example: When the physician disagrees with official coding guidelines, the case is referred to the medical records committee following review by the designated physician liaison from that group.

- A procedure for processing claim rejections

Example: All rejected claims pertaining to diagnosis and procedure codes should be returned to coding staff for review or correction. Any chargemaster issues should be forwarded to appropriate departmental staff for corrections. All clinical codes, including modifiers, must never be changed or added without review by coding staff with access to the appropriate documentation.

Example: If a claim is rejected due to the codes provided in the medical record abstract, the billing department notifies the supervisor of coding for a review rather than changing the code to a payable code and resubmitting the claim.

- A statement clarifying that codes will not be assigned, modified,

or excluded solely for the purpose of maximizing reimbursement. Clinical codes will not be changed or amended merely due to either physicians' or patients' request to have the service in question covered by insurance. If the initial code assignment did not reflect the actual services, codes may be revised based on supporting documentation. Disputes with either physicians or patients are handled only by the coding supervisor and are appropriately logged for review

Example: A patient calls the business office saying that her insurance carrier did not pay for her mammogram. After investigating, the HIM coding staff discover that the coding was appropriate for a screening mammogram and that this is a non-covered service with the insurance provider. The code is not changed and the matter is referred back to the business office for explanation to the patient that she should contact her insurance provider with any dispute over coverage of service.

Example: Part of a payment is denied and after review, the supervisor discovers that a modifier should have been appended to the CPT code to denote a separately identifiable service. Modifier -25 is added to the code set and the corrected claim is resubmitted.

Example: A physician approaches the coding supervisor with a request to change the diagnosis codes for his patient because what she currently has is a pre-existing condition that is not covered by her current health plan. The coding supervisor must explain to the physician that falsification of insurance claims is illegal. If the physician insists, the physician liaison for the medical record committee is contacted and the matter is turned over to that committee for resolution if necessary.

- The use of and reliance on encoders within the organization. Coding staff cannot rely solely on computerized encoders. Current coding manuals must be readily accessible and the staff must be educated appropriately to detect inappropriate logic or errors in encoding software. When errors in logic or code crosswalks are discovered, they are reported to the vendor immediately by the coding supervisor

Example: During the coding process, an error is identified in the crosswalk between the ICD-9-CM Volume III code and the CPT code. This error is reported to the software vendor, with proper documentation and notification of all staff using the

encoder to not rely on the encoder for code selection.

- Medical records are analyzed and codes selected only with complete and appropriate documentation by the physician available. According to coding guidelines, codes are not assigned without physician documentation. If records are coded without the discharge summary or final diagnostic statements available, processes are in place for review after the summary is added to the record

Example: When records are coded without a discharge summary, they are flagged in the computer system. When the summaries are added to the record, the record is returned to the coding professional for review of codes. If there are any inconsistencies, appropriate steps are taken for review of the changes.

Additional Elements

A coding compliance document should include a reference to the AHIMA Standards of Ethical Coding, which can be downloaded from AHIMA's Web site at www.ahima.org. Reference to the data quality assessment procedures must be included in a coding compliance plan to establish the mechanism for determining areas of risk. Reviews will identify the need for further education and increased monitoring for those areas where either coding variances or documentation deficiencies are identified.

Specific and detailed coding guidelines that cover the reporting of typical services provided by a facility or organization create tools for data consistency and reliability by ensuring that all coders interpret clinical documentation and apply coding principles in the same manner. The appropriate medical staff committee should give final approval of any coding guidelines that involve clinical criteria to assure appropriateness and physician consensus on the process.

The format is most useful when organized by patient or service type

and easily referenced by using a table of contents. If the facility-specific guidelines are maintained electronically, they should be searchable by key terms. Placing the coding guidelines on a facility Intranet or internal computer network is a very efficient way to ensure their use and it also enables timely and efficient updating and distribution. Inclusion of references to or live links should be provided to supporting documents such as Uniform Hospital Discharge Data Sets or other regulatory requirements outlining reporting procedures or code assignments.

Prepared by

AHIMA's Coding Practice Team and reviewed by the Coding Policy and Strategy Committee and the Society for Clinical Coding Data Quality Committee

---

Article citation:
AHIMA Coding Practice Team. "Developing a Coding Compliance Policy Document (AHIMA Practice Brief)." *Journal of AHIMA* 72, no.7 (2001): 88A-C.
