Dissecting the Details: Documentation Based Coding Model Offers Advanced Approach to Workforce Coding Training

By Diana Karff, RHIA, CCS

Inpatient and outpatient coders enter the HIM workforce only after they have taken medical terminology, procedural terminology, pharmacology, structural anatomy and physiology, disease and treatment, and all requisite coding courses. These required courses earn academic credit in a classroom setting, but some feel these basic courses are not enough to excel in a career centered on the art of medical coding. Why? Because coding is complex, and many feel it requires real world health records that are paired with skills learned not over a period of days, but months of face-to-face or online training.

Documentation Based Coding (DBC) is a vocational method that offers additional training, and while this approach to coding does not replace the classic academic curriculum, it has been shown to be a successful addition to that education.

DBC can only be taught in non-credit bearing or vocational settings. The workforce teaching and learning from this approach permits the coder to comprehend the key steps required to increase understanding of clinical documentation in tandem with associating coding rules and coding guidelines. Advocates of DBC feel it provides coders the ability to objectively read the health record in order to assign codes based solely on the recorded documentation.

A quick inventory of the workforce training challenges facing the HIM industry today in health information departments identifies:

- Training and concentrated feedback may be restricted due to senior staff members having multiple responsibilities, thus feedback may be limited, untimely, or not completed
- Current coding staff members are tasked with productivity and accuracy standards
- Current coding staff may be working in a remote setting, limiting peer-to-peer communication
- Previous academic coding courses and prerequisites are not learned in the context of reading medical documentation as it is presented in a chart
- A shortage of qualified coders in the workforce has made it difficult for facilities to hire and retain employees

By using chart-based documentation, the documentation is explained objectively in a logical order focusing on the following individual six steps applied to the documentation and, eventually, the assigned code:

1. Medical terminology
2. Structural anatomy
3. Clinical disease pathway
4. Treatment resources (such as medicinal, operative, therapeutic, or diagnostic)
5. Coding rules and additional guidelines pertaining to the documentation scenario
6. Code assignment

Define and Comprehend Documentation

When training is conducted from this DBC model, it creates a discipline for both the trainer and student. The trainer's goal is to increase the coder's knowledge base and refine the learner's judgment process. If a coder has a question or faces conflicting or minimal chart entries, they are taught to follow the sequential pathway as a road map to objectively comprehend the documentation. This process eliminates skipping over any clinical terminology used by physicians that may not be fully understood, and eliminates lone abstracting of diagnoses for reporting while increasing a coder's medical knowledge base in a positive, proactive manner.

The coder is disciplined to seek coding rules and guidelines relating to the documentation in DBC. Knowing the definition of documentation is vital to understanding the rationale behind using the term "documentation" in the title of DBC training. The term documentation is defined by the Merriam-Webster Dictionary as "the documents, records, etc., that are used to prove something or make something official."

Using this definition of documentation in DBC stresses that it is the coder who must understand the chart by reading multiple entries from the chart as a whole. By monitoring the clinical pathways and treatment, the coder will become more efficient and confident in accurate code assignment. All clinical documentation can be applied to this process. Documentation samples may be from operative notes, a history and physical, consults, orders, progress notes, a discharge summary, or the entire chart. The sample is objectively analyzed following the six steps listed earlier in a recurrent DBC pattern. By applying the pattern, a mandatory thinking framework occurs. The documentation analysis may be applied to ICD-9-CM, ICD-10-CM, ICD-10-PCS, or CPT coding.

Example of Documentation Based Coding Model

Gastrointestinal Bleeding		
	Potential Documentation	**Learning Instructions for Inpatient Coding ICD-10-CM and ICD-10-PCS**
Medical Terminology	GI bleed Hematemesis Melena Hematochezia BRBPR EGD NG	Gastrointestinal hemorrhage or bleeding; Vomiting of blood, also coffee-ground emesis (CGE); Tarry, black stools; Bright red blood per rectum The presence of bold, red blood in the stool Esophagastroduodenoscopy Nasogastric
Structural Anatomy	Basic, structural anatomy. Anatomical pictures will also aid the coder.	Upper gastrointestinal tract: Esophagus, stomach, small intestine segments (duodenum, jejunum, and ileum). Lower gastrointestinal tract: To the ascending or right large intestine (colon), transverse large intestine (colon), descending or left large intestine (colon), sigmoid colon, rectum and anus.
Clinical Disease Pathway Education	The practitioners and caregivers will never "explain" all of this defined content in a record. Coder's task is to comprehend the documented terms and how they relate to treating the patient's	Coffee-ground hematemesis or vomiting of blood indicates the patient's blood has been in contact with hydrochloric acid from the stomach thus identifying to the physician a potential 'upper' GI bleed. Tarry stools are a clinical marker indicating fecal bacteria or stool has been 'mixed' or in contact with blood, flagging physicians to diagnose 'lower' or 'upper' GI bleeding. Hematochezia or BRBPR indicates blood that has surged below any stool formation, may even include the anus. Coder is encouraged to seek documentation of varices or ulcer

	illness and utilization of facility resources.	formation. Investigate for documentation attributing the bleeding from the use of therapeutic non-steroidal anti-inflammatory drugs, diverticulosis, neoplasms, Mallory Weiss tears, colitis, fissures and hemorrhoids. Coder is encouraged to identify anemia with specific type and treatment pathway utilized.
Treatment: Medicinal/ Procedural	Basic clinical guidelines are taught. Coders are taught to seek a relationship between the orders and the progress notes or consults.	**Coders must understand the initial clinical treatment goal is to halt the bleeding.** The secondary goal is to identify the etiology of the bleeding. **Potential therapeutic fluids and drugs:** Intravenous (IV) fluids, packed red blood cell (PRBC) transfusion, proton pump inhibitors (PPI) such as IV omeprazole. Prokinetics such as erythromycin and metoclopramide, anticoagulants and antiplatelet agents. **Potential therapeutic and diagnostic procedures:** NG lavage, EGD (may include biopsy), colonoscopy (may include biopsy), open surgery in critical patients.
Diagnosis Coding Rules and Guidelines	Identify all official guidelines and additional coding rules. This step in the learning pathway should directly reflect the rules for the coding type (ICD or CPT). This grid reflects ICD-10-CM.	**Principal diagnosis:** Using approved provider documentation, identify the correct reason for admission, next identify the established condition following studies to be chiefly responsible for inpatient admission. Review ICD-10-CM Official Coding Guidelines: Diseases of the Digestive System (K00-K95). Decide if documentation meets adverse effect guidelines in Chapter 19 Section E: Adverse Effects, Poisoning, Underdosing and Toxic Effects. When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should have a 5th or 6th character “5” (for example, T36.0X5-). Guidelines state codes in categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects, and underdosing codes. **Identify diagnoses that meet criteria for additional diagnoses:** • Clinical evaluation • Therapeutic treatment • Diagnostic procedures • Extended length of hospital stay • Increased nursing care or monitoring

		1. Do not survey data from laboratory results (including pathology) to assign any secondary diagnoses. 2. Query initiation should reflect conflicting or scant documentation only. 3. Lone entries without any UHDDS criteria met do not meet a "documentation" standard. 4. Query if anemia is documented for type and acuity. 5. Review present on admission (POA) guidelines.
Procedural Coding Rules and Guidelines	Identify all official guidelines and additional coding rules. This step in the learning pathway should directly reflect the rules for the coding type (ICD or CPT). This grid reflects ICD-10-PCS.	**Understanding third character root operation assignment in PCS:** Depending on the endoscopic procedure, the root operation character will be "Biopsy -B- Excision" or "Visualization Only -J- Inspection" **Understanding fifth character surgical approach values in PCS:** Colonoscopy and EGD procedures are usually performed through natural anatomical openings. Reporting character "8- Via Natural or Artificial Opening, Endoscopic." Nasogastric lavage is insertion of instrumentation through the nose. Reporting character "7- Via Natural or Artificial Opening." Do not rely solely on general equivalence mappings (GEMs) assignment for reporting of ICD-10-PCS code(s).
Codes	From the documentation sample, the correct codes are offered. These codes are hypothetical.	Unspecified gastrointestinal bleed: K92.2 Anemia: Query pending Inspection of upper intestinal tract, via natural or artificial opening: 0DJD8ZZ Inspection of lower intestinal tract, via natural or artificial opening: 0DJ08ZZ Packed red blood cell transfusion via peripheral vein: 30230N1

Emphasis on Reason for Admission in Documentation Based Coding

When it comes to principal diagnosis selection utilization for documentation based coding, nearly all coders can quote the definition defined in the Uniform Hospital Discharge Data Set (UHDDS): "…that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." Understanding the word "occasioning" defined as an event, a time, immediate cause, grounds, reason, or requirement is the first step in DBC. The DBC coder's goal is the objective establishment of the correct reason for the clinical admission or reason for admission (RFA). This may be one straightforward clinical issue, it may be vague symptomology, or it may be numerous clinical reasons.

The history and physical and admission orders are used for occasion or reason for admission. If an emergency room record is present, final emergency room documentation is also considered. DBC coders must include a review of the discharge summary to identify the correct reason for admission. This is due to Joint Commission criteria, which require:

- Reason for hospitalization (this is also described as summary of the course of hospitalization)
- Significant findings (this has been stated also as diagnoses)
- Procedures and treatment provided
- Patient's discharge condition
- Patient and family instructions (as appropriate)
- Attending physician's signature

It is important that coders remember that the Joint Commission discharge criteria do not require a statement reflecting the UHDDS-defined principal diagnosis, although there are facilities with individual physician guidelines for privileges requiring the principal diagnosis be documented in the discharge summary. The documented reason or reasons for admission begin the process of correct principal diagnosis selection. Inpatient coder auditing from this Joint Commission perspective requires the medical or procedural reason for admission in the findings.

As for determining "The condition established after study to be chiefly responsible…" as defined in the UHDDS, this is arrived at by utilizing the record as a treatment process seeking recognized results or outcomes. The coder appreciates the accepted clinical pathways and accepted documentation usage. Typically coders trained from this DBC model do exceptionally well in assigning and defending principal diagnosis assignment.

Emphasis on Secondary Diagnosis in Documentation Based Coding

Documentation Based Coding can also be used to help with the explanation of secondary diagnosis. Again, most coders can recite the UHDDS guidelines, but they must know how to properly apply the following rules:

- Clinical evaluation
- Therapeutic treatment
- Diagnostic procedures
- Extended length of hospital stay
- Increased nursing care or monitoring

When a coder applies the objective steps utilized in the DBC, medical terminology, then structural anatomy, clinical disease pathway, treatment, coding rules, and additional guidelines pertaining to the documentation scenario secondary code reporting can be substantiated.

In order to reduce incorrect reporting from the beginning, DBC coders are tasked to fully understand the documentation and how it interfaces with coding.

Ground Rules Stressed During DBC Model Training

Over the past decade, DBC-trained coders have been taught from the following foundations:

1. With regard to the chart entries, physicians are communicating with colleagues and facility caregivers in the record in order to restore the patient's health. The documentation that coders encounter will never be explained from a non-clinical perspective. Coders are responsible for understanding physician-authored clinical communication and interpreting it for the reporting of codes. This fundamental is paramount. Sometimes the complaint of poor documentation may be an indication the coder needs increased knowledge of anatomy and established clinical disease pathways or treatment methodologies, and how they relate to the coding rules and guidelines.
2. Lone chart entries are not documentation. The presence of a term in a chart is not defined as "documentation."
3. Coding rules do not shadow or correlate to clinical strategies or treatment protocols.
4. Embrace coding and clinical references from the start. If a coder learns the clinical pathways properly they can incorporate the same clinical and procedural pathways into numerous records.

5. The need for queries will never disappear. Understanding the requirements of a meaningful query will lead to correct reporting. Coders who possess a solid foundation of understanding documented clinical pathways and the treatment of disease will communicate in a more effective manner with the physician.

Documentation Based Coding can be utilized for any level of coder training and audit training as well, since it is also advantageous to audit processes. Auditing coded records from this model generates improved coder feedback in respect to deepening the understanding of the clinical framework and weighing the genuine utilization of care with respect to facility resources.

Dawn Foerst, CCS, is an ICD-10 instructor with 17 years of experience in the medical billing and coding industry, and has been involved with the development of a CDI program as well as professional and facility coding. Foerst learned DBC six years ago. “After several years of working in the health information management industry, I was introduced to and educated with the Documentation Based Coding model. I truly believe this model provides such clarity when coding, discussing, auditing, and defending a medical record,” Foerst says. “The structure and process of evaluating documentation follows a uniform pathway to arrive at the most appropriate outcome. This model is beneficial for new coders, providing direction to analyzing complex documentation.”

Of course all documented and reported diagnoses and procedures are evaluated, but do they sincerely warrant reporting by coding guidelines? Did they require provider query? A procedure can be understood from the mind’s eye of the practitioner’s guiding principles including all procedural terminology and anatomy viewed in an organized manner with the coding rules. With DBC, the coder learns from a logical perspective.

Applications of the Documentation Based Coding Model

Another advocate for the DBC model is Elaine Moore, MS, RHIA, a senior director of coding quality and education at Piedmont Health System in Atlanta, GA. She encountered this training model in 2013 at the AHIMA Annual Clinical Coding Meeting. Since then, Moore and her management staff decided to implement DBC software for all apprentice and seasoned coders. “I believe that coders need a strong foundation in understanding the disease process in order to excel in becoming excellent coders,” she says. “Especially in the world of copy and paste, we have become aware that we cannot code based only on provider-listed diagnoses. As coders, we need to understand the clinical picture must support the diagnosis.”

For example, understanding and knowing when to code metabolic encephalopathy and when not to code, as a secondary diagnosis. Metabolic encephalopathy is always due to an underlying cause, Moore says, and coders have to answer the questions of whether or not the physician documentation reflects the underlying cause, treatment, etc. “Sometimes, provider documentation as we know today does not always communicate the true acuity level of the patient,” she says. “If a coder sees a diagnosis documented only once, he/she should be able to understand the disease process of the condition to know if this is a valid diagnosis or requires further clarification from the provider. This model approach allows coders to understand the clinical picture of a disease and see firsthand how to apply codes to their provider’s documentation.”

Also, the DBC approach of coding education allows coders to use actual patient data instead of practicing with test patient documents that a coder may never use. This model also allows coders to be cross-trained from one patient type to another as well as equip coders to become specialized coders, Moore says.

“The documentation based system provides all the basic knowledge tools to make it a smoother transition for coders to enhance their skill set using actual patient records from your own facility,” she says. “This learning approach is a one-stop-shop because you have the coding guidelines, clinical disease references, ICD-9-CM, ICD-10-CM/PCS codes, and anatomy at your fingertips. I truly believe that this approach speeds up the learning process for coders.”

Documentation Based Coding is a practical approach to workforce training. Today’s HIM industry faces many challenges. If the utilization of a seasoned model with a refined approach is applied to coding and auditing, HIM professionals can strengthen their current professional workforce and realistically train more subject matter experts in the industry.

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Diana Karff (Diana@americancodingschool.com) is the lead instructor for the American Coding School. She is an ICD-10 trainer, has written coding curricula and designed software for training using the DBC model, and has over 30 years of experience in health information.

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