Quest for Quality and Comparability in the National Healthcare Database: Announcing A Payer's Guide to Health Care Data Quality and Integrity

by AHIMA's Coding Policy and Strategy Committee

As the computer-based patient record slowly becomes a reality, the need has never been greater for a national cooperative effort to recognize and apply uniform terminology and coding guidelines for both the clinical community and fiscal intermediaries. AHIMA's Coding Policy and Strategy Committee has been charged with the development and dissemination of a manual describing the importance of consistent and reliable data gathering and reporting practices. Health insurance companies are the target audience for this manual.

Initially, copies of the manual will be provided to each component state association (CSA). The intent is for CSA representatives to meet face to face with payers to discuss data quality issues and educate payers on the availability of coding guidelines. The payer would keep the manual as a resource.

The manual will contain an extensive discussion of the importance of data quality, uses of data, and examples of ways data is being compromised by individual payer requirements and inconsistent application of coding guidelines, as well as information about official coding guidelines and how they are developed and maintained. It is anticipated that *A Payer's Guide to Health Care Data Quality and Integrity* will be published in November 1996.

Summary

Several studies have concluded that the selection of diagnosis and procedure codes reported by healthcare facilities and providers is driven by the reimbursement process.[1] This results in inadequate or inappropriate aggregate healthcare data used to characterize patients and address the underlying causes and comorbidities related to severity of illness and injury. The processes for diagnostic and procedure code selection and sequencing and uniform application of official coding rules, conventions, and guidelines may often vary across hospitals and by payer source. For example, recent efforts to predict relative risk of mortality and apply severity of illness index predictors to hospital discharge databases are controversial, mainly because of these variations. The collection of a comparable level of data quality across organizations must be supported by all healthcare providers, healthcare payers, and health information managers. Accurate and complete coded data must be provided in all healthcare settings to improve the quality and effectiveness of patient care, to ensure comparable healthcare reimbursement information, and to permit consistent research and analytical studies of aggregate coded data.

Background

In the United States, diagnostic and procedural information is coded using standardized nationally accepted classification systems. The International Classification of Diseases, Ninth Revision, Clinical Modification[2] (ICD-9-CM) is used for inpatient and ambulatory diagnoses, as well as for inpatient procedure coding. Current Procedural Terminology, Fourth Edition (CPT) is used for ambulatory procedure coding.[3]

Healthcare administrative databases contain coded diagnostic and procedural information, as well as some resource utilization data necessary for processing reimbursement claims. The recent popularity of multihospital administrative databases that are accessible within the public domain (e.g., MEDPAR files) as a source for analysis of processes, quality, cost, and outcome variability in healthcare can be traced to their ability to provide large, representative samples at low cost. This use of large databases as a source of national health data at a time when major health policy, access, and cost decisions must be made focuses attention on the importance of reliability and accuracy of such information.

Discussion

Hospital administrative databases are thought to be uniform because they rely on the data definitions of the Uniform Hospital Discharge Data Set (UHDDS).[4] Similarly, standardized billing formats (such as the HCFA Form 1450 and the HCFA Form 1500, for hospital and physician billing, respectively) recognized by Medicare, Medicaid, and many commercial insurers are often thought to provide accurate billing data linked to accurate diagnostic and procedural information.

The American Health Information Management Association (AHIMA) is in a unique position, thanks to its members and its involvement in the development of national coding policy and educational programs, to be aware of discrepancies in the system. The influence of health insurance organizations over the collection of data remains the primary reason for obtaining their cooperation and compliance with coding guidelines.

At issue are the various coding policy interpretations made by commercial insurers for their specific needs. Our concern is not with the coverage of services by individual companies, but rather with the lack of acceptance of valid codes that have been submitted according to established coding rules, guidelines, and sequencing requirements. These practices have led to the corruption of data due to the submission of codes that meet payment requirements rather than accurately reflecting diagnoses and treatment of patients.

As a part of the reimbursement process, a health insurance company may require codes as specific clarification for its data sets, and so to effectively reimburse a claim, some codes may not be accepted or certain unique code combinations required. For example:

- There is a lack of general acceptance of V codes for inpatient and outpatient services, especially when reported as the principal diagnosis. In California, one Medicare payer will deny pre-op claims (a V72.8 code) even when there are abnormal findings that would normally be covered-if the V72.8 is sequenced first and the abnormal finding is second. However, if the abnormal finding is listed as the principal diagnosis, the claim is paid. By listing the abnormal condition first, the payer and therefore the database will not recognize the encounter as a pre-op visit (even though V72.8 is in a secondary position) and may be assuming the visit is specifically to address the abnormal finding

- In Pennsylvania, a payer varies in the interpretation of myocardial infarction coding guidelines requiring a subsequent episode of care fifth digit (410.x2) on the second hospital's claim for a patient transferred during the acute episode of care. The data generated by the incorrect use of the episode of care fifth digit will affect length of stay and appropriateness of services conclusions

- Many payers do not make the transition to the current CPT versions when they are made available each January. Instead several versions of CPT remain "live" at once. Thus the CPT codes 49310 - 49311 for laparoscopic cholecystectomy (deleted and replaced with CPT codes 56340 - 56341 in 1994) are still being required for payment. The ability to pool information from different sources is compromised by this process

- Pediatric developmental delays coded to ICD-9-CM category 315 are rejected as uncovered "mental health" services in Massachusetts. Statistics on treatment of delayed development not due to intellectual retardation or inadequate schooling will be lost in this state.

- Some DRG payers will delete valid secondary diagnoses (e.g., CCS) if the condition is only monitored and/or evaluated. Incomplete coding of chronic or comorbid conditions on patients may affect assessments of patient risks of poor outcomes

Reliance on discharge databases populated by reimbursement data that contain inconsistencies and local interpretations in code assignments poses the question of bias in coding toward reimbursement and the potential for incomplete coded data. Databases used to provide comprehensive information for research and practice improvement, as well as basic communication for continuing patient care, can be employed to greatest advantage if their strengths and weaknesses are understood. Therefore, greater effort should be devoted to assuring their accuracy.

Conclusion

To ascertain successful outcomes, increase service efficiency, and improve the quality of patient care, healthcare organizations and third-party payers must uniformly subscribe to the same coding guidelines and practices, regardless of the level or location of healthcare service or the method of reimbursement. The value of data comparability and the benefits of pooling information to create clinical benchmarks for improved quality of care, to monitor resource utilization, and to maintain a competitive edge in the healthcare marketplace are incentives to work toward this goal.

Notes

1. Iezzoni, Foley, Daley, Hughes, Fisher, Heeren. "Comorbidities, Complications, and Coding Bias." *Journal of the American Medical Association* 267, no. 16 (1992): 2197-2203.

2. US Department of Health and Human Services, Public Health Service. *International Classification of Diseases, 9th Revision, Clinical Modification, 5th ed.* Washington, DC: US Government Printing Office, 1995.

3. American Medical Association. *CPT 1996*. Chicago: American Medical Association, 1995.

4. US National Center for Health Statistics. *Uniform Hospital Discharge Data Set*, DHEW Publication No. (PHS) 80-1157. Hyattsville, MD: NCHS, 1980.

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