Reliable Coded Data Require a Reliable Coding Process Framework

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A poorly managed coding process can thwart the effective use of coded diagnosis and procedure data. Take for example Hospital A, a fictitious hospital that does not effectively manage their coding processes. At this hospital, the coding professionals are concerned primarily with the impact that coding has on reimbursement. Decisions on code assignment are based first and foremost on the impact that the code has on reimbursement. Queries are written only if the increased specificity will result in higher reimbursement. As soon as the coder finds a diagnosis or procedure that places the encounter into the highest-paying DRG, the coding process stops and the coder moves on to the next chart.

Compare this scenario with that of Hospital B, a fictitious hospital with a strong information governance program which includes clear-cut policies, processes, and standards that result in coding compliance. At this hospital, everyone understands the impact that code assignment has not only on reimbursement but also on the other significant uses of coded data. Decisions on code assignment are based on coding rules, guidelines, standards, and relevant data set definitions. Queries are written when necessary to ensure data integrity. Principal and additional diagnosis codes on inpatient encounters are selected and reported in accordance with the Uniform Hospital Discharge Data Set (UHDDS) definitions of principal and additional diagnoses.

Diagnosis and procedure codes are not just reported for reimbursement purposes. There are many users and uses of coded data. Internally, coded data are used by the facility, including medical staff, administration, and management. The data are used internally to support clinical and administrative decision making and to evaluate quality and efficacy of care provided. Federal agencies, state data banks, policymakers, researchers, provider associations, third party payers, healthcare purchasers, and consumer organizations also rely on data reported by facilities and providers. Coded data are used by many entities outside the hospital for a variety of purposes including research, public health, health policy, quality and safety monitoring, and more.

More than Just Reimbursement

According to an AHIMA position statement, coded clinical data are used in order to:

- Assist with clinical performance improvement
- Measure the quality, safety, severity of illness, and efficacy of care
- Manage care and disease processes
- Track public health and risks
- Provide data to consumers regarding costs, quality, and treatment option outcomes
- Design payment systems and process claims for reimbursement, including pay-for-performance measures
- Perform research, epidemiological studies, and clinical trials
- Serve as “clinical” data set for some personal health records
- Design healthcare delivery systems and monitor resource utilization
- Identify fraudulent practices
- Set health policy[1]

The coding process must provide accurate, consistent, and reliable coded data. Policies, processes, and standards that ensure coding compliance are an important component of a healthcare entity’s information governance program. A compliant coding process which results in reliable coded data is highly valued for the many uses of coded data stated above. The users of coded data will trust the data if they are convinced that the process of coding the data is reliable.

Resources for Health Record Documentation Requirements

THE FOLLOWING IS a list of rules, regulations, standards, and other resources for health record documentation requirements in hospitals and provider practices. This is not intended to be a complete list but does highlight some of the more significant resources:

- State and/or county licensure requirements regarding health record content
- Reimbursement requirements (such as Medicare Conditions of Participation or Conditions for Coverage)
- Voluntary accrediting agency standards (such as The Joint Commission)
- ASTM International Computerized System Standards (such as ASTM E1384 Standard Practice for Content and Structure of the Electronic Health Record)
- Health Level Seven (HL7) International Standards
- Professional associations (such as AHIMA and physician specialty organizations)
- Professional liability insurance companies, malpractice insurance companies, physician insurance pools
- US Department of Health and Human Services Office of Inspector General Compliance Program Models
- Medical staff bylaws, facility rules and regulations

Reliable Data Depends on Documentation

For coded data to be reliable, the source documentation—the patient health record—must be reliable. The structure and content of the health record must conform to set expectations. This has a tremendous impact on code assignment. Inconsistent adherence to documentation requirements results in inconsistent reporting of coded data. Incomplete documentation results in inadequate reporting of coded data. Requirements with regard to health record documentation are set forth by a number of sources at the national, state, and local level as noted in the side bar on this page.

Certain date elements such as principal diagnosis, other diagnoses, and principal procedure are uniformly defined. The National Committee on Vital and Health Statistics developed standardized data elements for inpatient hospital data with the UHDDS and ambulatory care with the Uniform Ambulatory Care Data Set (UACDS). The UHDDS was adopted by the federal government for data collection and it is also used for a variety of other purposes. The definitions included in the UHDDS and UACDS are widely recognized and accepted for data collection by federal and state governments along with other public and private users of healthcare data.

The use of data sets such as the UHDDS allows for consistent and standardized reporting of data, but only if the data set definitions are applied correctly. A data set provides definitions to be used for a prescribed set of data elements. It is imperative that coding professionals understand the importance of following data set definitions that are applicable to the type of encounter being coded. Users of the coded data expect adherence to official coding guidelines, coding rules and conventions, and applicable data set definitions.

Information Governance Impacts Coding

Medical staff bylaws, rules, and regulations related to health records should be reviewed regularly to ensure compliance with external documentation requirements and standards. Facility guidelines on coding should also be reviewed and updated at least annually as part of an organization's information governance work.

AHIMA is one of the driving forces in an effort to introduce information governance into healthcare. Many AHIMA resources are available that discuss how to implement information governance practices and also discuss its role in ensuring the integrity of coded data. These resources can be found on the information governance landing page of AHIMA's website at www.ahima.org/topics/infogovernance and also in AHIMA's HIM Body of Knowledge.

Note

1. AHIMA. "Statement on Consistency of Healthcare Diagnostic and Procedural Coding." AHIMA Position Statement. December 2007.

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