Reporting Codes Accurately

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by Kathy Giannangelo, RHIA, CCS

Coding professionals routinely review records and, when appropriate, query physicians to clarify a condition. Once the specifics are known, ICD-9-CM is used to determine the appropriate codes to record a patient's diagnosis and report the healthcare claim. Coding professionals know that this process affects the reimbursement of services provided at their organizations.

However, there are instances when the diagnosis codes reported by coding professionals are not the same as those that ultimately end up in payer databases, and the consequences—such as incorrect payments—may not be readily apparent. It is important to understand how discrepancies can happen and the necessary steps to prevent them.

Steps to Reporting Accuracy

Coding professionals follow a series of steps to ensure that codes are reported accurately on claims. For example, coders in acute care hospital settings begin the process with two fundamental steps:

1. Analyze health record documentation for quality and completeness of coding (e.g., inclusion or exclusion of codes)
2. Determine when additional clinical information is needed to assign diagnosis or procedure codes

When coding professionals use a classification, clinical interpretation occurs. Coding professionals must have an understanding of the condition in order to correctly apply the coding standards and guidelines of the coding system being used. They are responsible for assessing physician documentation to ensure that it supports the codes reported.

However, coding professionals should not make assumptions, clinical judgments, or interpretations when coding. The US Office of Inspector General defines assumption coding as "the coding of a diagnosis or procedure without supporting clinical documentation."[1] Thus the third step is critical for coding accuracy:

3. Consult with physicians and other healthcare providers to obtain further clinical information to assist with code assignment

Accurately coded data originate from collaboration between physicians, who have a clinical background, and coding professionals, who have an understanding of classifications systems.[2] Coding professionals use their clinical knowledge about a disorder and the coding system in order to link the two and ensure complete and accurate documentation. When there are conflicting or ambiguous data in the health record, coding professionals query physicians for clarification and additional documentation prior to code assignment. The questions posed to the physician are derived from the evidence in the medical record that points to greater specificity in code assignment based on the coding system's conventions and guidelines.

Steps 4 and 5 involve adhering to all official coding guidelines published in the HIPAA standard transactions and code sets regulation. Additional official coding advice is published in the AHA quarterly publication Coding Clinic for ICD-9-CM.

4. Select the diagnoses and procedures that require coding according to current coding and reporting requirements for inpatient services
5. Select the principal diagnosis, principal procedure, complications and comorbid conditions, and other significant procedures that require coding according to Uniform Hospital Discharge Data Set (UHDDS) definitions and official coding guidelines

Once the codes are selected for the diagnoses and procedures, the order or sequence in which they appear on the claim is crucial to correct reimbursement. Verifying that the Diagnosis Related Group (DRG) assigned is in fact what the payer used for payment completes the final steps in the reporting process:

6. Sequence diagnoses and other reasons for encounter according to notations and conventions of the classification system and standard data set definitions (e.g., UHDDS)
7. Evaluate the effect of code selection on DRG assignment
8. Verify that the DRG assigned by the hospital is the same as that used by the payer for reimbursement

Sources for Reporting Guidance

Determining the number of diagnosis and procedure codes to report depends on a number of factors, which include a coding professional's analysis of the documentation, query responses from physicians or other healthcare providers, and the application of official coding and reporting guidelines. One such reporting guideline relates to the standard billing form's fields for reporting. For example, the UB-92 maintained by the National Uniform Billing Committee contains fields (form locators [FLs]) for nine diagnoses (one principal [FL67] and eight secondary [FL 68-75]).

Prior to HIPAA, UB-92 claims data were submitted either on paper or electronically in the form of a flat file. Thus, hospitals reported up to nine diagnoses and six procedures. When the HIPAA standards for electronic transmission were implemented, the number of diagnoses that hospitals could report increased. These standards of compliance for electronic claim and encounter transactions are explained in the ANSI ASC X12N 837 Institutional (837I) Implementation Guide (IG) and Addenda (004010X096A1). The 837I transaction is used to submit claims and encounter data to a payer for payment. The 837I format is the electronic corresponding format to the UB-92 claim form. The 837 IG and addenda are used for claim submission if a provider is currently submitting claims on the UB-92 electronic format. Any claims or encounter data submitted on the UB-92 form correlate to the 837I form when submitted electronically.

The HIPAA IGs and addenda provide assistance in developing and executing the electronic transfer of healthcare data. However, some payers have independently created companion guides to supplement the HIPAA IGs, which are tailored to meet individual health plans' particular needs. According to the Centers for Medicare and Medicaid Services (CMS), companion guides are health plan–specific versions of the HIPAA-adopted standard IGs that define the health plans' requirements for situational data elements and provide special instructions and further guidance on how the health plan is interpreting the HIPAA IGs.[3]

While the HIPAA IGs and addenda provide for the reporting of the principal (FL67), E code (FL77), admitting (FL76), and up to 24 other diagnoses (FL68-75), a review of a few payer companion guides revealed differences in the way the reported codes are processed. For example, AdminiStar Federal, a Medicare part A contractor, states, "You may send as many diagnosis codes as allowed in the implementation guide. However, only the primary/principal and the first 8 other diagnosis codes will be considered for adjudication and payment determination."[4] Blue Cross and Blue Shield of Alabama advises that "Up to fifteen (15) diagnosis codes may be sent. Principal, admitting, and an E code may come in one HI segment and up to twelve (12) other diagnosis codes may be sent in a second HI segment."[5] The Utah Medicaid State Department of Health states, "The first five diagnoses will be used for claims processing (principal diagnosis and four others)."[6]

The Impact on Hospitals

The number and order of the codes a hospital reports can have a significant impact on reimbursement and data integrity. For example, if complications and comorbid conditions are reported after the payer's cut-off, they are not being considered in DRG determination. This could result in a different DRG assignment and subsequent payment than what the hospital is expecting.

To prevent this from happening, some hospitals use software to help with step 7, evaluating the effect of code selection on DRG assignment. The software automatically sequences the diagnoses and procedures affecting reimbursement at the top. However, there is a possibility that resequencing could occur. Therefore it is essential that step 8—verify that the DRG assigned by the hospital is the same as that used by the payer for reimbursement—be performed. For example, if you use a clearinghouse or other third-party vendor, it is important to audit their submissions to ensure the codes sent to them are not changed or resequenced.

Ensuring that codes are reported accurately on a claim is a shared responsibility between coding professionals, clinicians, business services staff, and information systems integrity professionals. Coding professionals are responsible for supplying the diagnosis and procedure codes that are reported on the claim, and therefore they must ensure their accuracy. Making certain that appropriate coding and reporting principles are applied to business practices requires performance checks of selected data.

Insurance of data integrity is greatly increased when coding professionals complete the steps to reporting accuracy. Verifying that the codes reported are in fact the ones used by the payer in adjudicating the claim should lead to answers of how the discrepancy could happen. Then the necessary steps can be implemented to prevent consequences such as incorrect payment.

Notes

1. "OIG Compliance Program Guidance for Third-Party Medical Billing Companies." *Federal Register* 63, no. 243 (1998). Available online at http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf.
2. Prophet, Sue. "Developing a Physician Query Process." *Journal of AHIMA* 72, no. 9 (2001): 88I–M.
3. Centers for Medicare and Medicaid Services (CMS). "Frequently Asked Questions." What are Companion Guides? Where do I get them? Question number 4208. Available online at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php.
4. CMS. "Companion Document, ANSI X12N 837 Institutional Health Care Claim." Available online at www.adminastar.com/Providers/EDI/files/MedA_InstitutionalCompanion.pdf.
5. Blue Cross and Blue Shield of Alabama. "Companion Document for ANSI ASC X12N 837 4010 (Claim) Submission to Blue Cross and Blue Shield of Alabama for Institutional Claims." Available online at www.bcbsal.com/providers/vendors/pdfs/CcompanionDoc4Cross837.pdf.
6. Utah Medicaid State Department of Health. "Utah Specific Transaction Instructions." Available online at http://health.utah.gov/hipaa/pdfs/comguides/837I.pdf.

References

AHIMA. "Standards of Ethical Coding." *Journal of AHIMA* 71, no. 3 (2000): insert.

AHIMA Coding Products and Services Team. "Managing and Improving Data Quality (Updated)." *Journal of AHIMA* 74, no. 7 (2003): 64A–C. Available online in the FORE Library: HIM Body of Knowledge at www.ahima.org.

National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional, ASC X12N 837 (004010X096). Washington Publishing Company. Available online for download www.wpc-edi.com.

Kathy Giannangelo *(kathy.giannangelo@ahima.org) is a practice manager at AHIMA.*

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