Where to Find Answers to Your Coding Questions

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by Kathy Brouch, RHIA, CCS

For more information on physician queries, see the "Developing a Physician Query Process" practice brief in the October 2001 *Journal of AHIMA* and in the FORE Library: HIM Body of Knowledge in the Communities of Practice at www.ahima.org.

Is obtaining an answer to a coding question a daunting task? With the publication of coding guidelines, it should be a simple process. Yet many coders continue to claim that their questions go unanswered. This article will help you find solutions to your toughest coding questions.

To begin, keep in mind that all coding questions aren't necessarily about selecting the correct code from a specific classification. Instead, the question might have more to do with reporting a code to a particular payer, receiving appropriate reimbursement, or trying to compensate for poor documentation. To best answer a coding question, start by asking why you can't find the right code. The answer will determine the best way to find it.

Coding Dilemmas

The cause of coders' questions often has to do with problems with medical record documentation, coding, reporting, payer guidelines, or classification. Incomplete or conflicting documentation is frequently the cause of many coding questions. Though many coders may not like to hear "query the physician," it is often the required solution, according to Coding Clinic for ICD-9-CM, an official source for coding advice.

However, coders must be knowledgeable about the condition or procedure in question and the coding system's guidelines to be helped by the query. Using available resources such as clinical publications or the Internet to gain the necessary knowledge about unfamiliar conditions or procedures and applying that to the classification rules is vital to having a successful dialogue with a physician. Not only will it improve a coder's clinical knowledge but at the same time, it helps the coder educate the physician about appropriate documentation practices.

If documentation is not the problem, coding, reporting, or payer guidelines may be the cause for concern. The sources for coding guidelines are the rules of the classification system and the associated official coding guidelines. In the past, there has been a great deal of confusion about who should follow many of the ICD-9-CM official guidelines for coding and reporting. Their structure once led coders to believe certain guidelines did not apply to them because they did not work in a hospital setting. In Coding Clinic (second quarter 2002), the guidelines were reorganized into sections including a group that applies to all healthcare settings.

Payer guidelines that require certain codes to be reported or used to support medical necessity or coverage also present challenges. Because these are billing issues, they are handled differently than coding issues. In these cases, the payer is the chief source for solving billing problems. For example:

- a CMS program memorandum (http://cms.hhs. gov/manuals/memos/comm_date_dsc.asp) stating a HCPCS Level II G code must be used instead of a CPT code to report the rendered service
- a local medical review policy (www.lmrp.net) stated coding guidelines on medical necessity
- CMS offers instructions on completion of an advanced beneficiary notice to address questions of coverage of services

Your coding compliance policy should include directions on how to deal with payer-specific requirements. For recommendations, see the AHIMA practice brief "Developing a Coding Compliance Policy Document" in the July 2001 *Journal of AHIMA* and in the FORE Library: HIM Body of Knowledge in the Communities of Practice at www.ahima.org.

Solutions from CoP

When the physician query process and published guidelines do not provide the answer to your coding question, try seeking advice from your peers in AHIMA's Communities of Practice (CoP). Thousands of coding colleagues from across the country working in similar settings and dealing with similar issues are just a click away. In fact, there is a chance that your question has already been asked. With CoP's new search function, an answer can be found in seconds. Even if your search is unsuccessful, a Community Discussion post in the Coding (SCC) Community alone makes your question available to 6,500 members for a response.

Another source of help from the CoP is currently being developed. As published in the October issue of *CodeWrite*, a volunteer group is being formed to review submitted coding questions from community members and provide the appropriate resources and references from recognized authorities or official sources. Once completed, the frequently asked questions will be searchable, providing a wealth of information to community members.

Local, Regional, and State Networking

Coding Roundtables were formed as a means to improve coding skills through education, provide local networking opportunities, and share coding practices, challenges, and requirements to affect policy in the industry. In addition to using the CoP, check with your Coding Roundtable coordinator to determine if it is appropriate to bring the question along with supporting medical record documentation to your Coding Roundtable for discussion.

If, after review at the Roundtable, the coordinator determines further follow up is necessary, you may be referred to component state association (CSA) leadership to resolve reporting issues with local providers. To assist CSAs, AHIMA developed the Payer's Guide to Healthcare Diagnostic and Procedural Data Quality (2001), available on the AHIMA Web site at www.ahima.org. This guide was designed to help build a bridge between the payer community and the HIM professionals in that state.

The AHIMA Board of Directors also approved a position statement regarding consistency of coding. It emphasizes that to achieve consistency of healthcare diagnostic and procedure coding, healthcare entities must refrain from establishing or accepting rules (for example, reimbursement rules), regulations, or contracts that force healthcare entities to violate coding standards.[1]

Roundtable analysis may also show that significant variance in interpretation of a specific coding guideline exists or a particular coding problem common to coders has occurred at the state level, but no code or guideline is available in the classification. The types of circumstances would include instances when the coding guideline:

- is controversial and has not been previously addressed by the ICD-9-CM Coordination and Maintenance Committee or CPT Advisory Board or in *Coding Clinic for ICD-9-CM* or *CPT Assistant*
- was addressed by *Coding Clinic for ICD-9-CM* or *CPT Assistant* but needs to be clarified
- is the result of a conflict in direction provided in the code books and that with official coding or reporting advice

In these situations, the state coordinator should complete the feedback form located in the Coding Roundtable CoP and submit it to AHIMA. The AHIMA coding staff will review the request and determine the best course of action, which may include forwarding it to the appropriate official source of coding guidelines for a response.

The National Authorities

There are specific organizations that are recognized as the national authorities on coding advice. Classification changes and the associated guidelines development are the responsibility of the medical code set maintenance organizations. Two federal agencies, the National Center for Health Statistics (NCHS), and the Centers for Medicare & Medicaid Services (CMS), maintain ICD-9-CM. Representatives from these two agencies co-chair the ICD-9-CM Coordination and Maintenance Committee, an advisory body that holds public meetings to discuss possible updates and revisions to ICD-9-CM. The American Medical Association is responsible for CPT. CMS is also in charge of the Healthcare Common Procedure Coding System (HCPCS).

Regarding ICD-9-CM coding guidelines, the September 3, 1986, *Federal Register*, stated, "Coding guidelines are clarified through unanimous agreement by the Cooperating Parties of the ICD-9-CM *Coding Clinic*." Those cooperating parties are NCHS, CMS, AHIMA, and the American Hospital Association (AHA). Therefore, AHIMA cannot issue coding guidelines independently.

The Central Office on ICD-9-CM was developed to provide consistent and accurate advice for appropriate and effective application of the ICD-9-CM classification system. To achieve this, AHIMA and the other cooperating parties can only refer coders seeking official ICD-9-CM coding advice to the AHA.

In a profession such as coding, questions are sure to arise. When they do, be sure to evaluate all possible resources, including sharing your ideas and querying colleagues in the CoP. These techniques will help the goal of consistency of healthcare diagnostic and procedure coding to be achieved.

Notes

1. AHIMA. "Statement of Consistency of Healthcare Diagnostic and Procedural Coding." May 18, 2001. Available on the AHIMA Web site at www.ahima.org.

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For More Information

Contact the following organizations for more coding information.

AHA Central Office
1 North Franklin
Chicago, IL 60606
www.ahacentraloffice.org

CPT-IS Coding Questions
American Medical Association
515 N. State Street
Chicago, IL 60610
www.ama-assn.org/ama/pub/category/3117.htm

ICD-9-CM Coordination
and Maintenance Committee
NCHS: www.cdc.gov/nchs/icd9.htm
CMS: www.cms.hhs.gov/paymentsystems/icd9/

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