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# NASHVILLE GENERAL HOSPITAL

NEW

**POLICY NAME** Diagnostic and Procedural Coding Guidelines **POLICY #:** HIM-_____

**DEPARTMENT** Health Information Management **Effective Date:** _____

**Recommending Dept./Cmte.** Medical Records/Utilization Management Cmte **Page** 1 **of** 8

**APPROVALS:**

**Administration** _____ **Other** Compliance Cmte

**Nursing** Not applicable **Other** _____

**Medical Executive Cmte.** _____ **Board** Not applicable

**REVIEWED:** _____ _____ _____ _____

**REVISED:** _____ _____ _____ _____

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**PURPOSE:** To ensure proper reporting of ICD-9-CM and CPT-4 coded data according to all official coding guidelines as approved by the cooperating parties (and sequencing rules defined in the UHDDS). Further guidance is provided through specific policies and procedures for coding professionals at Nashville General.

**POLICY:**

1. Coding professionals at Nashville General Hospital are to adhere to the following guidelines: Official coding guidelines for diagnosis coding from the American Hospital Association (AHA) Coding Clinic for ICD-9-CM the official publication for ICD-9-CM coding. These guidelines and advice are designated by AHA, AHIMA, CMS and National Center for Health Statistics and required by the HIPAA law. For CPT procedure coding, rules and regulations set forth by the AMA in the CPT book and the AMA CPT Assistant monthly publication.

2. The attending physician must be queried in the event of conflicting, incomplete or ambiguous documentation. Do not make assumptions. The coding professional is to follow the Nashville General Physician Query Policy.

3. It is appropriate to code from the consultant documentation except in the event the attending physician documentation contradicts the consultant. In the event of contradiction, query the attending physician.

4. Coding professionals will follow the coding guidelines for Physicians at Teaching Hospitals (PATH) outlined in Supervising Physicians in Teaching Settings guidelines published by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Carrier Manual (MCM) Section 15016.

   The resident's documentation alone cannot be used for code assignment. The combined entries into the medical record by the teaching physician and the resident constitute the documentation for the services and together must support the medical necessity of the service.

   Services provided by the teaching physician require that they personally document at a minimum, the following:

   - The teaching physician performed the services or was physically present during the key or critical portions of the services when performed by the resident; and
   - The participation of the teaching physician in the management of the patient.

The teaching physician's notes should reference the resident's notes.

**Example:** "I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident's note."

**Examples of unacceptable documentation:**

- "Agree with the above"
- "Rounded, Reviewed, Agree"
- "Discussed with the Resident. Agree"

Such documentation is unacceptable because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient and/or had any involvement with the plan of care.

5. All coded data must be supported by documentation in the patient's medical record. All diagnosis that effect the current hospital stay should be reported

**A. Inpatient setting**

- Principal Diagnosis- designated and defined as "the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." The coding professional should follow guidance in the Official Coding Guidelines for assignment of principal diagnosis. If the coding professional is not able to make a determination of principal diagnosis based on chart documentation, the physician should be queried.

- Additional Diagnosis-designated and defined as all conditions that co-exist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay.

    1. Do not code conditions that were previously treated and no longer exist. However, history codes (V codes) may be used as secondary codes if the personal history or family history has an impact on current care or influences treatment.

- Operative Reports- Medical records are analyzed and codes selected only with complete and appropriate documentation by the physician. According to coding guidelines, codes are not assigned without physician documentation. Records will not be coded without a complete Operative/Procedure report.

- Discharge Summaries- If the coding professional codes a chart without a Discharge Summary- The coding professional will route the medical record to the HIM: CODED Waiting for Discharge Summary queue. Upon completion of the Discharge Summary, a notification will be sent to the Coding Manager to review for any coding changes. In the event that coding needs to be amended the account will be routed back to the coding professional for further review.

**B. Outpatient setting**

- First Listed Diagnosis-
    - In the out-patient setting the first listed diagnosis is used in lieu of a principal diagnosis. List first the ICD-9-CM code for the diagnosis, condition, symptom, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided.

    - Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", or working diagnosis. Rather, code condition(s) to the highest degree of certainty for that encounter/visit such as symptoms, signs, abnormal test results or other reason for visit.

- Additional Diagnoses:
  - Code all documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment or management. If the physician documents their existence they should be coded regardless if the patient is on medications for the condition or if it is currently being treated.
  - Do not code conditions that were previously treated and no longer exist. However, history codes (V codes) may be used as secondary codes if the personal history or family history has an impact on current care or influences treatment.
  - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the condition(s).
  - For outpatient encounters for diagnostic tests that have been interpreted by a physician and the final reports are available at the time of coding, code any confirmed or definitive diagnoses documented in the interpretation. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
  - For clinic records when a diagnostic test is ordered, do not use the ICD-9 codes written on the order form. These are often entered by someone other than a clinician. Use only the narrative diagnosis documented in the clinic record.
- Operative Reports- Medical records are analyzed and codes selected only with complete and appropriate documentation by the physician. According to coding guidelines, codes are not assigned without physician documentation. **Records will not be coded without a complete Operative/Procedure report.**

C. **Procedures:** All significant procedures are to be reported. Outpatient procedures are to be coded with ICD-9-CM procedure codes and CPT codes in the 10000-69999 range.

A significant procedure is one that is:
- Surgical in nature
- Carries a procedural risk
- Carries an anesthetic risk
- Requires specialized training (including arteriogram and SWAN Ganz insertion)

- **Selection of Principal Procedure – In-patient:**
  The procedure that was performed for a definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appears to be two procedures that are appropriate, select the one most related to the Principal Diagnosis.
- **Selection of First-Listed Procedure Out-patient**
  The procedure that was performed for a definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.

6. The following conditions are to be coded on Inpatients and Outpatients when confirmed by physician documentation:

    - Methicillin-resistant micro-organisms
    - Personal history of malignant neoplasm
    - Use of Platelet inhibitor (99.20)
    - Obesity (278.0x)
    - Code BMI (Body Mass Index) when the physician has documented obesity. BMI can be coded from a dietician or nutritionist note. If BMI is >40 or <19 and the physician has not documented any diagnosis, the physician should be queried.
    - Two diagnoses codes are required to completely report Pressure Ulcers. One code from category 707.0x (pressure ulcer), which will identify the ulcer site, and one from subcategory 707.2x (pressure ulcer stages).
    - When the physician has documented Pressure Ulcer, the code assignment for the pressure ulcer stages may be based upon documentation from the clinician or wound care nurse.
    - Anemia (280.X- 285.X)
    - Status post MI (412)
    - Tobacco abuse (305.1)
    - Code OB patients 35 years or older at time of delivery to 659.5x, 659.6x. Code OB patients less than 16 at time of delivery to 659.8x.
    - History of tobacco abuse (V15.82)
    - History of stroke or TIA without residuals (V12.54)
    - Non-compliance with medical treatment (V15.81)
    - Status of replacement of organ by artificial device, mechanical device or prosthesis (V43.0-V43.89)
    - Artificial opening status (V44.0-V44.9)
    - Pacemaker status (45.01)
    - Dialysis status (V45.11)
    - Angioplasty with stent insertion status (V45.82 and V45.09)
    - Ventilation Dependency (V46.11-V46.12)
    - Amputation status (V49.6- V49.77)
    - Laparoscopic procedure converted to open (V64.41)
    - Code acute and chronic pain (338.xx) in addition to the site of the pain. This is especially important when pain medication is maximized for comfort.
    - Add V codes when it is clear from the documentation that the condition influenced the stay. **Example:** History of child molestation may not be necessary to code, but if the patient has a mental condition, then the history is important.
    - Apply all E-codes that reflect any and all injuries or adverse drug/chemical reaction

    The AHA Coding Clinic for ICD-9-CM, Official Coding Guidelines and the AMA CPT Assistant are to be utilized by all coders to assist with answering coding questions. These are available through 3M encoder software references.

7. Abstracting/Coding specifics by Patient Type

    **Emergency Department:**

    1. All Emergency Department visits must have modifier 25 added to the E&M code in both 3M and STAR when there is any type of procedure performed. The Encoder in 3M will let you know when you "Compute" what is needed.

    2. Any procedures performed in the Emergency Room should have Revenue code 450 assigned.

3. ED –Horizon Emergency Care chart:

   - Clinician History of Present Illness- the nursing note can be used if the physician has stated that the RN note has been reviewed and is agreed with. The providers initials, date and time must follow this entry.
   - Any entry that has the physician initials, date and time can be used.
   - Documented Computer Assisted Codes should be reviewed by the coder who will select all applicable codes per coding guidelines and hospital coding guidelines.
   - Codes with a Primary Diagnosis: "Y" beside them indicates that these items were the focus of the exam. The coder needs to follow coding and hospital guidelines in the selection of the principal diagnosis.

**Clinic and Outpatient Diagnostic Visits:**

1. All Clinic visits must have modifier 25 added to the E&M code in both 3M and STAR when there is any type of procedure performed. The Encoder in 3M will let you know when you "Compute" what is needed.

2. All Outpatient Diagnostic visits MUST have an order AND results before it can be coded.

3. Diagnostic tests that have been interpreted by a physician - code any confirmed or definitive diagnosis documented in the interpretation.

**Our Kids:**

1. Our Kid accounts cannot be coded until the dictated report is available. These accounts are coded using V71.5.

**Same Day Surgery/ASU:**

1. After computing the APC in 3M, go to the list of Revenue codes. There will be two 360 Revenue codes listed. Delete one of them. The other Revenue code 360 that remains you will "right click" and then select "Copy Attributes". Then go back to the Principle procedure CPT code and "right click". Select "Paste Attributes".

**Observations/OBA:**

1. All Observation visits must have modifier 25 added to the E&M code in both 3M and STAR when there is any type of procedure performed. The Encoder in 3M will let you know when you "Compute" what is needed.

2. Use Observation code G0378 and/or G0379 as an additional code with Revenue code 762 for each day of service. After computing the APC in 3M, go to the list of Revenue codes. There will be 762 Revenue codes listed for each day of service. "Right click" and then select "Copy Attributes". Then go back to either the G0378 or G0379 code and "right click". Select "Paste Attributes".

3. OBA accounts are also Observation accounts but **do not** require G0378 or G0379 be assigned.

4. OBA accounts also require modifier 25 be added to the E&M in both 3M and STAR when there is any type of procedure performed. The Encoder in 3M will let you know when you "Compute" what is needed.

**Inpatient:**

**Acute Blood Loss Anemia:**

Documentation in the chart must state that the anemia is due to acute blood loss in order to code 285.1. Postoperative anemia, unspecified, is coded to 285.9. **Per CC 1st Q 2007, Page 19.**

**Beta Strep in Mother**:

If a mother is a beta strep carrier, use codes 648.91 and V02.51. If she has a current positive culture, use codes 647.8x and 041.02. **Per CC 1st Q 2002, pages 14, 15.**

**Coagulopathy due to Coumadin:**

If a patient is admitted with Coagulopathy due to Coumadin, do not use a code from the 286.x series. If the patient presents with a specific hemorrhage, such as GI bleed, code the bleed as principle with an E-code for adverse affect of Coumadin. If no current hemorrhage exists use code 790.92 Abnormal Coagulation Profile. **Refer to *Coding Clinic*, Third Quarter 2004, page 7, Fifth Issue 1993, page 16, and Third Quarter 1992, page 15, for additional discussion.**

**CVA**:

When a patient has a new CVA and a history of old CVA with residuals, code the new sequela from the current stroke as well as the deficits from previous strokes via category 438 **(per CC 1st Q '98 and 4th Q 2004, page 77)** (434.91,784.3, 342.90, 438.12). If a patient has a TIA or a diagnosis from 430-437 and a history of old CVA with residuals, do code from 438 category (435.9, 438.12). If a patient has a new CVA with residuals and a history of a CVA without residual, V12.54 may be used as an additional code (434.91, 784.3, V12.54).

**Diabetes (IDDM)**:

Unless the physician documents Type I Diabetes, IDDM is to be coded 250.00. Either type of DM may be insulin dependent at various stages of life. The fact that a patient is currently insulin dependent does not make them a Type I. **Per CC 4th Q 2004, pages 53 – 56.**

**Diabetes, Poorly Controlled:**

Poorly controlled Diabetes is not to be coded as out of control. Do not code based solely on lab values. Physician must also document either out of control or not controlled. **Per CC 2nd Q 2002, page 13**

**DVT/PE:**

If the pt. has a history of DVT or PE and is still under current treatment (Coumadin) and/or still has signs (x-ray is positive for DVT or PE), code the DVT or PE as a current diagnosis (415.19, 453.41).

Code V12.51, Personal history of certain other diseases, Diseases of circulatory system, Venous thrombosis and embolism as a secondary diagnosis for a patient with a history of DVT, receiving Coumadin prophylaxis. Because the patient no longer has DVT, it would not be coded. **Per CC 1st Q 2002, pages 15,16.** Need to also code long term use of Coumadin (V58.61).

If patient is receiving Coumadin prophylactively for DVT, than use long term use of Coumadin (V58.61) along with personal or family history of DVT.

**E-Codes:**

E codes are used in conjunction with all injury and poisoning codes, range 001-V89.09, which indicates an injury, poisoning or adverse effect due to an external cause. Assign the appropriate E code for the initial encounter of an injury, poisoning or adverse effect of drugs, not for subsequent treatment. An E code can never be a principle or first listed diagnosis. **Per ICD-9-CM Official Coding Guidelines**

**Hematuria:**

Hematuria due to Foley cath trauma is coded as hematuria (599.7, E879.6)
Per 3M – "this is a risk of Foley insertion/removals when a trained hospital staff performs as opposed to a patient induced cath trauma. Not a complication just a risk." If the hematuria is due to nurses or Drs. inserting or removing cath – only code hematuria. If the hematuria is due to the pt. pulling Foley cath out – code urethral injury (867.0, 599.7, E928.9, and place of occurrence). **Coding Clinic, November - December 1985 Page: 15**

**Induction of Labor by AROM or Pitocin:**

Code 73.09 for artificial rupture of membranes when a patient is in labor (this speeds up the labor).
Code 73.01 when membranes are ruptured to stimulate the beginning of labor.
Code 73.4 when Pitocin or Oxytocin is used to start labor.

**Intra-op Hemorrhage**:

If during an operative procedure, there are documented attempts to control bleeding via extensive electrocautery or use of surgical or Gelfoam, use hemorrhage complicating a procedure (998.11). Do not code 998.11 if patient simply lost a lot of blood in surgery without apparent cause or attempts at control. This would be addressed through an anemia code rather than an assumed complication. **Per CC 2nd Q 1992, pages 15 – 18.**

**Postoperative Conditions:**

Code postoperative complication codes if the provider states the diagnosis is a complication of the surgery or was due to the surgery. If you have any questions or doubts, query the physician.

**Prolonged Pregnancy:**

A mother, who has advanced beyond 42 completed weeks gestation.

**Post Term Pregnancy:**

Pregnancy over 40 completed weeks to 42 completed weeks gestation.

**Positive Sputum Cultures:**

When a physician documents sputum culture findings in the progress notes, he or she must also make a clear connection between the culture findings and a disease process. For example, a diagnosis of pneumonia, and a subsequent mention of positive sputum cultures in a separate progress note does not equate to a connection. The doctor must still state the type of pneumonia or be queried.

**V Codes:**

Status codes indicate that a patient is either a carrier of a disease or has the sequela or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.
A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. **For example**, code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information.

There are two types of history V codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring. The exceptions to this general rule are category V14, Personal history of allergy to medicinal agents, and subcategory V15.0, Allergy, other than to medicinal agents. A person who has had an allergic episode to a substance or food in the past should always be considered allergic to the substance.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

Assign a code from subcategory V58.6, Long-term (current) drug use, if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from subcategory V58.6 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis). **Refer to the ICD-9-CM Official Coding Guidelines**