

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 1 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

<p>SCOPE: All personnel responsible for performing, supervising or monitoring coding of inpatient services including, but not limited to:</p> <table border="0"> <tr> <td>Facility Health Information Management</td> <td>Administration</td> </tr> <tr> <td>Corporate Regulatory Compliance Support</td> <td>External Coding Contractors</td> </tr> <tr> <td>Case Management/Quality Resource Management</td> <td>Ethics and Compliance Officers</td> </tr> <tr> <td>Parallon Service Centers</td> <td>Physician Advisors</td> </tr> <tr> <td>Parallon Business Performance Group</td> <td></td> </tr> </table> <p>This policy applies to diagnosis and procedure coding of all inpatient services provided in Company-affiliated facilities (acute care and freestanding psychiatric). For outpatient services, refer to the Coding Documentation for Outpatient Services Policy, REGS.COD.002. For Coding Documentation for Rehabilitation Facilities, refer to REGS.COD.013. For Documentation for Outpatient Services Group Entities, refer to REGS.OSG.001.</p>	Facility Health Information Management	Administration	Corporate Regulatory Compliance Support	External Coding Contractors	Case Management/Quality Resource Management	Ethics and Compliance Officers	Parallon Service Centers	Physician Advisors	Parallon Business Performance Group	
Facility Health Information Management	Administration									
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<p>PURPOSE:</p> <p>To improve the accuracy, integrity and quality of patient data, ensure minimal variation in coding practices, and improve the quality of the physician documentation within the body of the medical record to support code assignments. The Company's commitment to data integrity is documented on Attachment A.</p>										
<p>POLICY:</p> <p>Diagnoses will be coded utilizing the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Procedures will be coded utilizing the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). Company facilities will follow the most current ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting for assignment of diagnoses and procedures.</p>										
<p>PROCEDURE:</p> <ol style="list-style-type: none"> <u>ICD-10-CM/AHA Coding Clinic</u> Diagnoses will be coded utilizing the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and/or other classification systems that may be required (such as DSM IV for classification of psychiatric patients). Procedures will be coded utilizing the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). The Company will follow the most current ICD-10-CM/PCS Official Guidelines for Coding and Reporting. <u>Selection of Principal and Secondary Diagnosis(es)</u> Inpatient diagnoses shall be coded in accordance with Uniform Hospital Discharge Data 										

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 2 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
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<p>Set (UHDDS) definitions for principal and additional diagnoses as specified in the ICD-10-CM Official Guidelines for Coding and Reporting.</p> <p>a. The principal diagnosis is defined in the UHDDS as, <i>“that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”</i></p> <p>The circumstances of the inpatient admission always govern the selection of principal diagnosis. In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over the application of the ICD-10-CM Official Coding Guidelines.</p> <p>b. ICD-10-CM Official Coding Guidelines for Coding and Reporting state that in the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided (and the Alphabetic Index, Tabular List, or another coding guideline does not provide sequencing direction), then any one of the diagnosis may be sequenced first.</p> <p>i. It is important that the coder validate that all of the conditions actually necessitated inpatient admission to the hospital and simply did not exist at the time of admission.</p> <p>ii. The Medicare Severity Diagnosis Related Group (MS-DRG) classification reflects the severity of illness of the resources utilized for the patient through the relative weight structure. In order to appropriately identify the severity of the patient and the resources utilized, sequence as principal diagnosis the condition that results in the higher relative weighted assignment. (Source: Medicare Claims Processing Manual, Chapter 3)</p> <p>iii. In the instance two or more diagnoses equally meet the criteria for principal diagnosis, and one of the diagnoses results in an Extensive or Non-extensive O.R. Procedure Unrelated to Principal Diagnosis (MS-DRGs 981-989), the diagnosis that does not result in the unrelated DRG would be the principal diagnosis.</p> <p>c. The UHDDS defines additional diagnoses as, <i>“all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.”</i> Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.</p> <p>3. <u>Selection of Principal and Secondary Procedure(s)</u></p> <p>In accordance with UHDDS definitions all significant procedures are to be reported.</p> <p>a. A significant procedure is one that is: (1) surgical in nature, or (2) carries a procedural</p>

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 3 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

<p>risk, or (3) carries an anesthetic risk, or (4) requires specialized training.</p> <p>b. When more than one procedure is reported, the principal procedure is to be designated by following the instructions published in the most current ICD-10-PCS Official Coding Guidelines for Coding and Reporting. This designates that the principal procedure is the procedure that is most related to the principal diagnosis.</p> <p>4. <u>Reportable Diagnoses/Procedures</u></p> <p>To achieve consistency in the coding of diagnoses and procedures, coders must:</p> <p>a. Thoroughly review the entire medical record as part of the coding process in order to assign and report the most appropriate codes;</p> <p>b. Adhere to all official coding guidelines as stated in this policy;</p> <p>i. Assign and report codes, without physician consultation/query, for diagnoses and procedures that are not listed in the physician's final diagnostic statement <u>only if</u> those diagnoses and procedures are specifically documented in the body of the medical record by a physician directly participating in the care of the patient, and this documentation is clear and consistent. Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear (per ICD-10-PCS Official Guidelines for Coding and Reporting). Areas of the medical record which contain acceptable physician documentation to support code assignment include the discharge summary, current history and physical, emergency room record, physician progress notes, physician orders, physician consultations, operative reports, anesthesia notes, and physician notations of intra-operative occurrences.</p> <p>ii. When diagnoses are stated in other medical record documentation (nurses' notes, pathology report, radiology reports, laboratory reports, EKGs, nutritional evaluation and other ancillary reports) but not documented by a physician directly participating in the care of the patient, a physician must be queried for confirmation of the condition. These conditions must also meet the coding and reporting guidelines outlined in the most current <i>ICD-10-CM Official Coding Guidelines unless specified otherwise (i.e., BMI or Pressure Ulcer Stage may be based on medical record documentation from clinicians who are not the patient's provider)</i></p> <p>iii. Utilize medical record documentation to provide specificity in coding physicians' diagnoses and procedures, such as utilizing the radiology report to confirm the fracture site or referring to the EKG to identify the location of a Myocardial</p>

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 4 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

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- iv. If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term; acute; long-term care; and psychiatric hospitals.

5. Present on Admission (POA) Indicator

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to law and/or regulation are required to report the present on admission (POA) indicators. The POA indicator is assigned to principal and secondary diagnoses and is defined as present at the time the order for the inpatient admission occurs.

To achieve consistency in the assignment of POA indicators to the final set of diagnosis codes assigned following the most current ICD-10-CM Official Guidelines for Coding and Reporting, coders must:

- a. Adhere to POA Reporting Guidelines; and
- b. Consult a physician for clarification and additional documentation when it is unclear as to whether the condition was present on admission.

6. Skilled Nursing Facilities (SNF) Minimum Data Set (MDS) Completion

- i. The HSC/HIM Director and MDS Coordinator should establish a protocol for completing Section I of the MDS. It is the responsibility of the HSC/HIM coding staff (or skilled/trained individual designated to perform the coding function) to supply ICD-10-CM codes to the MDS Coordinator for completion of Section I. The MDS Coordinator will be responsible for transferring the ICD-10-CM codes to the MDS Form.

Section I – Active Diagnoses:

Resident’s Primary Medical Condition:

- a. *#I0020B ICD Code for the Resident’s Primary Medical Condition:* Assign an ICD-10-CM code to indicate the resident primary medical condition that best describes the primary reason for admission.

Active Diagnosis:

- a. *#I8000 Additional active diagnoses:* Assign diagnosis ICD-10-CM codes to indicate

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 5 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

additional active diagnoses (active diagnoses in the last 7 days), when required.

7. SNF MDS/CAA Documentation Requirements

Each electronically submitted Minimum Data Set (MDS) must be maintained as a permanent part of the patient’s medical record. When applicable, any Care Area Assessment (CAA) generated must also be maintained as a permanent part of the medical record.

8. Query Process

Query the physician/provider participating in the care of the patient when a diagnosis or procedure has been determined to meet the guidelines for reporting but has not been clearly or completely stated within the medical record, when ambiguous or conflicting documentation is present or when documentation is unclear for POA indicator assignment. For specific guidelines for executing the query as well as detailed information on the query process, refer to the Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements, REGS.DOC.002.

9. Coding Summary

- a. A coding summary must be placed within the medical record of all inpatient discharges.
 - i. The coding summary must contain all reported ICD-10-CM diagnosis and ICD-10-PCS procedure codes, and their narrative descriptions, POA indicators, patient identification, and admission and discharge dates. The summary should also include discharge disposition, and may include MS-DRG assignment and description.
 - ii. The coder must ensure that changes to the ICD-10-CM or ICD-10-PCS narrative description of a diagnosis or procedure be consistent with the code descriptions in the ICD-10-CM or ICD-10-PCS manual.
- b. The coding summary should be either a system generated abstract or handwritten codes on the face sheet.
- c. The summary must be kept as a permanent part of the medical record.
- d. The HIM Director is required to ensure that the coding summary has been officially approved by the medical staff to be included as a permanent part of the medical record.
 - i. The coding summary should include a statement that the form will be filed as a permanent part of the medical record.
 - ii. Follow the process outlined in hospital policy or medical staff bylaws, rules and regulations for adding forms to the medical record.

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 6 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

10. Data Quality Application

Coders must not:

- a. Add diagnosis codes solely based on test results.
- b. Misrepresent the patient’s clinical picture through incorrect coding or by adding diagnoses or procedures unsupported by physician documentation for any reason.
- c. Report diagnoses and procedures that the physician has specifically indicated he/she does not support.
- d. Each facility must have a process in place to identify appropriateness of services and/or coverage issues before the service is rendered.

11. Coding Validation Reviews

Internal coding quality reviews must be completed in accordance with the Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy, REGS.COD.018.

12. Unique Payer Requirements

Each facility must ensure that coders are oriented about and aware of individual payer contracts and/or instructions that contain specific coding and reporting requirements.

- a. It is recognized that payers in various states may utilize coding guidelines that do not comply with those issued by the cooperating parties (*Source: Practice Brief on Data Quality (Updated), American Health Information Management Association (AHIMA), Chicago, Illinois, July/August, 2003*).
- b. Each facility must maintain, in writing, documentation of coding guidelines or coding requirements of a specific payer. Example: Fiscal Intermediary Transmittals, payer contracts, billing bulletins.
- c. Facility Health Information Management should be involved during contract negotiations with third party payers when coding guidelines are addressed.
- d. Written department procedures must also include how coding conflicts with payers are addressed. Since most facilities deal with many different payers who issue varied guidelines, coding issues with high volume payers should be addressed first.

13. Review of Claim Rejections, Claim Denials, Claim Return to, Claim Suspension, Line Item Rejection and Line Item Denials Related to HIM-Assigned Codes

In circumstances where there is to be a review of claim rejections, claim denials, claim return to, claim suspension, line item rejection and line item denials related to HSC/HIM-assigned codes, the review will be done by qualified coding colleagues.

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 7 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

14. Claims Adjustment

A written facility-specific policy must be developed which prohibits changing or resequencing of codes and/or HSC/HIM-assigned modifiers by business office, or Service Center patient personnel without review and approval by qualified coding personnel. Education and follow-up should be conducted with all coding professionals as applicable.

Exception: Billers are permitted to process seasonal influenza and pneumococcal vaccination claims due to the one-to-one correlation provided by CMS in the Medicare Preventive Services Quick Reference Information. Refer to CMS website for the Medicare Part B Immunization Billing (Seasonal Influenza, Pneumococcal, and Hepatitis B) document.

15. Policy Compliance Monitoring

Compliance with this policy will be monitored during reviews by the Corporate Regulatory Compliance Support Department and Parallon Business Performance Group.

- a. It is the responsibility of each facility’s administration to ensure that this policy is applied by all individuals involved in coding of inpatient services.
- b. Employees that have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy should discuss these situations with their immediate supervisor to resolve the situation.
- c. All day-to-day operational issues should be handled locally; however, if confidential advice is needed or a colleague wishes to report an activity that conflicts with this policy and is not comfortable speaking with the supervisor, colleagues may call the toll-free Ethics Line at (800) 455-1996 or [online](https://hcahealthcareethicsline.ethix360.com) at <https://hcahealthcareethicsline.ethix360.com>.

For any questions regarding this policy, please contact the [Reg Helpline](https://regshelpline.app.medicity.net) at: <https://regshelpline.app.medicity.net>.

REFERENCES:

1. *Coding Clinic for ICD-10-CM and ICD-10-PCS* are the official publication of ICD-10-CM/PCS coding guidelines and advice as designated by four cooperating parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS)
2. ICD-10-CM/PCS Official Coding Guidelines for Coding and Reporting
3. *AHIMA and ACDIS Guidelines for Achieving a Compliant Query Practice-2022 Update*
4. AHIMA Defining the Core Clinical Documentation Set for Coding Compliance– *AHIMA Thought Leadership Series 2012*
5. Medicare Hospital Manual

DEPARTMENT: Regulatory Compliance Support	POLICY DESCRIPTION: Coding Documentation for Inpatient Services
PAGE: 8 of 8	REPLACES POLICIES DATED: 2/8/96, 9/6/96, 7/14/97, 3/6/98, 4/16/99, 8/1/00, 4/1/01, 6/1/02, 12/15/02, 3/1/04, 5/31/04 (HIM.COD.001), 3/6/06, 6/1/07; 12/1/07, 1/24/09, 11/1/09, 5/15/12, 4/15/13, 10/1/15, 8/1/16, 2/1/20, 8/1/21
EFFECTIVE DATE: July 1, 2024	REFERENCE NUMBER: REGS.COD.001
APPROVED BY: Ethics and Compliance Policy Committee	

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| <ul style="list-style-type: none"> 6. Medicare Claims Processing Manual, Chapter 3 7. CMS Pub. 100-04 Transmittal 1240 (POA) 8. Coding Documentation for Outpatient Services Policy, REGS.COD.002 9. Coding Documentation for Non-Hospital Entities, REGS.OSG.001 10. Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements, REGS.DOC.002 11. Coding Documentation for Rehabilitation Facilities Policy, REGS.COD.013 12. Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy, REGS.COD.018 13. Physician Certification and Recertification for Post-Acute Services Policy, REGS.APS.001 14. MDS. 3.0 RAI Manual |
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Commitment to Data Integrity

One of the important philosophies of the Company is the commitment to conduct our business with integrity and always render our services on a highly ethical level.

This philosophy embraces the following principles related to coding:

1. We have great confidence in our colleagues and their commitment to collect, manage and report data in an unbiased, honest and ethical manner.
2. We believe that diagnosis and procedure coding should be governed by Official Coding Guidelines and that all codes mandated by the guidelines should be assigned and reported. Adherence to guidelines will promote consistency and accuracy of coded data in individual facility and company databases. The Company policy is that ICD-10-CM diagnosis and ICD-10-PCS procedure codes, CPT procedure codes and modifiers must be correctly submitted and will not be modified or mischaracterized in order to be covered and paid. Diagnoses or procedures will not be misrepresented or mischaracterized by assigning codes for the purpose of obtaining inappropriate reimbursement.
3. We believe that the diagnosis reported by the physician as the reason for the encounter or visit and the codes reported must be consistent.
4. We believe that the procedural codes reported should accurately reflect the procedures performed during the encounter as documented by the physician.
5. We are committed to providing the support needed to effectively classify our patients. Support provided to the Company's facilities includes coding seminars, training tools, group purchases of products at discounted rates, publications and nosology support.