HEALTH INFORMATION MANAGEMENT
CLINICAL CODING PROGRAM PROCEDURES

1. REASON FOR ISSUES. This Veterans Health Administration (VHA) Handbook provides procedures necessary for managing a VHA facility-wide clinical coding program.

2. SUMMARY OF MAJOR CHANGES. This revised Handbook provides updated procedure on conducting quarterly probe audits to ensure clinical coding is accurate and reliable for inclusion in national databases, which are used to provide clinicians, researchers, planners, and others with detailed information that is accurate and reliable.

3. RELATED ISSUES. VHA Handbook 1907.01, Health Information Management and Health Records.

4. RESPONSIBLE OFFICE. The VHA Office of Health Information Management (10P2C) is responsible for the contents of this Handbook. Questions may be referred to the VHA Director, Health Information Management at (217) 586-6082.

5. RESCISSIONS. VHA Handbook 1907.03, Health Information Management Clinical Coding Program Procedures, dated June 27, 2011, is rescinded.

6. RECERTIFICATION. This Handbook is scheduled for recertification on or before the last working day of September 2017.

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1. PURPOSE

   This Veterans Health Administration (VHA) Handbook provides procedures for managing the scope and operations of a VHA facility-wide clinical coding program. For the purposes of this Handbook, a facility-wide clinical coding program pertains to work assignments and other areas of interest to the facility coding staff. ***NOTE: VHA Handbook 1907.01 is to be utilized in conjunction with this clinical coding program Handbook.***

2. BACKGROUND

   a. VHA uses the official coding guidelines for clinical classification systems including, but not limited to, current editions of International Classification of Disease-Clinical Modification (ICD-CM), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, Coding Clinic, and CPT Assistant.

   b. The VHA Health Information Management (HIM) Coding Council annually publishes and updates a reference document that outlines correct coding guidance for many VHA-specific issues and is to be used as a supplemental coding guide. The Coding Council is comprised of a group of field volunteers who have expertise in ICD-CM, CPT, and HCPCS coding.

   c. The Coding and Documentation Tool Kit provides improvement strategies to educate staff involved in documentation, coding, billing, compliance, data capture, and leadership responsibility for overall data integrity. The kit contains PowerPoint presentations, examples of policies and procedures, examples of audit forms and reports, process flows, quick tip sheets, QuadraMed reports, and VHA Resident supervision guidelines. The Tool Kit must be used for educational efforts as the kit is updated on a recurring basis. The Tool Kit can be accessed at http://vaww.vhaco.va.gov/him/edutraining.html by clicking documentation tool kit and saving to the desktop. ***NOTE: This is an internal VA Web site not available to the public.***

3. DEFINITION OF CODING

   Coding. Coding is the process of assigning a number (alpha, numeric, or a combination of both) from a recognized and approved coding classification system that properly identifies and defines medical services, procedures, and diagnoses.

   (1) Coding requires specialized skills, training, and education, as accuracy in code assignment is essential in health care management.

   (2) Industry-established and VHA-specific guidelines and criteria must be followed to ensure accuracy and consistency of code assignment, proper code sequence, and valid data reporting.

   (3) Coding serves two primary purposes:

(a) Creating secondary records for the retrieval of diagnoses or procedures; and

(b) Creating details for reimbursement.

(4) Codes are used for a variety of purposes, including, but not limited to:

(a) Clinical studies;

(b) Performance measurement;

(c) Workload capture;

(d) Cost determination;

(e) Veterans Equitable Resource Allocation (VERA);

(f) Classifying morbidity and mortality;

(g) Indexing of hospital records by disease and operations;

(h) Data storage and retrieval; and

(i) Reimbursement.

4. SCOPE

a. The goal of a clinical coding program is for continuous accuracy of coded data contained within national databases. This data is used to provide clinicians, researchers, planners, and others with detailed information that is accurate and reliable.

b. To ensure the accuracy and consistency of coded data, the clinical coding program, policies, and practices are standardized across the system.

c. Health Information Management (HIM) professionals have the overall responsibility for ensuring that the functions of a clinical coding program are established, maintained, and supported within each Department of Veterans Affairs (VA) medical facility.

d. Employees performing coding activities, ranging from supervision to code assignment to coding education, must be qualified and preferably credentialed in one of the following:

(1) Registered Health Information Administrator (RHIA);

(2) Registered Health Information Technician (RHIT);

(3) Certified Coding Specialist (CCS);

(4) Certified Coding Associate (CCA);

(5) Certified Coding Specialist-Physician-based (CCS-P);

(6) Certified Professional Coder (CPC); or

(7) Certified Professional Coder-Hospital (CPC-H).

e. The clinical coding program encompasses review of documentation and other supporting reports to facilitate:

(1) Accurate assignment of ICD-CM, CPT, and HCPCS codes, including, but not limited to:

(a) Entry of those codes into the required database.

(b) Full use of the encoder system to include the full spectrum of encoder reports, such as the late identified insurance report. The encoder system must be utilized to expedite the coding process and ensure all billable events are coded in a timely manner. Reports are produced and reviewed at least weekly, to ensure all billable cases are coded in a timely manner. *NOTE: A detailed list of encoder reports can be accessed in the Tool Kit under QuadraMed Reports at http://vaww.vhaco.va.gov/him/edutraining.html by clicking the documentation tool kit and saving to the desktop. This is an internal VA Web site not available to the public.*

(c) Validation of code assignment in relation to all existing rules and standards.

(d) Continuous review and oversight to ensure that corrections and timely reporting are maintained and improved over time.

(2) Report monitoring to verify code acceptance by national databases.

(3) Correction of coding errors leading to non-acceptance by national databases.

(4) Continuous evaluation of coding practices to ensure consistency with coding rules and guidelines.

(5) Confirmation that correct code set versions are available and utilized.

f. A fully-functioning program ensures:

(1) Processes are in place to validate the accuracy of coded encounters.

(2) Appropriate classification of patients within the VERA model and appropriate third-party billing occurs.

(3) Continuous quality improvement activities are in place to review accuracy and reliability of coded data for external peer review, performance measures, health factors, clinical reminders, research purposes, and strategic planning.

(4) Reviews are conducted in collaboration with other program areas, at least monthly, to determine patterns of claims, denials, and other factors that may suggest inappropriate coding.

(5) Data monitoring processes are in place to ensure all services that are required to be captured are coded, transmitted, and accepted in the appropriate database.

g. Audits of clinician documentation and coding accuracy are conducted and shared with clinicians. Coders are utilized in the performance of Veterans Integrated Service Network (VISN) or facility-directed audits, such as VHA resident supervision, Compliance and Business Integrity (CBI), fee retrospective reviews, and others as needed.

h. Codes submitted for payment under the non-VA program for individual authorization or negotiated agreements that were submitted on VHA Form 10-7078 for inpatient care, VHA Form 10-7079 for medical services/outpatient care, or VHA Form 10-2750d for dental must be retrospectively reviewed to ensure that the clinical services identified on the VHA Forms were performed. An appropriate sample size determined by the facility must be conducted on a quarterly basis. Any coding inaccuracies found during a retrospective review of the documentation versus codes submitted on the VHA Forms are referred back to the Fee Section for follow-up with the non-VA purchased care provider.

i. The clinical coding program encompasses ongoing clinician and coder education. Clinician education supports quality of documentation and accuracy of code assignment by using audit results of the clinician's own work to provide meaningful educational efforts. Coder education assists coders in improving coding accuracy, promotes consistency in practice, and ensures current knowledge of coding rules and regulations. Encoder reports must be utilized to assist with training initiatives, such as the Evaluation and Management (E&M) Code Reason for Change Report and the Service Connected Tracking Report.

j. Both clinician and coder assigned codes are reviewed internally by a qualified coder at the highest level of knowledge and skill, or by utilizing an external coding consultation group that has knowledge of and experience in VA coding practices and requirements. Clinicians maintaining an acceptable level of accuracy (i.e., 95 percent) may be removed from the data validation review of billable encounters with random reviews to ensure compliance.

k. Open lines of communication among coding, billing, and compliance staff must exist to enhance the revenue process and to ensure all applicable billing workload is identified, reviewed, and billed in a timely and appropriate manner.

5. RESPONSIBILITIES OF THE HEALTH INFORMATION MANAGER (HIM) AND CODING SUPERVISOR

All coding functions must be under the supervision of an experienced, credentialed, health information manager to ensure non-biased, accurate, and consistent clinical coding, data capture, and education. The HIM Manager and Coding Supervisor is responsible for:

a. Monitoring, at a minimum on a quarterly basis, the accuracy and productivity of the coding staff.

b. Monitoring the accuracy of outpatient clinician coding on a quarterly basis using an appropriate sample size as determined by the facility and providing education on coding and documentation as needed. More frequent reviews are required for clinicians that continue to have high error rates in their coding.

c. Providing educational opportunities to coders based on data findings (see par. 7).

d. Notifying the billing supervisor, or designee, when a code(s) has been changed based on retrospective review.

e. Ensuring education initiatives are documented in the VA Talent Management System (TMS) and the results trended.

f. Determining and publishing in local medical facility policy, which E&M guidelines (1995 or 1997) are to be used for coding, for educating providers and for validating bills. The guidelines may be different based on clinical discipline (only), but not on a physician-by-physician basis. *NOTE: Sites may elect to use one set of guidelines for the facility or VISN-wide.*

g. Establishing policies and procedures at the facility, for obtaining physician clarification, such as allowing the coder to directly contact the physician about a record being coded.

h. Negotiating productivity and accuracy standards locally with the unions (see par. 14c).

i. Recruiting, hiring, and retaining experience personnel for the Coding Staff.

j. Ensuring that all Coding staff members are qualified and preferably credentialed to serve on the Coding staff.

k. Assessing and addressing the educational needs and knowledge deficits of each member of the coding staff on a quarterly basis.

6. CODING STAFF

a. To ensure that coded data accurately reflects the documented diagnoses and services provided to patients, it is essential to recruit, hire, and retain experienced and preferably credentialed (e.g., RHIT or RHIA, CCS, CCS-P, CPC, CPC-H) coding staff.

b. Coding functions must be centralized under a single supervisor for efficiency, improved communication, and support. However, coding staff performing those functions may be located in a centralized area or decentralized throughout the medical facility or clinic. Staff may reside in clinics within the facility, in a centralized coding unit, in a Community-based Outpatient Clinic (CBOC), or any combination of locations. The location of qualified coders in a setting with access to clinicians allows for easy communication with providers to facilitate coding educational efforts.

c. Use of VA's title 38 United States Code (U.S.C.) Hybrid Employment System (38 U.S.C. 7401(3)) includes qualification standards which provide health care facilities with flexibility in the recruitment and retention of qualified coding staff. These qualification standards outline minimum requirements that an individual must meet to be qualified for a position in the occupation. A peer review process is utilized to make judgments on qualifications of candidates for appointment and promotion, which allows grade and pay to be determined by an individual's qualifications. Candidates must show pertinent experience of increasing importance and responsibility at successively higher levels.

d. Contract coding services may provide time-limited coding support to assist with backlogs or may be utilized to cover regular coding duties. All coding contract services work must be monitored for quality, timeliness, and appropriate billing. The contractor must ensure that contract coders have appropriate coding information, that such education is documented, and that all individuals with access to VA data or systems in performing the contract are appropriately trained in applicable VA confidentiality and security requirements. *NOTE: A National Blanket Purchase Agreement (BPA) for Coding Services is available for use by all VHA facilities and vendor information is available at: http://vaww.vhaco.va.gov/him/coding.html#natl%20contract. This is an internal VA Web site not available to the public.*

e. Removing the code assignment responsibilities from the physician staff for all physician encounters is appropriate where additional coder resources are available and it is determined by the facility that the return on investment (ROI) spent on additional coder Full-Time Equivalent (FTE) Employees can be realized through such benefits as improved clinical documentation, additional staff time for patient treatment, increased VERA allocation, and improved identification of billable encounters.

7. EDUCATION

a. To ensure coder knowledge and skills are current and continuously improving, coders must receive continuing education through VHA-sponsored educational activities, such as coding satellites, EduCode, or other on-line coding education tools. Additionally, coders may receive education from any American Health Information Management Association (AHIMA) or American Academy of Professional Coders (AAPC)-approved coding seminars or sessions. *NOTE: The Coding Supervisor assesses and addresses the educational needs and knowledge deficits of each member of the coding staff on an annual basis.*

b. The encoder software provides every coder with current web-based copies of all required coding books, including ICD-CM, CPT, and HCPCS, as well as a number of references and support tools. In order to benefit from the full functionality of the encoder system, coders must utilize all of the available tools and resources. The American Hospital Association (AHA) Coding Clinic and CPT Assistant references contained in the encoder and other officially-recognized resources and publications must be used for training and reference purposes.

c. The Tool Kit is available to be used for educational efforts as the kit is updated on a recurring basis. The Tool Kit can be accessed at http://vaww.vhaco.va.gov/him/edutraining.html by clicking documentation tool kit and saving to the desktop. *NOTE: This is an internal VA Web site not available to the public.*

8. CODING

a. Coding processes, including collateral registry duties, must be streamlined to ensure maximum productivity (i.e., assigning similar work types on a given day). Non-coding duties, such as analysis, ROI, clinic, and ward duties must be assigned to non-coder staff.

b. All coding must be completed through the national encoder software. Inpatient coding must be completed and transmitted to the Austin Information Technology Center (AITC) Patient Treatment File (PTF) in accordance with current VHA policy. Inpatient and outpatient encounter coding and data corrections are to be completed and transmitted to the National Patient Care Database in accordance with current VHA policy. Data not received by the closeout date after the event (discharge or visit) may not be included in the statistical reports. Surgical coding must be completed immediately after the procedure when possible, and no later than one week from the date of surgery.

c. Billable workload is given priority to expedite the billing process. Coders are required to review codes or recode all billable encounters, as well as, code all inpatient discharges. *NOTE: In accordance with subparagraph 4j, clinicians maintaining an acceptable level of accuracy (i.e., 95 percent) may be removed from the data validation review of billable encounters with random reviews to ensure compliance.* In addition, coding staff must code:

(1) Surgical cases;

(2) Invasive procedures;

(3) Diagnostic procedures;

(4) Complex coding encounters;

(5) Durable Medical Equipment (DME) and Prosthetic encounters;

(6) High-risk or poorly-documented encounters by clinic, by area, or by clinician; and

(7) Other encounters that have a major impact on revenue or those encounters that are of concern to the Medical facility. *NOTE: Interventional radiology procedures <u>may</u> be coded exclusively by coders, but it is not required.*

d. Minimum core responsibilities of the coding staff are Inpatient Facility Coding, Inpatient Encounters, Surgical Case Coding, and Outpatient Encounters.

9. INPATIENT FACILITY CODING

Inpatient facility coding includes all episodes of care for acute care hospitalizations, observation stays, nursing home care, substance abuse, residential rehabilitation treatment program, census, inpatient fee service, contract nursing home, and domiciliary. It is necessary to:

a. Review appropriate electronic health record documentation and utilize encoder and reference materials to assign accurate diagnostic, complications and co-morbidities, and procedural codes reflective of documentation, including Diagnosis Related Group (DRG) assignment. Non-VA purchased care is excluded from this requirement as the non-VA invoice, as well as submitted clinical documentation if received, must be utilized to obtain the codes for non-VA PTF entry.

b. Verify demographic data, i.e., source of admission, discharge type, treating specialty, and treatment for service-connected conditions, etc.

c. Complete the PTF process (code, close, release, transmit, and correct errors).

d. Review and validate the Edit Analysis Lists (EALs) and the Dispositions in the PTF Master File (419). The EALs are sent in response to PTF or census transmissions that have data errors using e-mail. The 419 and census reports must be reviewed and the records corrected and re-transmitted as soon as possible after receipt. The 419 and census reports must be reviewed in their entirety and validated before closeout to allow time for any errors found to be corrected, transmitted, and accepted. *NOTE: Only checking that the records were transmitted by running reports from Veterans Health Information Systems and Technology Architecture (VistA) does not guarantee that the records were accepted by the AITC and that the facility is getting credit for the workload. It is essential that the AITC data is verified.*

10. INPATIENT ENCOUNTERS

Inpatient encounters equate to billable professional fee services performed during the inpatient episode of care and captured using the Patient Care Encounter (PCE) software. It is necessary to:

a. Review and determine whether documentation is adequate to support billable services.

b. Utilize encoder and reference materials to assign accurate diagnostic and procedural codes reflective of documentation.

c. Assign codes and enter data for professional services delivered by billable providers, i.e., Evaluation and Management (E&M) radiology, pathology, and anesthesia.

d. Identify and link Current Procedural Terminology (CPT) and International Classification of Disease-Clinical Modification (ICD-CM) codes, identify the provider, and the date(s) of service.

e. Generate or coordinate with the person responsible for managing the Ambulatory Care Reporting Program (ACRP) Action Required Report on a recurring basis to ensure all encounters have been transmitted and accepted and that proper workload credit is given.

11. SURGICAL CASE CODING

Surgical case coding includes the entry of coded procedures and diagnoses for all surgery cases. The operating room schedule with any add-on surgeries must be used to monitor surgical case coding and ensure complete data capture. It is necessary to:

a. Utilize encoder and reference materials to assign or validate diagnostic and procedural codes reflective of documentation for all cases in the surgery package.

b. Assign and enter the diagnostic codes and procedural codes with associated modifiers reflective of documentation using the encoder into the surgery package.

c. Validate that all cases successfully passed from the Surgery Package to the PCE using the PCE Filing Status Report.

d. Assign and enter associated billable anesthesia and pathology services related to the surgery using the encoder into the PCE.

e. Generate the PCE Filing Status Report and the ACRP Action Required Report (or coordinate with the person that runs this report) on a recurring basis to ensure all encounters have been transmitted and accepted and proper workload credit is given.

12. OUTPATIENT ENCOUNTERS

a. Outpatient encounters include face-to-face encounters and other occasions of service that are captured within the PCE. These services are captured through:

(1) The completion of electronic encounter forms;

(2) Review of documentation by qualified coding staff; and

(3) Automated data capture within radiology and laboratory VistA packages.

b. Coding staff are required to:

(1) Identify, review, and code all billable encounters;

(2) Review and determine whether documentation is adequate to support billable services;

(3) Utilize encoder and reference materials to assign or validate diagnostic and procedural codes reflective of documentation;

(4) Correct the PCE, if necessary, to reflect code changes and name(s) of provider(s); and

(5) Generate or coordinate with the person responsible for managing the ACRP Action Required Report on a recurring basis to ensure all encounters have been transmitted and accepted and proper workload credit is given.

13. ACCURACY

a. American Health Information Management Association (AHIMA) recommends maintaining a 95 percent accuracy rate as a minimum goal, while <u>Medical Records Briefing</u> recommends setting ranges for accuracy of 90-95 percent (see par.4). Suggested quality indicators for measuring accuracy include:

(1) Accurate coding of all diagnoses and procedures;

(2) Existence of documentation to substantiate codes assigned; and

(3) Correct sequencing according to coding guidelines.

b. The <u>minimum expected</u> coding accuracy standard for all types of work for experienced professional coders at the target-grade level is 95 percent. Appropriate lower standards may be set for coders in developmental positions.

14. PRODUCTIVITY

a. Health information managers and coding supervisors must utilize the tools available through VistA and the encoder to monitor productivity. *NOTE: Facilities are encouraged to develop incentive plans to recognize coders who exceed minimum productivity standards.*

b. The <u>minimum expected</u> coding productivity standards for experienced professional coders at the target-grade level performing the coder scope of work requirements are specified within the following Coder Productivity Standards table. *NOTE: Productivity and accuracy standards were developed from an analysis of a national HIM survey of 100 percent of all VA health care facilities on coder productivity and accuracy.*

Table 1.

Coder Productivity Standards	
Scope of Work	**Minimum Standard per Day** *NOTE: This is based on a 7.5 hour workday and does not include leave, educational hours, or non-coding activities. Appropriate lower standards may be set for coders in developmental positions.*
Inpatient Discharges with Professional Fees	9
Inpatient Discharges without Professional Fees	13
Surgery cases including Billable Pathology and Anesthesia Services	25
Outpatient, Outpatient Testing, and Inpatient Professional Encounters	70

c. Productivity and accuracy standards must be negotiated locally with the unions (see subpar. 5h).

15. DATA CAPTURE REQUIREMENTS

a. Monthly, semi-annual, and annual closeout of the patient data files (PTF and PCE), as well as the quarterly census, is directed by current VHA policy and must be followed accordingly.

b. Mandated electronic encounter forms must be utilized in:

(1) Selecting a diagnosis on the encounter form; this is <u>not</u> a substitution for documenting the diagnosis in the electronic health record.

(2) Diagnosis and procedural coding on the encounter form, which must be substantiated by documentation in the electronic health record. Assessment must be made of the documentation to ensure that it is adequate and appropriate to support the diagnoses and procedures selected to be abstracted.

(3) Encounter forms, which must be reviewed and updated annually to reflect changes in ICD-CM and CPT codes.

c. When there is conflicting or ambiguous documentation in the patient's electronic health record, the patient's physician(s) must be consulted for clarification.

d. Physician query forms are not to be filed in the body of the electronic health record, but maintained in a separate file. Physician queries must be written clearly and concisely and not "lead" the physician to provide a particular response.

e. Communication tools such as summary forms, attestation sheets, and query forms must <u>never be used as a substitute</u> for appropriate physician documentation in the electronic health record. Any response from the physician of a coding query that is used to support a code assignment must be documented by the physician in the electronic health record.

f. Data validation is an essential component of any coding program. This includes reviewing accuracy, completeness, and acceptance of:

(1) Workload information;

(2) Performance measure data;

(3) VERA reports; and

(4) External Peer Review Program data, etc.

NOTE: Appendix A provides a checklist of reports that require, at a minimum, ongoing review and validation by coding staff.

16. REFERNCES

a. "Performance Standards for Coding Professionals," <u>Journal of AHIMA</u>, October 2001.

b. "Start Tracking Coder Productivity and Watch It Soar," Medical Records Briefing,

REPORTS TO BE MONITORED AND WEB LINKS

1.	**Incomplete Encounters, Action Required, Transmitted Encounter Error Report, etc.** There are a variety of reports available to display incomplete encounters, encounters with errors, etc. The reports indicated are some of the more common reports utilized. Typically the Program Application Specialist (PAS), formerly known as the Health Administration Service (HAS), Medical Administration Service (MAS) Automated Data Processing Application Coordinators (ADPAC), can identify who runs these reports at each facility. The Ambulatory Care Reporting Manual can be accessed at: http://www.va.gov/vdl/documents/Clinical/Ambulatory_Care_Reporting/acrpuse.pdf. *NOTE: This is an internal VA site not available to the public.*
a.	**Census.** The Census Directive can be accessed at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2419. *NOTE: This is an internal VA Web site not available to the public.*
b.	The **Patient Treatment File (PTF) Manual** with details on the Census options can be accessed at. http://www.va.gov/vdl/documents/Clinical/Admis_Disch_Transfer_(ADT)/ptf.pdf. *NOTE: This is an internal VA Web site not available to the public.*
2.	**PTF Reports.** a. Dispositions in the PTF Master File (419). All inpatient cases validated for acceptance monthly. b. Error Analysis Listing. The reports available from Austin indicating PTFs with errors and/or rejects and what has been accepted can be accessed at: http://austin.aac.va.gov/Frntpage.EOS.html. *NOTE: This is an internal VA Web site not available to the public.*
3.	**Veterans Equitable Resource Allocation (VERA).** Workload data is to be validated to maximize vesting. The Allocation Resource Center web site containing information on VERA can be accessed at: http://vaww.arc.med.va.gov/. *NOTE: This is an internal VA Web site not available to the public.*
4.	**Patient Care Encounter (PCE) Filing Status Report (Surgery Package).** Documentation on the Surgery Package and coding reports, including the PCE Filing Status Report can be accessed at: http://www4.va.gov/vdl/ (Select clinical, surgery, surgery v.3.0 User Manual change pages-SR*3*166). *NOTE: This is an internal VA Web site not available to the public.*
5.	**QuadraMed Reports.** QuadraMed user guides with instructions on generating reports, such as the Code Me/Bill Me report and release notes can be accessed at: http://www.quadramed.com/web/customers/government/index.cfm?pageInc=documentation and Archives QuadraMed web conferences can be accessed at: http://www.quadramed.com/web/customers/government/index.cfm?pageInc=archived_web _conferences.