

**May 30, 2006**

## **SURGICAL CASE CODING**

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides policy for International Classification of Diseases 9<sup>th</sup> Revision Clinical Modification (ICD-9-CM) and Current Procedural Terminology, 4<sup>th</sup> Edition, (CPT-4) surgical code assignments.

### **2. BACKGROUND**

a. Accuracy in CPT-4 and ICD-9-CM coding is essential in contemporary health care management. Codes are used for valid clinical studies, performance measurement, workload capture, and to determine costs and reimbursement. Codes also provide an objective system for comparing the work performed across different surgical care sites, in such areas as case complexity, service utilization, volume, and quality. Critical resource decisions are commonly made by health care managers based solely on reports of the frequency and distribution of codes.

b. Recent software changes within the surgical package re-emphasize the need to assure continued collaboration among those who use the coded data and those who enter the codes in the Surgery Package. Disease and procedure coding is a highly-specialized function that requires knowledge in such areas as anatomy, physiology, medical terminology, and current health care regulations. Qualified coders have the training and experience necessary to arrive at the best coding decisions. Ideally coders are certified through such organizations as the American Health Information Management Association (AHIMA) and/or the American Academy of Professional Coders (AAPC).

**3. POLICY:** It is VHA policy that each VA health care facility must ensure ICD-9-CM and CPT-4 surgical coding accuracy within the surgical package, including the assurance of qualified coding staff, accurate source documentation, and timely and accurate entry of codes.

### **4. ACTION**

a. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring that the Surgery Version 3.0, SR\*3\*142 software patch is installed and maintained on all medical centers VistA systems in accordance with nationally-distributed software patches.

b. **Medical Center Director.** Each medical center Director must ensure that:

(1) Surgical coding is conducted by qualified staff using the Update/Verify Procedure/Diagnosis Codes option within the surgery package or using an encoder that is interfaced with the surgery package for entry of coded procedures and diagnosis for all surgery

**VHA DIRECTIVE 2006-035****May 30, 2006**

cases. All deletions, revisions, and additions of codes must be entered in the surgery package for PCE filing. Changes made in PCE will not reflect in the surgery package as the interface is not bidirectional. **NOTE:** *Attachment A provides guidelines for using the Update/Verify Procedure/Diagnosis Codes Option.*

(2) The source documentation for surgical ICD-9-CM and CPT-4 codes provide precise and accurate information about the actual procedures performed. **NOTE:** *Usually, the signed operative report is considered the source document for surgical coding as planned procedures often differ from the actual procedures performed. The operative report must be dictated and signed by the surgeon. If the surgeon was a resident, the operative report must contain evidence of appropriate resident supervision as delineated in VHA Handbook 1400.1. If the surgeon was a resident that no longer works at the facility, the supervising practitioner can sign the operative report for the resident. All deletions, revisions, and additions, including the names of all involved surgical staff and trainees, must be entered in the surgery package, as changes made in TIU will not reflect in the surgery package as the interface is not bidirectional.*

(3) Surgical coding is completed as soon after the procedure as possible, no later than one week after the final operation report is signed and the pathology report is received. The coding of a surgical procedure soon after its completion will help assure coding accuracy. The one-week time span is recommended when pathology reports are needed prior to coding. Surgery staff must be available to respond to questions the coding staff might have during the coding process. Questions or disparities should be brought to the attention of the surgery staff and/or NSQIP Nurse Reviewer for clarification and collaboration.

**5. REFERENCES**

- a. Surgery Version 3.0 Release Notes, October 2005.
- b. VHA Handbook 1907.1, Health Information Management and Health Records.
- c. VHA Handbook 1400.1, Resident Supervision.

**6. FOLLOW-UP RESPONSIBILITY:** The Office of Information (19F) is responsible for the contents of this Directive. Questions may be addressed to the Director Health Data and Informatics at phone number 760-777-1170.

**7. RESCISSIONS:** None. This VHA Directive expires May 31, 2011

Jonathan B. Perlin, MD, PhD, MSHA, FACP  
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 6/1/06

FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 6/1/06

**ATTACHMENT A****GUIDELINES FOR UPDATING AND VERIFYING PROCEDURE AND DIAGNOSIS CODES OPTION**

Patch SR\*3\*142 separates final coded procedures and diagnoses from the clinically captured procedures and diagnoses. The final Current Procedural Terminology, 4<sup>th</sup> Edition, (CPT-4) and ICD-9-CM codes no longer have a one-to-one relationship with the clinically entered free-text information.

1. After a Surgery case is completed, the coder will access the case using the Update/Verify Procedure/Diagnosis Codes option within the surgery package or using an encoder that is interfaced with the surgery package. When the option is first selected for a case, the planned codes entered by clinicians will be auto-populated from the SURGERY file. The coder can then accept or modify the planned codes.
2. A principal ICD-9-CM code and a principal CPT-4 code are required for coding a surgical case and sending the data to PCE.
3. An unlimited number of ICD-9-CM codes may be entered for other diagnoses and an unlimited number of CPT-4 codes may be entered for other procedures performed in the Surgery package. The National Patient Care Database will accept up to 99 ICD-9-CM codes and up to 200 CPT-4 codes.
4. Each CPT-4 code entered must be assigned the associated ICD-9-CM code(s) related to the procedure performed.
5. An unlimited number of CPT modifiers may be entered for each CPT-4 code entered.
6. For every ICD-9-CM code entered, the service-connected (SC) conditions or special treatment authority condition questions must be answered by the clinician or the coder when entering additional ICD-9-CM codes as appropriate for the patient based upon enrollment indicators.
7. Upon completion of coding for a case, the coder will mark the record as complete and send the record immediately to Patient Care Encounter (PCE). The case is only sent to PCE when flagged as complete within this option. After a case is filed with PCE, if codes passed to PCE are changed within the Surgery software, the Surgery to PCE interface will send an update to PCE immediately.