

POLICY TITLE: Inpatient and Outpatient Facility and Professional Coding Compliance Policy	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL
POLICY #: 800.49	CATEGORY: Compliance and Ethics
System Approval Date: 9/15/16	Effective Date: 11/12
Site Implementation Date: 10/28/16	Last Reviewed/Approved: 11/12
Prepared by: Office of Corporate Compliance	Superseded Policy(s)/#/Notations: N/A

GENERAL STATEMENT of PURPOSE

The purpose of this policy is to affirm the commitment of Northwell Health to coding practices that are consistent with the ICD-9-CM, ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting (the Official Coding Guidelines), advance the prevention of fraud and abuse, and further the mission of providing quality care to our patients. Northwell Health is dedicated to providing health information that is complete and accurate and that reflects reasonable and necessary services performed by appropriately licensed medical professionals.

POLICY

Northwell Health facilities must follow the most current and relevant official guidelines for coding and reporting diagnoses and procedures published in the Official Coding Guidelines and, where appropriate, the relevant guidelines published in the American Hospital Association (AHA) Coding Clinic for ICD-9-CM, ICD-10-CM, and ICD-10 PCS (the AHA Coding Clinic). Diagnoses and procedures will be coded utilizing the International Classification of Diseases, Ninth and Tenth Revision, Clinical Modification (ICD-9-CM ICD-10-CM & PCS), and/or other classification systems that may be required or updated thereafter (such as DSM IV for classification of psychiatric patients).

SCOPE

This policy applies to all members of the Northwell Health workforce including, but not limited to: employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at Northwell Health; faculty and students of the Hofstra Northwell School of Medicine conducting Research on behalf of the School of Medicine on or at any Northwell Health facility; and the faculty and students of the Hofstra Northwell School of Graduate Nursing & Physician Assistant Studies.

DEFINITIONS

ICD-9-CM, ICD-10-CM & ICD-10-PCS Official Guidelines for Coding and Reporting (the Official Coding Guidelines): are a set of rules that have been developed and approved by the four Cooperating Parties to accompany and complement the official conventions and instructions provided within the ICD-9-CM, ICD-10-CM & ICD-10-PCS itself. These guidelines are based on the coding and sequencing instructions in ICD-9-CM for hospitals, ICD-10-CM for Hospitals and the ICD-10-PCS coding books, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM, ICD-10-CM & ICD-10-PCS, diagnoses and procedure codes is required under the Health Insurance Portability and Accountability Act. The four Cooperating Parties are the AHA, the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

AHA Coding Clinic for ICD-9-CM, ICD-10-CM & PCS (the AHA Coding Clinic): provides supplementary advice to the Official Coding Guidelines. It is approved by the four Cooperating Parties.

Current Procedural Terminology (CPT): is a set of codes, descriptions and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code.

Health Care Procedure Coding System (HCPCS): is the standard for hospital reporting of outpatient procedures and physician reporting.

CPT Assistant: allows users to access archived issues of coding-related newsletters issued by the American Medical Association (AMA) from 1990 onward to help answer daily coding questions, stay apprised of changes and trends, train staff and validate coding to external sources.

PROCEDURE/GUIDELINES

CODING RESOURCES

1. Coding resources are available to the appropriate coding staff, including the following: the Official Coding Guidelines, the AHA Coding Clinic, CPT Assistant and updated encoder software, including the appropriate version of all DRGs, including MS-DRG, AP-DRG, APR-DRG and the APC grouper software, which includes CPT4 and NCCI edits. Updated ICD-9-CM, ICD-10-CM & PCS, CPT4, and HCPCS Level II code books are used by all coding professionals.
2. All Northwell Health facility Coding Departments must maintain a minimum set of required HIM coding references and tools and make them available to coding staff to facilitate complete, consistent and accurate coding. Coding Managers must review these materials on an annual basis and, if necessary, update them.
3. Northwell Health's Corporate Finance Department will maintain, in writing, documentation of coding guidelines or coding requirements and will make such documentation available to coding staff.

CODE ASSIGNMENT RESPONSIBILITY

4. For Part A records and outpatient records, HIM coding staff is responsible for the assignment of the correct ICD-9-CM, ICD-10-CM , ICD-10-PCS codes and CPT (when required) codes based on the source documentation in the medical record in accordance with the Official Coding Guidelines. For Part B records, providers are responsible for the assignment of the correct ICD-9-CM or ICD-10-CM codes and CPT codes based on the source documentation in the medical record in accordance with the Official Coding Guidelines.

PRESENT ON ADMISSION "POA"

5. Coders must assign the Present on Admission (POA) indicators to all diagnoses that have been coded, subsequent to the assignment of the ICD-9-CM or ICD-10-CM codes. The POA regulation applies only to inpatient records. Outpatient claims are excluded from submitting POA indicators.

EMERGENCY SERVICES FACILITY CODING GUIDELINES

6. At this point, there is no national standard for hospital assignment of E&M code levels for outpatient services in clinics and the Emergency Department (ED). CMS has stated that each hospital may utilize its own unique system for assignment of E&M levels. Facility billing guidelines should be designed to reasonably relate the intensity of hospital services to the different levels of effort represented by the codes. Coding guidelines should be based on facility resources, should be clear in order to facilitate accurate payments, should only require documentation that is clinically necessary for patient care and should not facilitate up coding.
7. Northwell Health utilizes a modified American College of Emergency Physicians (ACEP) facility coding model to assign E&M levels. For guidance on how to apply guidelines on the assignment of the Modified ACEP Facility Coding Model, please refer to the local HIM and Emergency Departments.
8. Physician E&M level assignment can be assigned according to either the 1995 Documentation Guidelines for Evaluation and Management Services published by CMS or the 1997 Documentation Guidelines for Evaluation and Management Services published by CMS.

CLINICAL DOCUMENTATION CLARIFICATION

9. The appropriate providers should be queried in situations including, but not limited to, the following: when there are clinical indicators of an undocumented condition in the medical record; when ambiguous or conflicting documentation is present in the medical record; when documentation is unclear for POA indicator assignment; when there is a need to clarify a potential cause and effect relationship; and when there is a need for further specificity or information regarding the degree of severity of a documented condition. For more guidance, please consult applicable departmental policy (e.g.,

Physician Documentation Query Guidelines (Inpatient). Standard protocols for the addition of documentation to a record must be followed, in accordance with Northwell Health medical record completion requirements, the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and applicable state law.

PROCESSING REJECTIONS FOR BOTH INPATIENT AND OUTPATIENT CLAIMS

10. If a claim is rejected from Northwell Health's billing system because of codes assigned during the medical record abstraction, the relevant coders must review the claim and resubmit it into the hospital's billing system. If the initial code assignment did not reflect the actual services, coders may review and assign the code(s) based on the supporting documentation and resubmit the claim. Codes may not be assigned, modified or excluded solely for the purpose of reimbursement or avoiding reduced payment.

MONITORING TO DETECT AND PREVENT CODING DISCREPANCIES

11. HIM will perform periodic monitoring to ensure the accuracy of clinical documentation and code assignments. This monitoring will be designed to provide reliable assessments of current coding practice and to encompass both inpatient and outpatient services. Monitoring must be implemented to track key indicators of patient mix and coding practices.
12. The Coding Manager/DRG Validator/Coordinator or designee will be responsible for designing and conducting monthly chart reviews for coding quality and accuracy. All cases in which coding revisions result in a lower or higher weighted DRG assignment must be identified and correctly re-billed and/or refunded to the payor, as applicable, within 60 days of identification. The Coding Manager/DRG Validator/Coordinator or designee must maintain written documentation of all such revisions.
13. Whenever an HIM coding discrepancy is identified (from any internal or external source), the relevant Northwell Health facility must undertake the appropriate investigation to determine the root cause(s) of the variance and immediately work to correct any adverse result of the variance.
14. Coding staff must report identification of material trends or variations to the Office of Corporate Compliance upon identification. The Office of Corporate Compliance will investigate such material trends or variations and, if applicable, work with the appropriate department(s) to resolve the issue. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education and training sessions.

15. All overpayments must be refunded and appropriately reported to the applicable federal and state payors within 60 days after identification or within such additional time period as may be agreed to by the payor. The corrective action will include correcting the underlying cause of the overpayment and taking remedial action to prevent the overpayment from recurring. See Northwell Health Policy #800.07- Compliance with Government-Funded Healthcare Claims and Cost Reporting Requirements.
16. Professional fee monitoring is performed annually for billing by providers (including PAs and NPs). Reviews are performed pre-billing. Any discrepancies will be revised and billed appropriately.

AUDITING TO DETECT AND PREVENT CODING DISCREPANCIES

17. The Coding Manager provides feedback to the coding staff on coding errors. The Coding Manager provides follow-up education, references to the applicable AHA about correct coding of these conditions, where appropriate, and the process to be used to correct the deficiency. Each coding professional will comply with mandatory annual coding education.
18. The Office of Corporate Compliance performs audits or, if appropriate, arranges for external audits of the coding processes on a regular basis to monitor compliance with coding policies and all applicable federal and state laws, as well as to identify and monitor risk areas. At the conclusion of each such audit, the Office of Corporate Compliance will investigate the root causes of any coding discrepancies, discuss the audit and investigation findings with the appropriate department(s) and, if necessary, work with the appropriate departments to resolve any identified issues. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education and training sessions regarding trends identified, if any.
19. Based on its audit findings and/or any investigations it undertakes, the Office of Corporate Compliance periodically will prioritize certain compliance activities as appropriate.
20. Northwell Health Physician Partners (NHPP) Director of Coding reimbursement provides summary reports of chart review findings for providers. Feedback is provided to departmental leadership regarding these reviews. The providers also receive education on any material findings.

CODER AND FACILITY/CORPORATE DEPARTMENT CODING TRAINING REQUIREMENTS

21. Employees are expected to share the responsibility for upholding company standards as well as coding standards. All coders are required to take a skill competency test prior to employment. Upon employment and on a regular basis thereafter, all coding staff must complete additional education on applicable coding topics and meet coding continuing education requirements.

22. All coders contracted with Northwell Health to provide coding services must follow the coding compliance guidelines and meet all applicable Northwell Health coding education and training requirements.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

AHA Coding Clinic for ICD-9-CM, ICD-10-CM and ICD-10-PCS

AHIMA Standards of Ethical Coding, American Health Information Management Association (AHIMA) House of Delegates, Chicago, Illinois, September, 2008

American College of Emergency Physicians (ED Facility Coding Guidelines), *available at* <http://www.acep.org/content.aspx?id=30428>

CD! Toolkit, American Health Information Management Association (AHIMA), Chicago, Illinois, 2010

Medicare Claims Processing Manual, CMS Pub. 100-04, Transmittal 1240 (POA)

Developing a Coding Compliance Policy Document, American Health Information Management Association (AHIMA) Coding Practice Team, Chicago, Illinois, *Journal of AHIMA* 72,no. 7 (Jul.2001): 88A-C

Guidance for Clinical Documentation Improvement Programs, American Health Information Management Association (AHIMA), Chicago, Illinois, May 2010

ICD-9 CM for Hospitals-Volumes 1,2, & 3

ICD-10-CM for Hospitals

Managing an Effective Query Process, American Health Information Management Association (AHIMA), Chicago, Illinois, October, 2008

Medicare Claims Processing Manual, CMS Pub. 100-04, Chapter 3 – Inpatient Hospital Billing

Physician Documentation Query Guidelines (Inpatient), Finance, Clinical Documentation Management, Health Information Management

Practice Brief on Data Quality, American Health Information Management Association (AHIMA), Chicago, Illinois, July 2003

CLINICAL REFERENCES

N/A

FORMS

N/A

ATTACHMENTS

N/A

APPROVAL:	
System Administrative P&P Committee	8/25/16
System PICG/Clinical Operations Committee	9/15/16

Standardized Versioning History:

*=Administrative Policy Committee Approval; ** =PICG/Clinical Operations Committee Approval
10/25/12 * 11/15/12 **