

**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 VHA Handbook provides new guidance on clinical coding 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 and VHA Handbook 1400.1.
- 4. RESPONSIBLE OFFICE.** The VHA Office of Information is responsible for the contents of this Handbook. Questions may be referred to the VHA Director, Health Information Management at 760-777-1170.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This Handbook is scheduled for recertification on or before the last working day of November 2012.

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CONTENTS

**HEALTH INFORMATION MANAGEMENT
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PARAGRAPH	PAGE
1. Purpose	1
2. Background	1
3. Definition	1
4. Scope	2
5. Coding Staff	4
6. Education	4
7. Coding	5
8. Inpatient Facility Coding	5
9. Inpatient Professional Fees	6
10. Surgical Case Coding	6
11. Outpatient Encounters	7
12. Productivity	7
13. Accuracy	8
14. Data Capture Requirements	8
 APPENDIX	
A Reports to be Monitored and Web Links	A-1

HEALTH INFORMATION MANAGEMENT CLINICAL CODING PROGRAM PROCEDURES

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, Health Information Management and Health Records, 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 such as, 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), 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/or 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 resident supervision guidelines. **NOTE:** *The tool kit needs to be used for educational efforts as the kit is updated on a recurring basis; it can be accessed at <http://vaww.vhaco.va.gov/him/Training.asp> by clicking documentation tool kit and saving to the desktop.*

3. DEFINITION

Coding is an art and science requiring specialized skills, training, and education. 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. Coding serves two primary purposes: to create secondary records for the retrieval of diagnosis or procedures, and to create details for reimbursement. Accuracy in code assignment is essential in health care management. Codes are used for a variety of purposes, such as: clinical studies, performance measurement, workload capture, cost determination, Veterans Equitable Resource Allocation (VERA), classifying morbidity and mortality, indexing of hospital records by disease and operations, data storage and retrieval, and reimbursement.

4. SCOPE

a. The goal of a clinical coding program is the continuous improvement of the coded data that are contained within national databases. This data are 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, clinical coding program scope, policies, and practices must be standardized across the system.

c. HIM professionals have 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 Center. 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 supervisor needs to:

- (1) Monitor, on a regular, recurring basis, accuracy and productivity of the coding staff; and
- (2) Provide educational opportunities to coders based on data findings.

d. Employees performing coding activities, ranging from supervision to code assignment to coding education, must be qualified and preferably credentialed (e.g., Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), Certified Coding Specialist-Physician-based (CCS-P), Certified Professional Coder (CPC), and/or 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:
 - (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. This needs to be utilized to expedite the coding process and ensure all billable events are coded in a timely manner. Reports need to be run 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://vawww.vhaco.va.gov/him/Training.asp> by clicking documentation tool kit and saving to the desktop.*

- (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 that lead to non-acceptance by national databases.

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

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

d. A fully-functioning program must ensure:

(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 occur.

(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, strategic planning, or other efforts.

(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.

e. Audits of clinician documentation and coding accuracy need to be conducted and shared with clinicians. Coders need to be utilized in the performance of Veterans Integrated Service Network (VISN) or facility-directed audits, such as: resident supervision, Compliance and Business Integrity (CBI), fee retrospective reviews, and others as needed. Education initiatives are to be documented and results trended.

f. The clinical coding program encompasses ongoing clinician and coder education. Clinician education supports quality of documentation and accuracy of code assignment by using audits 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. Education initiatives are to be documented and results trended.

g. Both clinician and coder assigned codes may be 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. Clinic areas that continue to have high error rates may be reviewed more frequently.

h. Open lines of communication among coding, billing, and compliance 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. 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 may be centralized under a single supervisor for efficiency, improved communication, and support. However, coding staff who perform those functions may also be centralized or decentralized. Staff may reside in clinics within the facility, in a central coding unit, in a Community-based Outpatient Clinic, 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. **NOTE:** *Space within clinic areas may be limited and not allow for optimal coding productivity.*

c. Use of VA's Title 38 U.S.C. Hybrid Employment System (38 U.S.C. 7401(3)) includes qualification standards which provide medical centers 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 individual 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. **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/CodingCouncil.asp>.*

e. Removing the coding aspect from the physician staff for all physician encounters is appropriate where it is felt that the return on investment (ROI) spent in additional coders can be realized. Such benefits could include improved clinical documentation, additional staff time for patient treatment, increased VERA allocation, and improved identification of billable encounters.

f. Coding submitted on Fee (non-VA invoices) for unauthorized medical services is to be validated, prior to payment, to ensure that the appropriate services submitted for payment were provided.

6. 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 (AHIMA) or American Academy of Professional Coders (AAPC)-approved coding seminars or sessions.

b. The Coding Supervisor must assess and address the educational needs and knowledge deficits of each member of the coding staff on an annual basis.

c. 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 need to 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 are to be used for training and reference purposes.

7. CODING

a. Coding processes, including collateral registry duties, need to be streamlined to ensure maximum productivity, i.e., assigning similar work types on a given day. Non-coding duties, such as analysis, release of information, clinic, and/or ward duties need to 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 VA Corporate Franchise Data Center (CFD) Patient Treatment File (PTF) no later than the 14th calendar day following the patient discharge. Outpatient coding and data corrections must be completed and transmitted to CFD National Patient Care Database no later than 14 calendar days after the outpatient visit. Data not received by the 14th calendar day after the event (discharge or visit) may not be included in statistical reports. Surgical coding must be completed as soon after the procedure as possible, and no later than 1 week from the date of surgery.

c. Billable workload needs to be 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. In addition, coding staff must code all surgical cases, all invasive procedures, all diagnostic procedures, all complex coding encounters and all other encounters believed to be high-risk, poorly-documented encounters by clinic, by area or by clinician, and other encounters that have a major impact on revenue or those encounters that are of concern to the medical center. **NOTE:** *Interventional radiology procedures may be coded exclusively by coders, but it is not required.*

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

8. INPATIENT FACILITY CODING

Inpatient 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/or comorbidities, and procedural codes reflective of documentation, including Diagnosis Related Group assignment.
- b. Verify demographic data, i.e., source of admission, discharge type, treating specialty, 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 are to be reviewed and the records corrected and re-transmitted, as soon as possible after receipt. The 419 and census reports need to be reviewed in their entirety and validated before closeout, to allow time for any errors found to be corrected, transmitted, and accepted. Just 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 Corporate Franchise Data Center (CFD) and that the facility is getting credit for the workload. It is essential that the CFD data are verified.

9. INPATIENT PROFESSIONAL FEES

Inpatient Professional Fees equate to billable professional fee services performed during the inpatient episode of care and captured using the PTF 801 screen or 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., E&M, radiology, pathology, and anesthesia.
- d. Identify and link CPT and ICD codes, identify provider, and 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 proper workload credit is given.

10. SURGICAL CASE CODING

Surgical case coding includes 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 and/or validate diagnostic and procedural codes reflective of documentation for all cases in the surgery package.

- b. Assign and enter diagnostic codes and procedural codes with associated modifiers reflective of documentation via the encoder into the Surgical 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 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.

11. OUTPATIENT ENCOUNTERS

Outpatient encounters include face to face encounters and other occasions of service that are captured within the PCE. These services are captured through the completion of electronic forms, through review of documentation by qualified coding staff and through automated data capture within radiology and laboratory VistA packages. Coding staff are required to:

- a. Identify, review, and code all billable encounters.
- b. Review and determine whether documentation is adequate to support billable services.
- c. Utilize encoder and reference materials to assign and/or validate diagnostic and procedural codes reflective of documentation.
- d. Correct the PCE, if necessary, to reflect code changes and name(s) of provider(s).
- e. 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.

12. PRODUCTIVITY

- a. Health Information Managers and Coding Supervisors need to 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 minimum expected coding productivity standards for experienced professional coders at the journeyman (target grade) level performing the coder scope of work requirements are:

Coder Productivity Standards	
Scope of Work	Minimum Standard per Day <i>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.</i>
Inpatient Discharges with Professional Fees	9
Inpatient Discharges without Professional Fees	13
Surgery cases including Pathology and Anesthesia Services	25
Outpatient, Outpatient Testing, and Inpatient Professional Encounters	70

NOTE: Productivity and accuracy standards were developed from an analysis of a national HIM survey of 100 percent of all VA medical centers on coder productivity and accuracy.

13. ACCURACY

a. AHIMA recommends maintaining a 95 percent accuracy rate as a minimum goal (see “Performance Standards for Coding Professionals,” Journal of AHIMA, October 2001), while Medical Records Briefing recommends setting ranges for accuracy of 90-95 percent (see “Start Tracking Coder Productivity and Watch It Soar,” Medical Records Briefing, December 2001). 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 minimum coding accuracy standard for all types of work for experienced professional coders at the journeyman (target grade) level is 95 percent. Appropriate lower standards may be set for coders in developmental positions.

14. 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 not 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 and CPT codes.

c. When there is conflicting or ambiguous documentation in the patient's electronic health record, physicians need to be consulted for clarification.

(1) 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. **NOTE:** *Policies and procedures must be established, at each facility, for obtaining physician clarification, such as allowing the coder to directly contact the physician about a record being coded.*

(2) Communication tools such as summary forms, attestation sheets, and query forms must never be used as a substitute for appropriate physician documentation in the electronic health record. Any response from the physician of a coding query that will be used to support a code assignment must be documented by the physician in the electronic health record.

d. Data validation is an essential component of any coding program. This includes reviewing accuracy, completeness, and/or 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, at a minimum, that require ongoing review and validation by coding staff.*

REPORTS TO BE MONITORED AND WEB LINKS

1.	<p>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 Cordinators (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</p>
a.	<p>Census. The Census Directive can be accessed at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1296</p>
b.	<p>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</p>
2.	<p>PTF Reports. Dispositions in the PTF Master File (419). All inpatient cases validated for acceptance monthly 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</p>
3.	<p>Veterans Equitable Resource Allocation (VERA). Workload data should 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/</p>
4.	<p>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://www.va.gov/vdl/documents/Clinical/Surgery/sr_3_tm_r0607.doc</p>
5.	<p>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 Archives QuadraMed web conferences can be accessed at: http://www.quadramed.com/web/customers/government/index.cfm?pageInc=archived_web_conferences</p>