NORTHERN NEVADA ADULT MENTAL HEALTH
POLICY AND PROCEDURE

SUBJECT: CLINICAL CODING

NUMBER: NN-IM-MR-25

ORIGINAL DATE: 3/19/09

REVIEW/REVISE DATE: 5/17/12

APPROVAL: ____________Cody L. Phinney, MPH_________, Agency Director

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I. PURPOSE

To provide written guidelines for accurate coding of medical record documentation to substantiate consumer management and care, including medication, therapy, and/or diagnostic evaluation of each condition reported according to established coding principles.

II. POLICY

All electronic medical records (EMR) will be coded accurately and within 12-hours of contact with the consumer or by the end of the clinician's work shift.
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III. PROCEDURES

CLINICAL DOCUMENTATION

A. Members of the medical staff and clinical staff will assure that each diagnosis and service performed is addressed and justified by appropriate documentation in the EMR.

1. Clinical documentation must substantiate that the consumer's management and care was affected by the conditions which co-existed at admission or which developed subsequently.
   The documentation should indicate that the consumer received medication, other therapy, or diagnostic evaluation for each condition reported. (Example: For Diabetes Mellitus, the record should show the consumer was administered insulin or oral diabetic. The results of at least one blood sugar determination should be recorded.)
2. Conditions such as blindness will be assigned codes because extra nursing resources are required to care for such consumers.
3. For conditions developing subsequent to hospitalization, clinical staff is expected to describe signs and symptoms in progress notes.
   (Example: For urinary tract infection, the record should describe symptoms of dysuria and frequency with orders for urine cultures.)
4. The following documents are to be consulted to identify all diagnoses that needs to be coded and to increase the accuracy and specificity of coding.
   a. Discharge summary: Code diagnoses listed as discharge diagnoses, and those that are not listed in the psychiatric assessment.
   b. Psychiatric Assessment: Ensure all diagnoses identified on the psychiatric assessment are included in those listed on the discharge summary. Ensure that any deferred diagnosis codes have been adjusted appropriately.

c. History and Physical: Scan to identify conditions such as history of cancer or pacemaker in situ. These should be coded as they may increase ancillary service costs – e.g., additional scans or EKGs.
d. Progress notes: Scan to detect complications and/or secondary diagnoses for which the patient was treated.
e. Consultations: Scan to detect additional diagnoses or complications for which the patient was treated and query the physician as to whether to code or not.
f. X-ray and laboratory: Use reports as guides to identify diagnoses or for more detail. Requests for X-rays and / or labs must be based on medical necessity and noted in the EMR.
g. Physician's orders: Scan to detect treatment for unlisted diagnoses – e.g. insulin, antibiotics, etc.
h. Resource material is not limited to the above. Other documents or resources may be used as required.
i. It is desirable to code only complete medical records, but while waiting for the record to be completed, and with the approval of the physician, a coded diagnosis, that is not deferred, can be provided so billing can progress timely. However, the above procedure must be completed before the coding of a record can be considered final.

B. Health Information Services (HIS)

1. Admission and concurrent coding:
   a. Admission inpatient/POU records will be reviewed by 1:00 p.m. the day following admission to justify codes entered into Avatar.
   b. The record will be reviewed for additional or change of codes every three (3) days while the consumer is on the units.

c. If required, changes will be made to reflect appropriate diagnoses either added or changed.

2. Discharge coding:

a. Discharged inpatient/POU records will be accounted for by HIS within 48 hours of discharge.

b. Records will be assembled in established format, and analyzed for content and completeness.

c. The HIS Coding Worksheet will be completed within 72 hours of discharge. The diagnosis as established from the above activities will be evaluated by the coder for completeness, coded, and entered on the coding form.

d. After entry on the coding form, changes to the diagnoses and codes can be made by HIS coders only. After submission, code or diagnoses changes must be approved by the attending physician.

3. Training:

a. Training for designated staff will be provided as required.

b. Staff responsible for coding will use current and standard coding manuals provided by NNAMHS.

4. Review and Correction:

a. Prior to submission of final codes, a second coder will check for correctness and completeness.

b. Records designated by third party payers as incomplete or incorrectly coded will be monitored by Financial Services.

c. Quarterly reports of errors and returned bills will be made to the Agency Director.