Are You Coding with Blinders On?

USING CRITICAL THINKING SKILLS WHILE CODING

by Victoria Weinert, RHIT, CCS

In October 2017, the Centers for Medicare and Medicaid Services (CMS) implemented the ICD-10-CM Official Guidelines for Coding and Reporting guideline *I.A.19 Code Assignment and Clinical Criteria.* It states:

> The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

How were HIM coding professionals affected by this guideline? Was it seen as a green light to accept everything documented in the record and not question it? The answer is an emphatic *"No!"* More than ever, coding requires critical thinking skills in conjunction with a strong knowledge of medical terminology, pathophysiology and pharmacology, as well as correct application of coding practices, as directed in the ICD-10-CM Official Guidelines for Coding and Reporting.

An organization's high productivity standards and need for optimized revenue should not be an impediment to coding excellence. HIM coding professionals may feel a reluctance to query when a provider's documentation in the medical record does not meet the clinical criteria for establishment of the diagnosis or the condition does not follow the guidelines for reporting additional diagnoses. Before worrying about "the numbers," it needs to be asked, "was the condition evaluated or treated? Did it extend the length of the hospital stay, or did it increase nursing care or monitoring?" Concern over potential payer denials should not influence proper coding.

HIM coding professionals cannot adopt the mentality that, *"clinical documentation improvement (CDI) staff should have validated the diagnosis before the record became available for coding."* Nor should a HIM coding professional conclude, *"if the provider put it in the record, it can be coded!"* Rather, critical thinking skills to properly interpret and code the medical record should be employed, and the following questions asked:

MORE THAN EVER, CODING REQUIRES CRITICAL THINKING SKILLS IN CONJUNCTION WITH A STRONG KNOWLEDGE OF MEDICAL TERMINOLOGY, PATHOPHYSIOLOGY AND PHARMACOLOGY, AS WELL AS CORRECT APPLICATION OF CODING PRACTICES

- Do the codes paint an accurate picture of the patient's stay/visit?
- Were the coding conventions and/or official coding guidelines correctly applied?
- Can all the codes that have been assigned be supported?

The question that should not be asked is, "how can the lack of supporting clinical validation or treatment for a diagnosis be ignored when the provider documented it?"

When Words Are Not Enough

Provided are common coding situations an HIM professional may encounter and should pause to ask critical questions.

Sepsis: Patient admitted for sepsis due to a urinary tract infection (UTI) and is discharged home after one-day length of stay. There is no ignoring the current controversy over the definition of sepsis that lingers among physicians, payors and CMS. However, it is possible that assuming a working diagnosis on admission is the equivalent of final condition "after study." Many facilities do not require discharge summaries for short stays — all the more reason that the documentation in the record makes the most sense for the admission (Kalantari, Mallemat, & Weingart) (Chism & White, 2019).

Acute Respiratory Failure: Physicians consistent documentation for acute respiratory failure should reflect clinical indicators and manifestations, such as shortness of breath (or air hunger), cyanotic appearance,

sleepiness, irregular heartbeats and confusion. The documentation should not include "no distress." Is it possible the provider means that the patient is noted with an abnormal lab finding such as hypoxemia or hypercapnia? (U.S. Department of Health & Human Services).

Encephalopathy: Toxic metabolic encephalopathy due to sepsis or UTI should be clarified for a source of toxin. If no toxic agent is identified, clarification should be sought in order to assign the appropriate encephalopathy code (i.e. metabolic encephalopathy or encephalopathy due to infectious process) (Chalela & Kasner, 2019).

Urinary Tract Infection (UTI): Without signs or symptoms of infection or inflammation, is it just a lab discovery—bacteriuria? (Green-Hines, Rupp, & Van Schooneveld).

Conclusion

HIM coding professionals need to take the blindfolds off and should ask hard questions of the provider and collaborate with other health care professionals, such as CDI specialists. HIM coding professionals are encouraged to *live by the AHMA Standards of Ethical Coding, owning responsibility for pursuing accurate, complete and reliable coded data* (AHIMA, 2016).

Resources

AHIMA House of Delegates. (2016, December) American Health Information Management Association Standards of Ethical Coding [2016 version]. AHIMA. Retrieved from bok.ahima.org/doc?oid=302237#.XcWwwG5Fzt5

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U.S. Department of Health & Human Services. (n.d.) Respiratory failure. Retrieved from nhlbi.nih.gov/health-topics/respiratory-failure

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