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EFFECTIVE DATE: February 1, 2020	**REFERENCE NUMBER:** REGS.COD.013
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All Company-affiliated facilities including, but not limited to, hospitals and all Corporate Departments, Groups and Divisions.

All personnel responsible for performing, supervising or monitoring coding of inpatient and outpatient rehabilitation services, including, but not limited to, employees in the following departments:

Facility Health Information Management
Corporate Regulatory Compliance Support
Physician Advisors
Case Management/Quality Resource Management
Ethics and Compliance Officers
Parallon Business Performance Group
Service Centers
Administration
IRF PAI Coordinator
External Coding Contractors
Rehabilitation Director

This policy applies to diagnosis and procedure coding of all rehabilitation services provided in Company-affiliated facilities. For outpatient services, refer to the Coding Documentation for Outpatient Services Policy, REGS.COD.002. For inpatient services in acute care hospitals, refer to the Coding Documentation for Inpatient Services Policy, REGS.COD.001.

PURPOSE: To improve the accuracy, integrity and quality of patient data, ensure minimal variation in coding practices, and improve the quality of the physician documentation within the body of the medical record to support code assignments. The Company's commitment to data integrity is documented on Attachment A.

POLICY: Diagnoses will be coded utilizing the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Procedures will be coded utilizing the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). Company facilities will follow the most current ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting for assignment of diagnoses and procedures.

PROCEDURE:

1. **ICD-10-CM/AHA Coding Clinic**
   Diagnoses will be coded utilizing the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and/or other classification systems that may be required (such as DSM V for classification of psychiatric patients). Procedures will be coded utilizing the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)

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The Company will follow the most current ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting of diagnoses and procedures.

2. **Selection of Principal and Secondary Diagnoses**

Uniform Hospital Discharge Data Set (UHDDS) definitions have been expanded to include all nonoutpatient settings (acute care, short term care, long term care and psychiatric hospitals, home health agencies, rehab facilities, nursing homes, etc.).

Inpatient diagnoses and procedures shall be coded in accordance with UHDDS definitions for principal and additional diagnoses and procedures as specified in the ICD-10-PCS Official Guidelines for Coding and Reporting.

a. The principal diagnosis is defined in the UHDDS as, "*that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care*."
b. The UHDDS defines additional diagnoses as, "*all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay*." Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

3. **Selection of Principal and Secondary Procedure(s)**

In accordance with UHDDS definitions all significant procedures are to be reported.

a. A significant procedure is one that is: (1) surgical in nature, or (2) carries a procedural risk, or (3) carries an anesthetic risk, or (4) requires specialized training.
b. When more than one procedure is reported, the principal procedure is to be designated by following the instructions published in the most current ICD-10-PCS Official Coding Guidelines for Coding and Reporting. This designates that the principal procedure is the procedure that is most related to the principal diagnosis.

4. **Reportable Diagnoses/Procedures**

To achieve consistency in the coding of diagnoses and procedures, coders must:

a. Thoroughly review the entire medical record as part of the coding process in order to assign and report the most appropriate codes.
b. Adhere to all official coding guidelines and/or specific payer instructions as stated in this policy.
c. Assign and report codes, without physician consultation or query, for diagnoses that are not listed in the physician's final diagnostic statement only if those diagnoses are specifically documented in the body of the medical record by a physician directly participating in the care of the patient, and this documentation is clear and consistent.
    i. Areas of the medical record which contain acceptable physician documentation to

support code assignment include the discharge summary, history and physical, physician progress notes, physician orders, and physician consultations.

ii. When diagnoses or procedures are stated in other medical record documentation (nurses notes, IRF PAI (Rehabilitation), pathology reports, radiology reports, laboratory reports, EKGs, nutritional evaluations and other ancillary reports) but not documented by a physician directly participating in the care of the patient, the attending physician must be queried for confirmation of the condition. These conditions must also meet the coding and reporting guidelines outlined in the most current *ICD-10-CM Official Coding Guidelines,* unless specify otherwise in the coding guidelines (*i.e.*, BMI or Pressure Ulcer Stage may be based on medical record documentation from clinicians who are not the patient's provider).

iii. Utilize medical record documentation to provide specificity in coding physician diagnoses, such as utilizing the radiology report to confirm the fracture site or referring to the EKG to identify the location of a myocardial infarction.

iv. Do not code diagnoses documented as "probable," "suspected," "likely", "questionable," "possible," "rule out" , "compatible with," or "consistent with" as if they are established. Rather, code the condition(s) to the highest degree of certainty, such as symptoms, signs, or other reason for the Rehabilitation visit.

5. **Query Process**

Query the physician participating in the care of the patient when a diagnosis or procedure has been determined to meet the guidelines for reporting but has not been clearly or completely stated within the medical record or when ambiguous or conflicting documentation is present. For detailed information on the query process, refer to the Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements, REGS.DOC.002.

6. **Coding Summary**

A coding summary must be placed within the medical record of all inpatient discharges.

a. A coding summary must contain all reported ICD-10-CM diagnosis and ICD-10-PCS procedure codes, and their narrative descriptions, patient identification, and admission and discharge dates.
   i. The summary should also include discharge disposition, and may include DRG assignment and description.
   ii. The coder must ensure that changes to the ICD-10-CM/PCS narrative description of a diagnosis or procedure be consistent with the code descriptions in the ICD-10-CM/PCS manuals.

b. The coding summary should be either a system generated abstract or handwritten codes on

the face sheet.

c. The summary must be kept as a permanent part of the medical record.
d. The HIM Director is required to ensure that the coding summary has been officially approved by the medical staff to be included as a permanent part of the medical record.
    i. The coding summary should include a statement that the form will be filed as a permanent part of the medical record.
    ii. Follow the process outlined in hospital policy or medical staff bylaws, rules and regulations for adding forms to the medical record.

7. **Data Quality Application**

Coders must not:

a. Add diagnosis codes solely based on test results;
b. Misrepresent the patient's clinical picture through incorrect coding or by adding diagnoses or procedures unsupported by physician documentation for any reason; or
c. Report diagnoses and procedures that the physician has specifically indicated he or she does not support.
d. Each facility must have a process in place to identify appropriateness of services and/or coverage issues before the service is rendered.

8. **Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) Completion**

The HSC Coding/HIM Director and IRF PAI Coordinator should establish a protocol for completing the Medical Information (#22 and 24) and the Discharge Information (#46 and 47) Sections of the IRF PAI. It is the responsibility of the HSC/HIM coding staff (or skilled/trained individual designated to perform the coding function) to assign ICD-10-CM codes for completion of Medical/Discharge Information Section.

Medical Information:

a. *#22 Etiologic Diagnosis:* Assign an ICD-10-CM code to indicate the etiologic problem that led to the condition for which the patient is receiving rehabilitation
b. *#24Comorbid Conditions:* Assign an ICD-10-CM code to indicate any Comorbid Conditions or Complication (up to twenty five) except for those conditions/complication that develop the day prior or the day of discharge.

Discharge Information:

a. *#46 Diagnosis for Interruption or Death:* Assign an ICD-10-CM code to indicate the diagnosis of interrupted stay or death.
b. *#47 Complications during rehabilitation stay:* Assign an ICD-10-CM code to indicate

six conditions that began with this rehabilitation stay, except for those conditions/complication that develop the day prior or the day of discharge. These conditions (ICD-10-CM codes) should also be listed in #24 Comorbid Conditions.

9. **IRF PAI Documentation Requirements**
Each electronically submitted Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) must be printed and maintained as a permanent part of the patient's medical record. Confirmation of each electronic IRF PAI submission should be maintained as part of the facility's business records. These do not have to be a permanent part of the patient's medical record but can be maintained with the medical record if desired.

10. **Medical Record Documentation Requirements**
Rehabilitation medical records should be created and maintained following the facility policy and procedure for record processing for rehabilitation units, including the certification and recertification.

Medical records for visits occurring during the Rehabilitation stay that are excluded from Rehabilitation PPS (non-Medicare) should be created and maintained following the facility policy and procedure for record processing for the specific patient type (*i.e.*, inpatient, outpatient).

11. **Coding Validation Reviews**
Internal coding quality reviews must be completed in accordance with Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy, REGS.COD.018.

12. **Unique Payer Requirements**
Each facility must ensure that coders are oriented about and aware of individual payer contracts and instructions that contain specific coding and reporting requirements.

a. It is recognized that payers in various states may utilize coding guidelines that do not comply with those issued by the cooperating parties.
b. Each facility must maintain, in writing, policies and procedures/instructions that document the coding guidelines or coding requirements of a specific payer.
c. Facility Health Information Management should be involved during contract negotiations with third party payers when coding guidelines are addressed.
d. Written department procedures must also include how coding conflicts with payers are addressed. Since most facilities deal with many different payers who issue varied guidelines, coding issues with high volume payers should be addressed first.

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13. **Review of Claim Rejections, Claim Denials, Claim Return to, Claim Suspension, Line Item Rejection and Line Item Denials Related to HIM-Assigned Codes**
    In circumstances where there is to be a review of claim rejections, claim denials, claim return to, claim suspension, line item rejection and line item denials related to HSC/HIM-assigned codes, the review will be done by qualified coding employees.

14. **Claims Adjustment**
    A written facility-specific policy must be developed which prohibits changing or resequencing of codes and/or HSC/HIM-assigned modifiers by business office, or Service Center patient personnel, or the IRF PAI Coordinator without review and approval by qualified coding personnel. Education and follow-up should be conducted with all coding professionals as applicable.

15. **Policy Compliance Monitoring**
    Compliance with this policy will be monitored during reviews by Corporate Regulatory Compliance Support Department and/or Parallon Business Performance Group.

    a. Each facility's administration is responsible for ensuring that this policy is applied by all individuals involved in coding of inpatient services.
    b. Employees who have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy should discuss these situations with their immediate supervisor to resolve the situation.
    c. All day-to-day operational issues should be handled locally; however, if confidential advice is needed or an employee wishes to report an activity that conflicts with this policy and is not comfortable speaking with the supervisor, employees may call the toll-free Ethics Line at 1-800-455-1996.
    d. For any questions regarding this policy please contact the Regs Helpline at http://trinisys.app.medcity.net/regshelpline.

REFERENCES:

1. *Coding Clinic for ICD-10-CM and ICD-10-PCS* is the official publication of ICD-10-CM/PCS coding guidelines and advice as designated by four cooperating parties: American Hospital Association (AHA), American Health Information Management Association (AHIMA), Health Care Finance Administration (HCFA), and the National Center for Health Statistics (NCHS).
2. *ICD-10-CM Official Coding Guidelines for Coding and Reporting*
3. *ICD-10-PCS Official Coding Guidelines for Coding and Reporting*

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4. AHIMA Defining the Core Clinical Documentation Set for Coding Compliance – *AHIMA Thought Leadership Series 2012*
5. Coding Documentation for Inpatient Services Policy, REGS.COD.001
6. Coding Documentation for Outpatient Services Policy, REGS.COD.002
7. Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements, REGS.DOC.002
8. Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy, REGS.COD.018
9. IRF-PAI Training Manual, Completion of IRF-PAI Form for Rehabilitation Billing.
10. *Federal Register, Department of Health and Human Services,* Centers for Medicare and Medicaid Services, Washington, DC, August 7, 2001.

Attachment A

Commitment to Data Integrity

One of the important philosophies of the Company is the commitment to conduct our business with integrity and always render our services on a highly ethical level.

This philosophy embraces the following principles related to coding:

1. We have great confidence in our employees and their commitment to collect, manage and report data in an unbiased, honest and ethical manner.

2. We believe that diagnosis and procedure coding should be governed by Official Coding Guidelines and that all codes mandated by the guidelines should be assigned and reported. Adherence to guidelines will promote consistency and accuracy of coded data in individual facility and company databases. The Company policy is that ICD-10-CM diagnosis and procedure codes and CPT procedure codes and modifiers must be correctly submitted and will not be modified or mischaracterized in order to be covered and paid. Diagnoses and procedures will not be misrepresented or mischaracterized by assigning codes for the purpose of obtaining inappropriate reimbursement.

3. We believe that the diagnosis reported by the physician as the reason for the encounter or visit and the codes reported must be consistent.

4. We believe that the procedural codes reported should accurately reflect the procedures performed during the encounter as documented by the physician.

5. We are committed to providing the support needed to effectively classify our patients. Support provided to the Company's facilities includes coding seminars, training tools, group purchases of products at discounted rates, publications and nosology support.