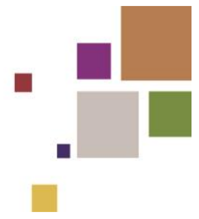


Understanding Clinical Coding Process Review

The Clinical Coding Process established in each facility will be dependent on specific policies and processes to have a systematic and organized way of handling the clinical information to be converted into accurate claims.

Clinical Coding Process Review is one of the domains for audit as per the methodology of JAWDA Data Certification for Healthcare Providers. Coding processes will be audited at the facility to assess the establishment of policies based on standard and regulatory requirements of HAAD Coding manual, normative references mentioned in the methodology, other standard references and adherence to it.

It is imperative that properly trained hospital staff is involved at the appropriate phases to ensure accuracy of information reported on each claim.

The Clinical Coding Process Review will assess mainly on the below mentioned:

Coding Process Flow Chart represents the process followed specifically at one's facility (Hospitals/ Centers). Each of the facilities might have a slightly different way, however it is expected to meet the minimum requirements referring to HAAD Coding Manual and other standard references.

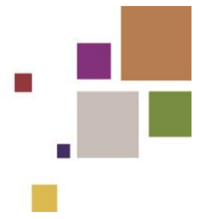
Policies relevant to Clinical Coding:
All the facilities are expected to have written policies to ensure a systematic guidance for the involved work force.

Identify the location of all policies as to Clinical Data Reporting or Submission:

- Coding Practice policies
- Healthcare Documentation policies
- Employee Orientation and/or Training policy

Coding Practice Policies:

- All the coders should be aware of the list of references available for coding
- Should have accessibility to the standard references like books, HAAD Coding Manual, HAAD Adjudication rules and other source of standards information from Shafafiya, and additional references like CMS, AMA, AHA, AHIMA as required.
- Each coder and all the staff involved with clinical information should have a proper understanding of HAAD Code of Ethics
- A policy for Coder- Physician query process on unclear/insufficient clinical documentation, with timelines
- A policy on Coder's role in Pre-authorization, the professional should have the patient's medical record available for reference when requesting pre-authorization/pre-certification.
- Coding, Quality check on Coding, and coding related resubmissions.



Documentation Policies:

A patient's health record plays five unique roles: (*1*) It represents that patient's health history (*2*) It provides a method for clinical communication and care planning (*3*) It serves as the legal document describing the healthcare services provided. (*4*) It is a source of data for clinical, health services, and outcomes research. (*5*) It serves as a major resource for healthcare practitioner education

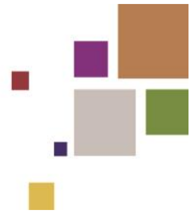
The below mentioned topics can be considered as the recommendations in compliance with medical record documentation standards as per HAAD JCI and other standard references.

- Policy on Timeliness of documentation- Completion of Documentation within 24 hours of the service being rendered.
- Completeness of medical record and documentation
- Documentation supporting the medical necessity for rendered services and evaluated conditions
    - Reason for the encounter and **relevant** history, physical examination findings and proper diagnostic test results
    - Assessment, Clinical Impression or Diagnosis
    - Medical Plan of Care
- Policy on Record Keeping principles and alterations to medical records
    - Corrections
    - Delayed entries
    - Amendments
    - Authentications
    - Time, date, and signatures
- Protected Health Information (PHI) security and privacy - Policy on confidentiality/breach
- For Electronic medical records or Electronic Health Records
    - Audit Log Status
    - Synchronized clocks on EHR systems
    - Documentation Integrity
    - Avoid misuse and abuse in template documentations - Compliance or policy on copy and paste in the E.H.R. system
    - Narrative diagnosis instead of drop down selection of diagnosis

Training Policies/Orientation Policies:

To ensure that-

- New staff are oriented to the hospital/Center, their department, job responsibilities, their specific assignments and sufficient training to use the technical applications required to perform the job.
- Receives ongoing in-service and other education and training to maintain or advance his or her skills and knowledge and meet continuing education requirements of their credentials
- The process and personnel shall abide by relevant laws and regulations.
- All staff members are trained and knowledgeable about their roles in the organization
- The education is relevant to the settings in which the staff member works



Training Recommendations for Clinical Coding staff:

- Review topics where deficit areas were identified
- Review HAAD coding guidelines
- Review specific topic related to specialty
- E/M documentation guidelines
- ICD-10-CM awareness
- Coding and documentation guidelines, coding updates, and changes in carrier or HAAD requirements

Key Areas of Interviews with Nominees

1. **Provider Data and Documentation Accuracy**

Medical Records Department

- Completeness of Medical records
- Date and Legible Identity of the Observer
- Alteration or correction in the medical records
- Availability of Medical records/Confidentiality, Privacy and Security of PHI
- Timeline for completion of documentation

Authorization Department

- Policies on verification process for services meeting the health insurer’s medical necessity criteria. (Who determines the reportable code to the insurances)
- Prior Authorizations based on initial documentation
- Verifying all rendered services are properly documented
- Verify if rendered services are per approved services, if any change to notify insurances for re-approval. (Who determines the reportable code to the insurances for re-approval)

Meet with the Provider

- Communication between the provider and the auditor is vital
- Action based on findings in the chart audit process is a critical step in the audit process
- Time frame and process to make needed changes in documentation based on the coder/provider’s determination of the issues that require immediate attention

Billing Office

- Proper training in coding or process if coding assistance is required
- Charge entry accuracy and Timing

2. Claims Submission Accuracy:

Things to Look For:

- Overbilled and /or under-billed services
  - All services, including E/M and surgical procedures, should be documented with sufficient details to allow coders to select the proper CPT® & ICD-9-CM/ICD-10-CM.
- Undocumented services or Services not compliant with documentation
  - identify instances where codes are billed without proper supporting documentation
- Un-billed services
  - By comparing the medical record to what was submitted for payment, can identify services that have been documented but were not billed.

Risk Areas include

- Violation of HAAD official coding guidelines
- Documentation inadequate to support level of service billed (E/M code selected)
- Noncompliance with HAAD adjudication rules
- Incorrect place of service or category of service (hospital, office, consultation, ED, homecare)
- Check for the medical necessity of services rendered with the available documentation

Top Check points to avoid potential errors

- Up-coding and or Down-coding
- Chief Compliant/reason for visit missing or incorrect
- Assessment and/or Plan not clearly documented
- Documentation not signed
- Test ordered not always documented on the patient encounter, but billed
- Incorrect Diagnosis or not referenced correctly for medical necessity
- Illegible documentation

This JAWDA Data Certification methodology identifies two key measurement criteria used for judging the quality of coded and submitted clinical data:

- Accuracy
- Completeness