County of Los Angeles **Department of Health Services**

VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
HEALTH INFORMATION MANAGEMENT SERVICES
POLICY & PROCEDURE

NUMBER: 1520
VERSION: 1

SUBJECT/TITLE: **HIMS - INPATIENT/OUTPATIENT CODING GUIDELINES**

POLICY: Coding Guidelines

PURPOSE: To ensure accuracy and consistency in coding

DEPARTMENTS: **HEALTH INFORMATION MANAGEMENT SERVICES / Inpatient, Outpatient Medical Audit**

DEFINITIONS: To ensure that guidelines for coding are followed

PROCEDURE:
HIST,HIT,HIA,HITT

The following procedures will describe, in detail, the steps the coding staff must adhere to in coding the medical records of discharged Inpatients and Outpatients from this facility.

Tools Used In Coding:

Medical Record
Quantim Coding
CPT Guidelines
Anatomy
Clinical Indicators
Coding Clinic
CPT Assistance
ICD-9 Guidelines
Lab Values
Drugs (PDR)
Medical Dictionary
Coding Clinics for HCPCS
Abbreviations
Faye Brown
Physician Queries

Primary Responsibility for Procedures:
Coding Guidelines

Always adhere to the general principles of coding.

Unresolved issues or problems should be referred to the Coding Supervisor so that final processing will not be delayed.
Each individual member of the coding staff is responsible for assuring that all coding updates are read and noted (i.e. quarterly coding clinic publications and annual CMS updates).

Medical Record Review

- Read the entire medical record from the facesheet through the nursing notes.
- Review in particular the following documents:

Inpatient

1. Face Sheet
2. Discharge Summary
3. History and Physical
4. Operative Note
5. Progress Note
6. Consultation Reports
7. Pathology Reports
8. Diagnostic Tests
9. Autopsy Report

Outpatient

1. Progress Note
2. Procedure Note
3. Diagnostic Reports
4. Pathology Reports

Code Determination:

- Principle Diagnosis: The condition, disease, injury that, after study, occasioned the patient's admission to the facility. The disease, not the symptom should be coded.

- Secondary Diagnosis should be coded as follows:
  All diseases or conditions actively treated during the hospitalization. Other secondary, pre existing conditions that were managed during the hospitalization or pre existing conditions which had a bearing on treatment of the patient. Complications and co-morbidities are to be coded and should be coded among the first four diagnosis.

- Use V-Codes as applicable to describe the reason for admission and/or personal history of a diagnosis such as cancer.

- E-Codes are to be used to:
  1. Identify external causes of adverse effect or poisoning.
  2. Misadventures
  3. External cause of injury
  4. External cause of illness
  5. Place of Occurrence
  6. External cause status

- Outpatient coders list the diagnostic codes in the sequence in which they were written on the physician progress note. Exception would be they come to cardiology and the Dr. rights finger pain, chest pain, HTN ect, you would then put the chest pain as principle diagnosis not finger pain.

- Inpatient list the diagnostic codes in the sequence in which they were abstracted on the Medical Summary Sheet.

- List the procedural codes in the sequence in which they were abstracted following the diagnosis.

- Print Abstract and file as 1st page of the inpatient chart.

- Enter your initial/date on the cover of the inpatient charts.

All coded charts (encounters) are routed to the Discharge Clearance unit for further analysis, completion and filing into the Outpatient chart.

References:	
Approved by: Tillie Acosta (Medical Records Director I)	Date: 10/27/2010
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Distribution: Health Information Management	

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