Clinical Coding Process Review – Standard References (Linked with ISO 9001:2015 Req.)

Methodology Clinical Coding Process Review - Parameter	Details and Specific standard references	(9001:2015) Req.
Coding Process Flow chart: To review Coding process flow • Coder Physician Query loop • Minimum 2 quality check points • Coder reporting department	Flow map of coders role in the claim cycle	4.4 Quality Management system and its processes
Coding Policies review: **Coding Practice policies** • Accessibility of updated Coding references (books /Electronic) ○ Shafafiya, CMS • List of Standard Coding References *HAAD Coding Manual;* *HAAD Claims and Adjudication Rules* *AMA* Official ICD-9 CM / ICD-10 CM Coding Guidelines CPT Coding Clinics CPT Assistants CMS • Ethical coding Assignment • Coder-Physician query process • Coding for Pre-Authorization	*HAAD Coding Manual;* *HAAD Claims and Adjudication Rules* *AMA* CMS Medicare Quarterly Provider Compliance Newsletter." Volume 1, Issue 4. July 2011 Medicare claims processing Manual-Coding requirements Standards of Ethical Coding 1.1 - HAAD Coding Manual, Pg 6,7; AHIMA code of ethics Compliant query practice-AHIMA	7.5 Documented information 7.5.2 Creating and updating 7.5.3 Control of documented information 7.2 Competence 7.3 Awareness

Documentation policy: *General—Healthcare Documentation:* 4.2.1 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. **Timeliness:** Encouraged to enter all details at the time of rendering service eCFR 482.24, Standard AOP.1.2 **Completeness:** maintaining the records and for insuring that they are completely and accurately documented, readily accessible, and systematically organized. **Medical Necessity documentation:** **Medical necessity** is **defined** as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Medical necessity is best supported in MDM documentation;	Standard Practice for Content and Structure of the Electronic Health Record (EHR)- Active Standard ASTM E1384-07(2013) 4.2 Complying with Medical Record Documentation requirements-ICN909160 CMS Transmittal- Amendments in Medical Documentation 42 CFR 482.24 - Condition of participation- Medical record services (4) (i) (A), (B); JCI pg 21 Medical Record Manual -WHO HAAD JCI standards *AMA Practice Management Center Reference;* https://www.ama-assn.org/ Department of Health and Human Services-E and M Documentation	7.5 Documented information 7.5.2 Creating and updating 7.5.3 Control of documented information 7.2 Competence 7.3 Awareness

• *Address the clinical significance of abnormal test results* • *Support the intensity of patient evaluation and treatment* • *describe the thought processes and complexity of medical decision making;* • *include all diagnostic and therapeutic procedures, treatments, and tests ordered and performed, in addition to the results;* **Paper Medical Records:** **Record keeping Principles:** clearly identify Amendments, Corrections, Delayed entries; using a single line strike through so that the original content is still readable. clearly indicate date and author- *author of* the alteration must sign and date the revision; delayed entries to paper records must be clearly signed and dated upon entry into the record **Electronic Medical Records:** **Security:** *standards to protect electronic health information created, maintained, and exchanged- encryption and decryption of electronic health information*	Centers for Medicare & Medicaid Services' manual system, Pub 100-4, Chapter 12, Subsection 30.6.1 Ahttp://www.acmq.org/policies/policy8.pdf; Medical record review Guidelines-NCQA Medical necessity Rule-CMS CMS Manual System- Pub 100-08 Medicare Program Integrity-Transmittal 442; 3.3.2.5/Amendments, Corrections and Delayed Entries in Medical Documentation pg-4,5 CMS Transmittal- Amendments in Medical Documentation Complying with Medical Record Documentation requirements-ICN909160 §491.10 Patient health records eCFR42Chapter IV eCFR45-Part170-Subpart B-§170.210	

Audit log status: *Record actions related to electronic health information, audit log status-original entry must be viewable, along with a date and time stamp, the name of the person making the change, and the reason(s) for the change, and encryption of end-user devices.* **Synchronized clocks:** *The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol* **Documentation Integrity:** *Patient identification, authorship validation, authorized amendments and record corrections;* ***Template documentation:*** *Ensure no over documentation and patient specific documentation; Avoid Cloning, Copy/Paste Practice, overuse of this can result in fraud and abuse.* **Narrative Diagnosis vs Drop down:** *Providers must document the diagnosis statement and should not list the code number or select a code number from a list of codes.*	Standard Guide for Amendments to Health Information-ASTM E2017 - 99(2010) EHR-Amendments ASTM. "E2017 99(2005) Standard Guide for Amendments to Health Information." http://www.astm.org/Standards/E2017.htm EHR Documentation Integrity Medicare Claims Processing Manual, Chapter 12. 2013. Narrative Diagnosis-AHA Coding Clinic; AHA Coding Clinic for ICD-9-CM, First Quarter 2012, Page 6, American Hospital Association Central Office	

Coder qualifications/CEU validation: **Requirement:** Validation of Coder current certification and/or experience which includes proof of coding experience with a minimum of 2 years in coding (NOT billing), and provide CEU's within 2 years from current year. Please refer to Normative references. **Coder credentials:** • *From AHIMA / AAPC* **Credential Maintenance:** • *Active member status for AAPC/or Annual Self-Assessment for AHIMA* • *CEU reporting as required by certifications* **Continuing Education Units:** • *Copy of recent CEU*	www.ahima.org www.aapc.com	7.2 Competence 7.5.3 Control of documented information
Orientation or Training Policy: **New Physicians/New coders training**: Basic orientation on all applicable: • Coding, Documentation, ethical policies • Standards and Regulations • Health Information System • software applications • Standard Operating procedures	HAAD Providers Policy Manual- 81 Duty to Give Orientation Training; 82 Duty to Support Continuing Professional Education	7.1.6 Organizational knowledge 7.3 Awareness

Check on Coding Process adherence by relevant staff– Successful processes should be understood and followed by all involved. The Auditor will rate the facility's understanding and adherence to their process by interviewing nominated members of staff from the various departments that are involved in the coding process. The process of adherence check is to understand the deficiencies in the system but not to evaluate any personnel.		7.1.6 Organizational knowledge 8.5 Production and service provision 7.5.3 Control of documented information
Coder Observation • The Auditor will observe a coder performing the coding role to verify and gain a thorough understanding if the observed coding process is complaint with standard policies.		8.5 Production and service provision 7.5.3 Control of documented information
Physician Interview (Count- 2); • The Auditor will interview nominated physicians at each facility who contribute to the coding process by direct coding in EMR or ticking on a superbill. • The Auditor may additionally choose from a list of physicians based on the documentation findings during claims review. • Evaluate the coder physician interaction regarding ambiguous or non-specific clinical documentation done by physicians.		8.5 Production and service provision 7.5.3 Control of documented information
Medical Records Department Interview • The Auditor will interview at least one member of the Medical records department of the facility to understand the process of filing an additional	Medical Record Manual -WHO HAAD JCI standards	7.5 Documented information 7.5.3 Control of documented information

documentation and availability of medical records for editing.		
Insurance Department Interview The Auditor will interview at least one member from insurance department to understand • pre-authorization process • Role of coders in the processes of pre-authorization • Billing, claim submission and re-submission		8.5 Production and service provision 7.5.3 Control of documented information 8.7 Control of nonconforming outputs
Finance Department Interview The Auditor will interview at least one member of the Finance Department at the facility to trace any influence of revenue drive on the claims after being determined by the Coders.		8.5 Production and service provision 7.5.3 Control of documented information