Tips for assigning diagnoses codes on inpatient records

Are you are a new inpatient coder overwhelmed with the task of reading through a huge inpatient record and assigning all the necessary diagnoses and procedures? Well, I would like to share my experience with starting to code inpatient records. Inpatient was about the first kind of coding I did and I really enjoyed it. I started by recoding/auditing charts at an acute care facility. I would purposely pick the thickest charts I could find and challenge myself to pick up every diagnosis there. I handled charts that had up to 20 diagnoses assigned to them and I coded them myself before comparing my codes to what had already been assigned.

I usually started with the face sheet and/or discharge summary. I would jot down everything I saw on a small scratch sheet. I recorded the diagnosis code, if I already knew it, to save time instead of writing out the name of the condition. Some coders choose to start with the history and physical report since this report gives a summary of the patient's stay. This may work for some, but as a new coder, I did not prefer to start with the H&P because many resolved conditions are usually listed there and I did not want to loose time reviewing those. I found it faster for me to start with the discharge summary or face sheet because the most of the conditions listed there seemed to be most pertinent to the present encounter.

As I proceeded through the record, I confirmed and further refined each of my diagnoses and procedures and added any additional ones that may not have been mentioned in the first documents I reviewed. Since the records at the facility where I volunteered were organized by source, I chose to describe the rest of my techniques in order of the record forms that I encountered. I also added some additional tips from the reference below.

Labs: After the d/c summary and H&P, were all the labs. I just briefly scanned seeing that remembering that I could not assign a code directly from anything there since this is not physician documentation. I would have to make sure the physician confirmed the significance of any findings that I though were significant.

A. A time when one might scan the lab reports a bit more carefully is in cases where infections were present. The key is to possibly catch more specifics in regards to the infection for possible physician query and to improve the DRG. An example is a culture that identifies a specific bacteria or other organism for an infectious disease such as sepsis or pneumonia.

B. There are also abnormal values that are clinical indicators for conditions like anemia, metabolic imbalances, renal failure, etc. One should note these for future verification and possible query if needed.

Radiology/pathology: Recall that per the official coding guidelines, one may not pull diagnosis from these reports when they have not been documented by the attending M.D. The only thing that you pick up from these reports is some details of a diagnosis that has already been documented by the attending physician. Therefore, I looked at these reports more closely to see if anything more specific could be

gained from them: like the specifics of a fracture. One may need to query if a significant finding or diagnoses like COPD or CHF are only documented there and not by attending M.D.; one could use other documentation found in the record of any of the usual treatment protocols directed to these pathologies to back up the query. Also, be sure to note any procedures that may be recorded on the radiology report including basic interventional procedures such as biopsies, centeses, spinal taps, aspirations, injections, and insertions of medical devices such as chest tubes or catheters.

Other Ancillary reports: I may not have the order right but next is a category that I call medicine reports (like EKG, sleep study, therapy reports, and all other ancillary reports, etc) which I looked over for specifics that may not have been documented already by the M.D. Examples include more details on the use of mechanical ventilation or a more detailed respiratory diagnosis (dx) documented in the respiratory therapy notes; more detailed diagnoses like malnutrition on dietary reports; etc [you would use the same approach as for radiology/pathology reports for any needed M.D queries because the same rule apply concerning not picking up raw diagnoses from these reports without those diagnosis having been already documented by the attending physician] Also, be sure to pick up or refine any procedure codes based on the details of any therapy or other procedure described in these reports.

Consultations: I read these thoroughly since the info is physician documentation. Remember that any documentation in these reports that conflicts with the attending physician's documentation needs clarification most likely via query otherwise, one can freely code from these documents. Recall that non-operating room procedures (especially those done at the patient's bedside) may be documented here also.

Orders: I thoroughly reviewed these to catch any other chronic/acute conditions being treated with medicines or complications. We can code directly from these since this attending physician documentation. Also, check admitting orders to see the conditions/diagnoses that were cause for admission. You may also note what treatments were ordered for the patient including dialysis, chemo, or mechanical ventilation with intubation. Since these are also non-OR procedures, a separate report for them is not likely, and you can verify that they were done by looking at the progress notes or other documentation within the record.

Progress notes: I thoroughly reviewed these to catch any other chronic conditions being treated or complications/adverse reactions. We can code directly from these since this attending physician documentation. Recall that non-operating room procedures (especially those done at the patient's bedside) may be documented here also such as transfusions, infusions, wound repairs, or debridements.

Operative reports: I carefully reviewed these for the details of the procedure(s) and finding(s). For example, an extensive/complicated lysis of adhesions would be

documented here, if it is done and this can actually be coded separately if it is extensive or complicated.

Anesthesia reports: This is physician documentation and since anesthesiologists have to be so thorough in their assessments, you can sometimes find more conditions here. I looked at these closely.

Nurses notes: I rarely looked at since this is not M.D documentation; the facility policy was to review those for wound debridements.

As you proceed through the report, meticulously record everything you can find. You might like to use a few colored pens or highlighters for recording different dx/findings. One approach you could use is to write down everything (histories, diagnoses, findings, etc) in pencil and then as you confirm a dx that you have recorded, check it off or highlight it. For example, as you proceed through the record, you could highlight each dx that you find that has been recorded by the appropriate physician and that has been treated or has affected patient care and/or length of stay in blue. You know that these dx are OK to code. In this way, you can rule out the ones that were not significant and did not affect the current encounter/length of stay.

Also, if you record any diagnosis or abnormal finding from documentation other than that recorded by the attending/consulting physician, you could use a different color pen to record those. Once you confirm that the physician indeed did document the significance of the finding or the actual condition, you could highlight it in blue since this is OK to code. Upon a complete review of the record, you can review your list to either cross out insignificant findings/history of conditions, etc. or highlight them a different color to identify them for possible query.

An entirely different approach could be this: You could try using green for a code that you know is OK; blue for an abnormal finding/diagnosis that needs to be documented by M.D. or for which the significance needs to be documented by the attending M.D. (I think of the blue lab sheets); red for a dx for which you need to search for evidence of treatment/significance (like histories) and yellow for any clinical indicators or other information that relates to a needed query. This is just another idea.

The key is to have an organized plan: this is what I am going to record and this is how I am going to record it. I am going to start with this portion and proceed accordingly. Knowing when to carefully read through documentation such as that from the attending physician, consulting physician, anesthesia report, et al; and knowing when to only quickly scan for specific things in other documentation from ancillary reports/nurses notes and such like, based on your knowledge of the general conditions in the encounter, can help save you time in the long run. As you refine your skills, you will readily recognize what you likely will not be able to code anyway and not need to even write that down. You will also recognize clinical indicators for certain conditions and know to be on the careful look-out for a definitive diagnosis and if it is not found be prepared to consider physician query. Knowledge of pharmacology is almost a must for

substantiating diagnoses reported or conditions for query. I hope that this article and these ideas will be helpful to you in your inpatient coding career.

Enjoy Coding!
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Appendix: a few more tips
-Histories: ensure whether or not each history diagnosis is still present and/or being treated (e.g. cancer)
-Conditions/complications: may need to verify if a condition is truly due to a procedure or not (e.g. acute blood loss anemia in hip replacement case)
-Late effects/secondary to's: verify conditions that may be due to an underlying pathology (e.g. late effects of CVA)
-Manifestations: look for a link if required for two conditions to be coded together. (E.g. Is the chronic renal failure stated as being due to the DM?)
-Rule outs: These are coded per official coding guidelines, but if the condition is ruled out, then you don't code it.
-Complications and Commorbidities: Keep a list of CCs in front of you as a reminder while you are coding

References and Resources:
Professional Review Guide for the CCS Examination, 2005 edition, by Patricia Scherning

Article by Tammy McClanahan, RHIT, CCS:
http://www.msqim.com/documentationtips.htm