

The FY 2019 ICD-10-CM Official Guidelines for Coding and Reporting (effective with discharges of October 1, 2016) contain noteworthy changes, including the following:

**I.A.19. Code Assignment and Clinical Criteria:**

*“The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”*

**A *Coding Clinic* reference on the subject of the I.A.19 Guideline follows:**

*ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2016 Pages: 147-149 Effective with discharges: October 1, 2016*

***Question:***

*Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: “The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.” Some people are interpreting this to mean that clinical documentation improvement (CDI) specialists should no longer question diagnostic statements that don’t meet clinical criteria. Is this true?*

***Answer:***

*Coding must be based on provider documentation. This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. Coding Clinic and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in Coding Clinic over the years, diagnosing a patient’s condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis, can “diagnose” the patient. As also stated in Coding Clinic in the past, clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient’s medical condition.*

*The guideline noted addresses coding, not clinical validation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient’s clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill. The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief (“Clinical Validation: The Next Level of CDI”) published in the August issue of JAHIMA: “Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.”*

*While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria. In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same-as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded. For example, if the physician documents sepsis and the coder assigns the code for sepsis, and a clinical validation reviewer later disagrees with the physician’s diagnosis, that is a clinical issue, but it is not a coding error. By the same token, coders shouldn’t be coding sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria. A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.*

To summarize the above referenced information, the content in Guideline I.A.19 is not a new concept. The guideline reaffirms the long-standing principle that coding should be ultimately based on provider’s documentation. Furthermore, coders should not exclude coding a reportable diagnosis that is documented by a provider based solely on the coder’s interpretation of clinical indicators or a perceived lack thereof. **Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis, can “diagnose” the patient.**

The RAC Scope of Work document from 2013 states: “Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.”

We must remember that clinical validation is somewhat subjective and providers do not always agree on how to define conditions. The provider is responsible for choosing the criteria used to establish a diagnosis, not the coding professional or CDS.

Under-coding is not playing it safe; it can be viewed as a misrepresentation of services with compliance risks attached. Both over-coding and under-coding are enemies of data integrity.

So, what is a coder to do? We must exercise common sense in the execution of our role and continue to appropriately rely upon the query process to help ensure good documentation and correct coding.

The UHDDS reporting criteria are still valid, alive and well. Refer to Section II “Selection of Principal Diagnosis” and Section III “Reporting Additional Diagnoses” of the Official Guidelines for Coding and Reporting.

Specifically let’s revisit:

**“Section III: Reporting Additional Diagnoses”**

For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

* clinical evaluation; or
* therapeutic treatment; or
* diagnostic procedures; or
* extended length of hospital stay; or
* increased nursing care and/or monitoring

Secondly, let’s consider the following excerpt from the AHIMA Practice Brief:

**“Guidelines for Achieving a Compliant Query Practice” (2016 Update):**

**When and How to Query**

The generation of a query should be considered when the health record documentation:

* Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
* Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
* Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
* Provides a diagnosis without underlying clinical validation
* Is unclear for present on admission indicator assignment

Additionally, the newly published AHIMA practice brief “Clinical Validation: The Next Level of CDI” does a good job describing the distinction between coding and clinical validation and should be referenced by *all* stakeholders.

Clearly, I.A.19 does not erase the importance of the UHDDS Guidelines nor does it negate the advice as outlined in the 2016 AHIMA Practice Brief on compliant queries. First and foremost, I.A.19 does not exist in a silo; it must be viewed through the lens of all guidelines and coding conventions. Secondly, I.A.19 reminds the coding professional of the fact that the assignment of a diagnosis code is *ultimately* based on the provider’s diagnostic statement that the condition exists, although we must continue to perform our due diligence as coders to dialogue with Clinical Documentation Improvement professionals and create compliant queries as warranted.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting:

*“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.”*

The coding professional should not put themselves in a position to exclude coding a reportable diagnosis that is documented by a licensed provider based solely upon the coder’s interpretation of clinical indicators. Naturally, UHDDS reporting criteria are vital to correct code assignment. If the validity of a given diagnosis is truly in question, the coding professional should refer to the criteria for query generation as outlined in the aforementioned AHIMA Compliant Query Practice Brief. Dialogue with CDI staff, prior to initiation of a query, may prove most useful to the coding professional.

In the broader sense, it would behoove facilities to develop guidelines pertaining to documentation requirements of problem-prone and/or denial-prone diagnoses. After all, good documentation is the foundation of accurate coding.

Bear in mind that much discussion about Guideline I.A.19 will ensue over the coming weeks and months and many voices will contribute to the discussion. It is an exciting time in HIM and CDI. Stay tuned!

References:

1. AHIMA. “Clinical Validation: The Next Level of CDI”. Journal of AHIMA 87 no. 7 (July 2016), pages 54-57.
2. AHIMA Practice Brief. “Guidelines for Achieving a Compliant Query Practice (2016 Update)”
3. American Hospital Association. AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS, Fourth Quarter 2016, Pages: 147-149.
4. AAPC. “Under coding is no better than over coding”. Blog post (April 4, 2014): <https://www.aapc.com/blog/26957-undercoding-is-no-better-than-overcoding/>
5. Centers for Medicare and Medicaid Services. “ICD-10-CM Official Guidelines for Coding and Reporting FY 2017”: <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2017-ICD-10-CM-Guidelines.pdf>