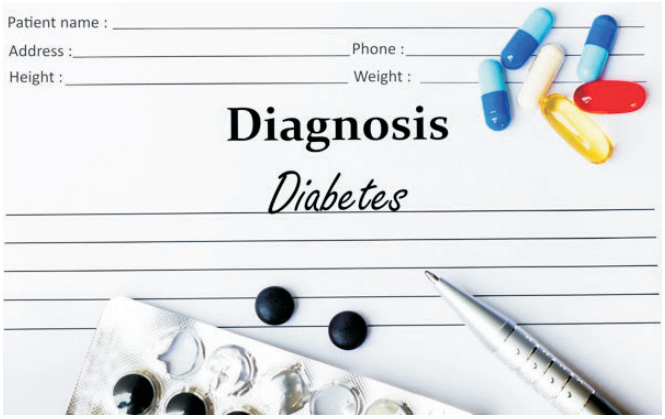
Inpatient and Outpatient Coding

THE TWO TYPES of medical coding are inpatient coding and outpatient coding. Inpatient coding is for overnight hospital stays. Outpatient coding covers only the day of treatment in an outpatient setting, such as a doctor's office. There are distinct variations between inpatient and outpatient medical coding. They vary in terms of guidelines, codes, and approaches. This unit introduces the differences between the two types of medical coding. Coding, whether inpatient or outpatient, begins with a diagnosis.



Objective:

Summarize inpatient and outpatient coding protocols.

Key Terms:

admission diagnosis
chief complaint
comorbidity
complication
diagnosis
first-listed diagnosis
ICD-10
inpatient coder
inpatient coding
inpatient medical facility
outpatient coder
outpatient coding
present on admission (POA) indicators
principal diagnosis
secondary diagnosis

Medical Coding: Inpatient and Outpatient

INPATIENT CODING PROTOCOLS

ICD-10

ICD-10 (International Classification of Diseases, Tenth Revision) is the system used by physicians and other healthcare providers to define, classify, and code the universe of diseases, disorders, injuries, and other related health conditions. ICD-10 went into effect on October 1,

2015. The current ICD-10-CM revision includes more than 68,000 diagnostic codes. By comparison, ICD-9-CM contained 13,000 codes. ICD-10-CM diagnosis codes consist of three to seven digits. ICD-9-CM was a three to five-digit system. The increase in the amount and length of ICD-10-CM codes allows for greater coding specificity.

Inpatient Coding

Inpatient coding is a review of the entire medical record for the length of stay and the selection of the principal diagnosis. Inpatient coding refers to the procedures (and the associated codes) for an individual who has been officially admitted to the hospital under a physician's order. The patient is classified as an inpatient until one day before discharge. Inpatient coding is usually more complex than outpatient coding because the inpatient records are typically long and very detailed.

Principal Diagnosis

The **principal diagnosis** is the chief reason for an inpatient stay. It is the condition that prompted admission to the hospital. For example, a patient might present symptoms of dehydration and is admitted for gastroenteritis. In this example, gastroenteritis is the principal diagnosis. Coders also select the secondary diagnoses for a patient's coexisting conditions.

Inpatient Medical Facility

An **inpatient medical facility** is a healthcare setting that admits patients for 24 hour care (overnight). Hospitals are the most common types of inpatient facilities. During the hospital stay, the patient may have a variety of tests, and there might be changes in diagnosis and treatments. Other inpatient facilities include:

- Nursing homes
- Rehabilitation centers
- Acute and long-term care hospitals
- Skilled nursing facilities
- Hospices
- Home health services

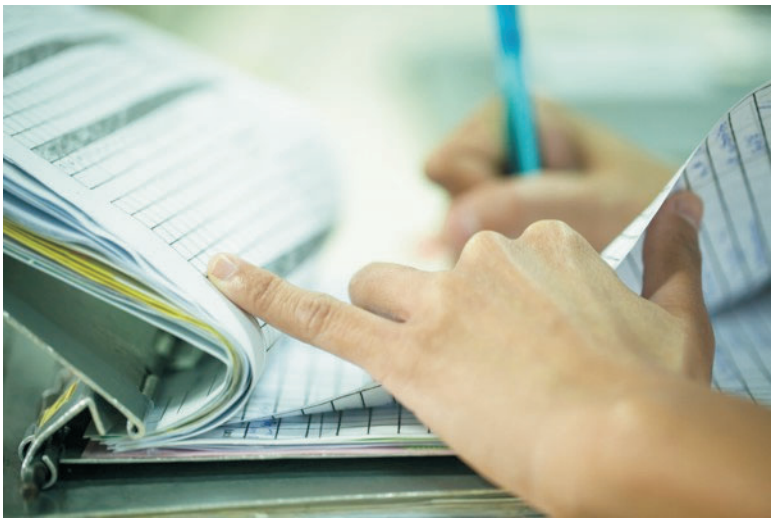


FIGURE 1. Medical coders review patient charts for billable information.

Inpatient Coder

An **inpatient coder** is a medical coding professional who is responsible for assigning the procedure codes that identify a patient's diagnosis and treatment while within a hospital or a long-term care facility. Inpatient coders primarily use International Classification of Diseases (ICD) codes that are designed to

FURTHER EXPLORATION...

ONLINE CONNECTION: Inpatient Coders

Read the JFAMC blog article "A Typical Workday in My Life as an Inpatient Coder" at https://www.jfamc.org/a-day-in-the-life-of-an-inpatient-coder/. Then read the Branford Hall website article "A Day in the Life of a Medical Coder" at https://www.branfordhall.edu/a-day-in-the-life-of-a-medical-coder/. Both articles provide additional information about the responsibilities and tasks of a medical coder.

describe a patient's diagnoses or medical conditions. Accuracy is extremely important in medical coding. To ensure accuracy, inpatient coders may need to speak with physicians and nurses to clarify some patient information. Responsibilities for an inpatient coder include:

- Reviewing patient charts and physician notes (either paper or electronic).
- Determining and assigning the proper and most accurate medical codes for diagnoses and procedures.
- Performing coding services for each day of a patient's stay in the facility.
- Performing varied and complex diagnostic and procedural coding for accurate DRG (diagnosis-related group) severity of illness, and risk of mortality assignment.
- Determining the patient's principal diagnosis that prompted admission to the hospital or long-term care facility. [NOTE: The physician must link the presenting symptoms, which necessitated the admission, to the final diagnosis. Coders cannot infer a cause-and-effect relationship.]

Diagnosis

A **diagnosis** is the identification of the nature of a disease or condition, by examining a patient's signs and symptoms. A diagnosis describes the cause, nature, or indicators of a condition, situation, or problem. In some clinical situations, it may be impossible for the provider to make a definitive diagnosis at the time of admission. Sometimes, a patient may not recognize or report a condition immediately.

Present on Admission Indicators

Present on admission (POA) indicators are the medical conditions that are present at the time the order for inpatient admission occurs. The POA indicator differentiates conditions present at the time of admission from those conditions that develop during the inpatient stay. When the same diagnosis code applies to two or more conditions during the same encounter (e.g., acute and chronic conditions classified with the same diagnosis code), the POA assignment depends on whether all conditions, represented by the single diagnosis code, were POA.

Admission Diagnosis

According to the Centers for Medicare and Medicaid Services, the **admission diagnosis** (admitting diagnosis) is the medical condition, identified by the physician, at the time of a patient's hospitalization. It is an initial analysis/judgment. Coders can only assign one admission diagnosis code, even if more than one is documented. The first admission diagnosis, documented on the inpatient face sheet, is documented by:

- The patient's primary care physician. This is the doctor who determined that inpatient care was necessary for treatment of a condition diagnosed in the doctor's office (e.g., acute exacerbation of chronic asthma).
- Elective surgery, which was previously scheduled (e.g., elective vasectomy).
- The facility's emergency department physician. This is the doctor who provided treatment and determined that inpatient care was necessary (e.g., trauma, heart attack, stroke, etc.).
- The ambulatory surgery unit surgeon who performed outpatient surgery and determined that inpatient care was necessary (e.g., laparoscopic cholecystectomy was converted to open cholecystectomy, requiring postoperative overnight monitoring.)

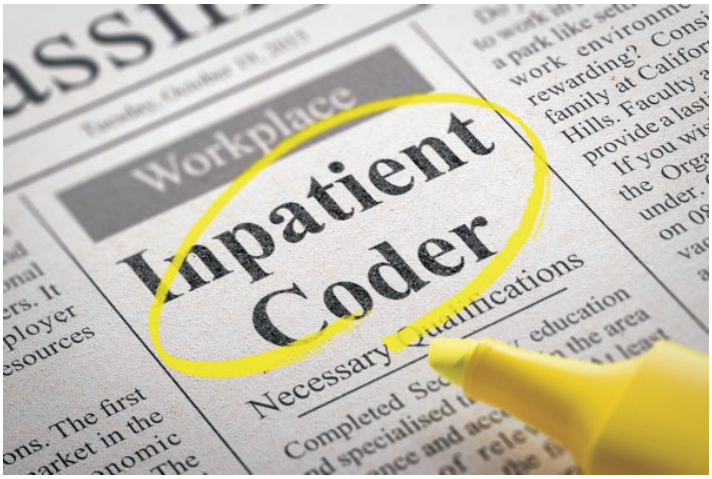


FIGURE 2. Inpatient coders are responsible for reviewing paper and electronic patient charts and physician notes. Inpatient coders are very much in demand.

Secondary Diagnosis

A **secondary diagnosis** is a condition, which coexists with the principal diagnosis, at the time of admission, or a coexisting condition that develops after admission. Secondary diagnoses include comorbidities, complications, and other diagnoses, documented by the attending physician on the inpatient face sheet or discharge summary.

Comorbidity

Comorbidity is the presence of one or more medical conditions that exist simultaneously and, usually, independently, of each other. Comorbid diseases or disorders affect the treatment, which is provided to the patient during the current relevant episode of care.

Complication

A **complication** is a condition that arises during the relevant episode of care, and affects treatment provided to the patient.

Secondary Diagnoses

Coders must review inpatient record reports to locate secondary diagnoses that are not documented on the face sheet or discharge summary. To assign secondary codes, inpatient coders research:

- History and physical documents
- Chronic conditions
- Personal history and family history of conditions
- Ancillary reports that document bacteria that cause infection (lab data), type of fracture (X-ray report), location of myocardial infarction (electrocardiogram report), and other documented and reviewed secondary diagnoses.

Physician Query

When a question arises about a code assigned to a secondary diagnosis in the patient's health record, a physician query (a written question to a physician) may be generated to obtain clarification and an amendment of the list of secondary diagnoses.

Subsequent Hospital Care

Subsequent hospital care is the treatment of a patient that follows the initial hospital care. This is frequently referred to as "follow-up." The frequency of these follow-up visits is determined by the provider, based on the patient's condition and need. The provider, as a result of the physician query process, resolves issues related to inconsistent, missing, conflicting, or unclear documentation.

OUTPATIENT CODING AND PROTOCOLS

Outpatient Coding

Outpatient coding is a review of medical records from a particular date of service and the selection of the first-listed diagnosis code. Outpatient coding also included selecting codes for any secondary diagnoses. The selected codes support the services provided on the same day as the appointment, or trip to the outpatient facility. Outpatient coding comprises most of the coding performed in the healthcare industry. All coding for doctors' offices, clinics, outpatient and ambulatory care facilities, hospital emergency rooms, etc. is classified as outpatient coding. In the outpatient setting, ICD-10-CM coding guidelines are used and they take priority over other coding rules. A **first-listed diagnosis** is the term used by medical coders in an outpatient setting, in lieu of the term "principal diagnosis," because a diagnosis may not be established at the time of the initial visit. It often takes two or more visits before a diagnosis is confirmed. The **chief complaint** is the patient's reason for the medical visit. It is one of the keys in determining the first-listed diagnosis. From the patient's perspective, the chief complaint is the reason for the visit.

1. Should no specific diagnosis be established, and the patient presents with only signs or symptoms, the first-listed diagnosis may be the signs and symptoms. Outpatient coders cannot code "probable," "suspected," "likely," or "rule out" conditions. Physicians tend to use this verbiage, even though the conditions cannot be coded unless definitively diagnosed.
2. For a patient who presents for outpatient surgery (same day surgery), the reason for the surgery is coded as the first-listed diagnosis, even if the surgery is not performed due to a contraindication.
3. For a patient who is admitted for observation for a medical condition, the medical condition is coded as the first-listed diagnosis.
4. For a patient who presents for outpatient surgery and develops complications requiring admission for observation, the reason for the surgery is coded as the first-reported diagnosis, and the complications are coded as secondary diagnoses.

Outpatient Coder

An **outpatient coder** is a medical coding professional who is responsible for assigning the procedure codes that identify a patient's diagnosis and treatment, when hospital admission is not required and the treatment is performed outside the hospital setting. Outpatient coding, reimbursed under Medicare Part B, is used to report diagnostic services in which the patient does not stay at the medical facility long-term. Such services can include everything from conducting a blood test to treating trauma injuries in the emergency room. ICD-10-CM codes are used to report diagnoses. The CPT and HCPCS code sets are used to report services and the accompanying supplies.

FIGURE 3. Outpatients often receive diagnostic services, such as an electrocardiogram, during their encounter with an outpatient facility.

Guidelines

Standards for outpatient coders promote accuracy and efficiency.

Documented Conditions

All documented conditions, which coexist at the time of the encounter/visit and require, or affect, patient care treatment or management, should be coded. Conditions that were previ-

ously treated and no longer exist, are not coded. However, patient history may be used as secondary codes if the historical condition or family history has an impact on current care, or influences treatment.

Diagnostic Services

Outpatients, who receive only diagnostic services during their visit, should be coded first with the diagnosis, or condition, that is chiefly responsible for the outpatient services provided. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

Laboratory or Radiology

Encounters for routine laboratory or radiology testing, in the absence of any signs, symptoms, or associated diagnosis, are assigned the code Z01.89 (encounter for other specified special examinations). If routine testing is also performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both Z01.89 and the code describing the reason for the non-routine test.

Diagnostic Tests

When the results of outpatient, diagnostic tests have been interpreted by a physician, and the final diagnostic report is available at the time of coding, any confirmed or definitive diagnosis(es) described in the interpretation should be coded. Coders should not code related signs and symptoms as additional diagnoses.

Therapeutic Services

For patients receiving therapeutic services only during a visit, coders should sequence first the diagnosis, or condition, that is chiefly responsible for the outpatient services provided. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses. [NOTE: The exception to this rule is a situation in which the primary reason for the admission/encounter is chemotherapy or radiation therapy. In this case the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed is listed second.]

Preoperative Evaluations

For patients receiving preoperative evaluations only, coders should first sequence a code from subcategory Z01.81 (encounter for pre-procedural examinations) to describe the pre-op consultations. As an additional diagnosis, coders should assign a code for the condition that led to the surgery. Any findings, which are related to the pre-op evaluation, should also be coded.

Ambulatory Surgery

For ambulatory surgery, the diagnosis, for which the surgery was performed, should be coded. If the confirmed, postoperative diagnosis is different from the preoperative diagnosis, the postoperative diagnosis should be selected for coding, since it is the most definitive.

TABLE 1. Outpatient versus Inpatient Coding

Outpatient / Physician Coding	Inpatient / Facility Coding
ICD-10 for diagnoses	ICD-10 for diagnoses
Coding for probable, suspected, or ruled-out conditions *is not* allowed	Coding for probable, suspected, or ruled-out conditions *is* allowed
Medical/surgical procedures: CPT and HCPCS Level II	Medical/surgical procedures: ICD-10-PCS
Reimbursement: Primarily based on physician fee, insurance contracted rates, ambulatory surgical center rates, etc.	Reimbursement: Primarily based on diagnosis-related group (DRG)

Summary:

One important aspect of coding is consideration for the differences between inpatient and outpatient services. To maximize reimbursement for healthcare costs, coders must understand the differences between inpatient and outpatient coding. The biggest difference remains the criteria and instructions for uncertain conditions. However, coders should always check the guidelines for additional instructions within the tabular and alphabetic indexes. The overall goal of medical coding is efficient and accurate coding.

Checking Your Knowledge:

1. Summarize inpatient coding duties and protocols.
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3. Describe types of diagnoses.
4. Describe the services provided by inpatient facilities and by outpatient facilities.
5. Explain the significance of signs and symptoms to both inpatient and outpatient coding.

Expanding Your Knowledge:

Investigate the American Academy of Professional Coders (AAPC) website at https://www.aapc.com/. AAPC is the world's largest medical billing and coding training and credentialing organization, with more than 174,000 members worldwide. Look for information about careers and opportunities in medical coding.

Web Links:

Find-A-Code

https://www.findacode.com

ICD-10-CM

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf

Medical Coding Reference

http://www.icd10data.com/

Occupational Outlook

https://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.htm