Statement on
Consistency of Healthcare Diagnostic and Procedural Coding

Approved – December 2007

The AHIMA Position

The collection of accurate and complete coded data is critical to healthcare delivery, research, public reporting, reimbursement, and policy-making. The integrity of coded data and the ability to turn it into functional information requires all users to consistently apply the same official coding rules, conventions, guidelines, and definitions (the basis of coding standards). Use of uniform coding standards reduces administrative costs, enhances data quality and integrity, and improves decision-making – all of which leads to quality healthcare delivery and information.

For the United States to maintain quality data and information, coding standards must be consistently required, promoted, and uniformly applied across sites of service. AHIMA coding professionals are educated and certified to ethically apply and utilize national uniform coding standards to support these data quality, analysis, and maintenance functions.

Complete, clear, and accurate health record documentation is the foundation for complete and accurate coding. Therefore, this documentation, whether electronic or paper-based, must be clear, accurate, complete, and timely in order to produce quality coded data.

Facts That Support the AHIMA Position

Coding clinical diagnostic and procedure data involves the translation of clinical information collected during healthcare encounters into diagnostic and procedural codes. These codes accurately reflect patient medical conditions and the services provided to them. A medical code set is an established system for encoding specific data elements pertaining to the provision of healthcare services, such as medical conditions including history of present illness, timing as to whether medical condition was present on admission, signs and symptoms, diagnostic, and therapeutic procedures, devices, supplies, and quality measures. A code set includes the codes and code descriptions and the rules, conventions, and guidelines for proper use of the codes. Healthcare providers, payers, researchers, government agencies, and others use coded clinical data to:

- Assist with clinical performance improvement
- Measure the quality, safety, severity of illness, and efficacy of care
- Manage care and disease processes
- Track public health and risks
- Provide data to consumers regarding costs, quality, and treatment option outcomes
- Design payment systems and process claims for reimbursement, including pay-for-performance measures
- Perform research, epidemiological studies, and clinical trials
- Serve as a "clinical" data set for some personal health records
- Design healthcare delivery systems and monitoring resource utilization
- Identify fraudulent practices
- Set health policy

While determining reimbursement is only one use for coded data, it remains the largest factor in the incorrect use of coding and the largest barrier to the US adopting more contemporary classification systems. Contrary to standards for proper use of code sets, many coding practices today are driven by health plan or payer reimbursement contracts

or policies requiring providers to add, modify, or omit selected medical codes to reflect the plan or payer coverage, policies, or government regulations. Payers do not uniformly abide by standards for proper application of medical code sets, and the identification of HIPAA transaction standards has not corrected this problem.

Code sets are not all revised at the same time, and some payers do not implement new versions of codes on the official effective date. Individual health plans and different contractors for the same plan (including Medicare and other government contractors) develop their own rules and definitions for the reporting of a given code. These variable requirements, which affect all the medical code sets currently required for third-party payer reimbursement claim submissions, undermine the integrity and comparability of healthcare data.

New uses of healthcare data are constantly evolving, further demanding careful attention to accurate and consistent application and reporting of coded data. Code sets must be sufficiently flexible to ensure data comparability while maintaining stability and continuity over time. Those responsible for coding clinical data must be educated and trained to apply coding standards correctly and uniformly.

Recommendations

AHIMA believes that consistency of healthcare diagnostic and procedure coding will be achieved when:

- All healthcare entities agree to:
  - Use only valid, current versions of the medical codes sets and coding standards
  - Report only the codes that are clearly and consistently supported by health record documentation in accordance with code set rules and guidelines
  - Commit to report complete information that accurately portrays healthcare encounters
  - Establish and enforce health record documentation requirements in compliance with government, regulatory, and industry standards
  - Refrain from establishing or accepting rules, regulations, or contracts that force healthcare entities to violate coding standards.

- The US adopts and implements contemporary classification and terminology standards that maintain data integrity through current medical knowledge and practices, including the immediate adoption of ICD-10-CM and ICD-10-PCS.

- A task force is formed and funded to determine the characteristics of a public/private coordinating authority for US terminology and classification development, maintenance, and interoperability that would later exist as an oversight authority once the task force completes its role.

- Certified coding professionals are utilized to assign and validate codes and assist in the development of policies that affect or depend on coding accuracy.

- Medical code set maintenance organizations:
  - Provide fully public processes to give input to updates and maintenance of the code set standard
  - Include representation from all stakeholders in decisions regarding code set revisions
  - Publish and implement code set revisions and standards on a scheduled basis for clarity of implementation requirements, due dates, and timely publishing of education materials by others outside the organization.

- Medical code sets are:
  - Flexible to accommodate changes in healthcare that affect diagnoses, changes in medical and clinical practices, and other events
  - Maintained to ensure stability and comparability of coded data over time
  - Maintained and updated on a timely basis to accommodate advances in medicine
  - Unique, so that users do not have to choose between or among different code sets
  - Capable of uniform use across different sites offering the same service

- Subject to a national central coordinating authority
- Part of the facilitation of a national healthcare information infrastructure.

References

"US Must Adopt and Implement ICD-10-CM and ICD-10 PCS." AHIMA position statement, 2007. Available at www.ahima.org/dc/positions. For more on ICD-10, see also www.ahima.org/icd10.

"Healthcare Terminologies and Classifications: An Action Agenda for the United States." White paper jointly released by AHIMA and the American Medical Informatics Association, 2006. Available at www.ahima.org. The white paper calls for coordination of US terminologies and classifications and coordination and cooperation with international efforts.

The American Health Information Management Association (AHIMA) is the premier association of health information management (HIM) professionals. AHIMA's 51,000 members are dedicated to the effective management of personal health information needed to deliver quality health care to the public. Founded in 1928 to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning.

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