



Coding Process WorkFlow

Clinical coding workflows vary from organization to organization, based on a number of variables, such as the amount of non-coding activities performed by coders or the location where the patient encounter occurs.

Coding is highly interdependent upon the multiple steps that are taken during the patient encounter process within each healthcare organization.

Coding process typically is made up of a set of steps that start with the patient registration process and end when the claim is paid. Automation is typically not applicable to the entire process but can be applied to various steps within the process.

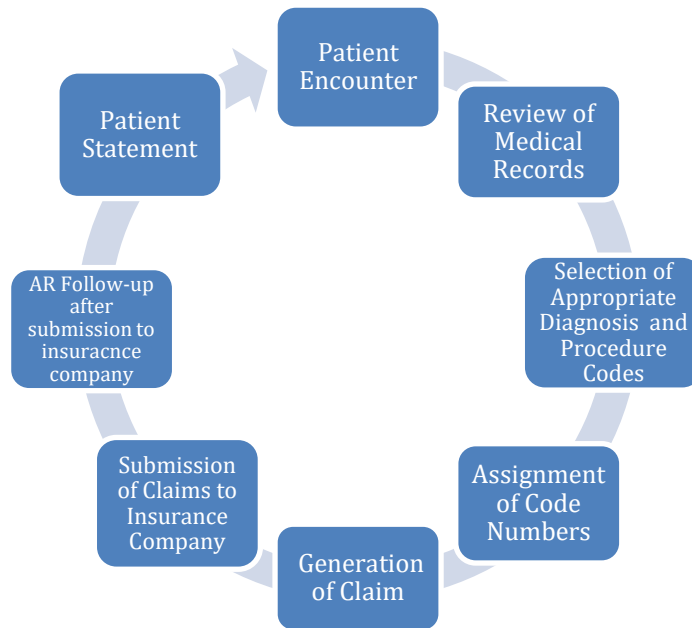
A coding workflow diagram is a pictorial representation of the sequence of steps that are taken by each person or group of people involved in the coding process, shown in the order that they are performed.



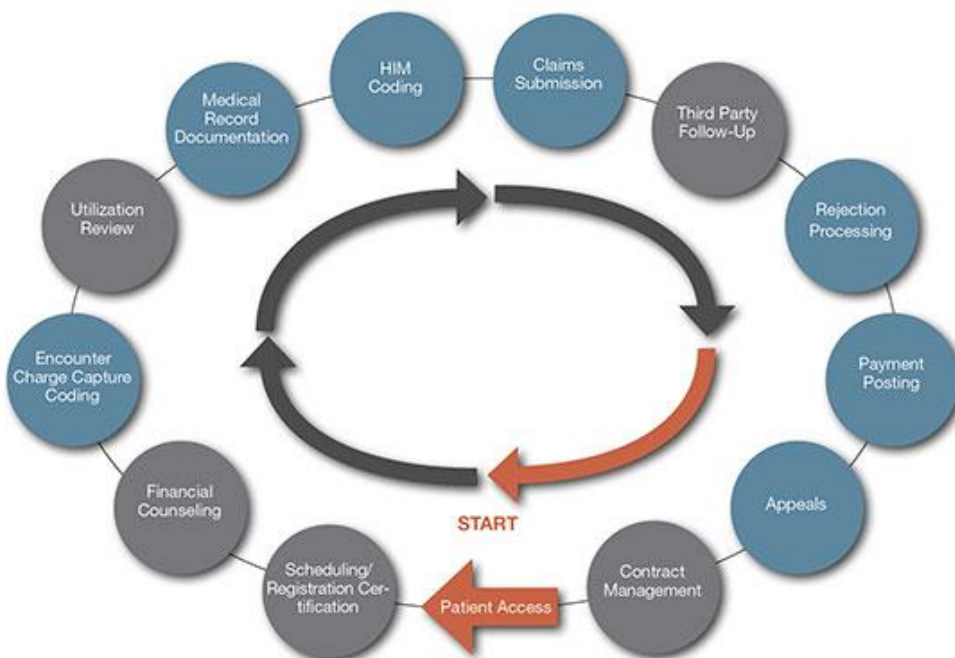
Coding Process Flow Chart Example

The coding flow chart is a chart and/or text policy which describes the process by which coding is done in the facility.

Flow Chart Example 1:



Flow Chart Example 2:





Text Format Coding Process Example:

The main task of a medical coders is to review clinical statements and assign standard codes using CPT[®], ICD-9/10-CM, classification systems. The diagnoses and procedure codes are taken from medical record documentation, such as transcription of physician's notes, laboratory and radiologic results, etc.

Medical coders help ensure the codes are applied correctly during the medical billing process, which includes abstracting the information from documentation, assigning the appropriate codes, and creating a claim to be paid by insurance carriers from CPT, HCPCS, and ICD-9/10- CM Coding.

Each patient's account is to be released, or re-released, for billing only when all of the following are met:

1. All ICD-9-CM/ ICD-10-CM and Outpatient Procedure CPT/HCPCS codes (including select modifiers) that are submitted for billing purposes under provider number must be assigned by a Coder, who is adequately supervised, as well as trained and oriented, as appropriate, to the type of Coding to be assigned.
2. All ICD-9/10-CM and Outpatient Procedure CPT/HCPCS codes to be reported on the patient's claim are supported by legible, complete, clear, consistent, precise and reliable provider documentation.
3. A sufficient clinical documentation set exists in the patient record from which to assign a complete set of codes.
4. Diagnoses and procedure codes are assigned and sequenced appropriately according to Official Coding Guidelines.
5. Other claim elements including the discharge disposition code, admission status (inpatient or outpatient) and admit/discharge dates as recorded in the patient accounting system correlate with documentation in the patient's medical record.
6. Accounts with identified discrepancies in one or more of the above areas must not be released for billing until the discrepancy is resolved and the account can be billed with a complete, accurate and compliant code set.
7. When a discrepancy is detected with the Coding on a previously submitted claim, the department must undertake reasonable efforts to correct the deficiency and prevent the defect from reoccurring on future claims. Overpayments must be corrected and resubmitted to the payer.