CONNECTICUT VALLEY HOSPITAL
OPERATIONAL PROCEDURE MANUAL

SECTION II:	Organization Focused Functions
CHAPTER 9:	Management of Information
PROCEDURE 9.6:	**Diagnoses: Admission, Discharge and Changes in Diagnosis** **Coding of Behavioral Diagnoses using ICD-10-CM and DSM 5 Criteria** **Coding of Medical Diagnoses Using ICD-10-CM**
REVISED:	9/97; 3/07; 10/20/09; 8/12; 7/29/15; 3/7/16; 4/15/18; Reviewed 11/16/18
Governing Body Approval:	11/19/18*(electronic vote)*

PURPOSE: To provide instruction for accurate, complete, and consistent coding practices for the production of quality healthcare data. Coding adheres to coding conventions and official coding guidelines and rules, to include the selection and sequencing of diagnoses, established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes have been adopted under HIPAA for all healthcare settings.

SCOPE: Psychiatrists, Physicians, Utilization Management and Health Information Management

POLICY:

All Behavioral Diagnoses are coded according to ICD-10-CM and DSM 5 criteria.
All Medical Diagnoses are coded according to ICD-10-CM.

The admitting/attending/discharging physician/psychiatrist assigns the appropriate ICD-10-CM diagnostic codes according to the Official Coding Guidelines provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). ICD-10-CM Coding Guidelines are:

 https://www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf

Diagnostic Coding Protocols:

1. The establishment of a diagnosis is an essential component of the clinical and financial processes. Clinically, the diagnosis provides a framework for understanding the current presentation of the patient, and leads to the treatment planning in order to meet the patient's needs. The diagnosis is also essential in billing for services. No service can be billed if there is no diagnosis. A diagnosis must be provided for the patient no later than 24 hours after admission.

2. It is acceptable to provide a provisional diagnosis that reasonably describes a patient's current symptoms and functioning, and then to change that diagnosis later when additional evaluations or treatment has taken place. A provisional diagnosis is acceptable as an initial billing diagnosis. A "rule-out" diagnosis is not acceptable for a primary diagnosis.

3. The primary diagnosis is the principle billing diagnosis. When a person receives more than one diagnosis, the principal diagnosis is the condition that was chiefly responsible for occasioning the evaluation or admission to clinical care. In most cases this condition will be the main focus of attention or treatment. Deferred or no diagnosis are not acceptable billable codes for a Behavioral primary diagnosis.

4. Discharge Diagnoses:

   Diagnoses may not be listed on the Discharge Summary as:
   - Deferred
   - Rule-Out

PROCEDURE:

1. Admission Diagnosis – Behavioral and Medical
   The admitting physician/psychiatrist records the admission diagnoses on the Admission Psychiatric Evaluation and enters the corresponding ICD-10-CM codes in the DMHAS Health Information System (WITS).

2. Updated Diagnoses – Behavioral and/or Medical
   Diagnostic updates are entered by the Attending Psychiatrist (behavioral diagnoses) and/or the Attending Physician (medical diagnoses) when diagnoses change.

3. Discharge Diagnoses
   Diagnoses are recorded on the Discharge Aftercare CVH-2 form in GDP. In the ASD the final diagnoses are recorded in the discharge progress note. The diagnoses are coded by the Physician/Psychiatrist and entered in the DMHAS Health Information System (WITS) when the patient is discharged.