Coding Medical Records: A Comprehensive Guide

In the ever-evolving world of healthcare, medical coding plays a crucial role in capturing and organizing patient data for various purposes, including medical billing, research, and quality assessment. Coding medical records involves translating the complex information contained within patient records into standardized codes, enabling efficient data analysis and communication among healthcare providers.

In this article, we will explore a comprehensive ten-step process for coding medical records, highlighting the key considerations and tasks involved at each stage.

Coding Medical Records:

Step 1: Review the Face Sheet or Registration Record

The coding process begins with a thorough review of the Face Sheet or Registration Record, which serves as the front page of the medical record (MR). This document contains essential patient identification data, insurance information, and sometimes clinical data such as admitting and final diagnoses. During this step, medical coding professionals should pay attention to key elements such as the patient's length of stay, age, sex, and admitting diagnosis.

These details provide valuable insights into the complexity of the case and help determine the
appropriate coding approach. It is also crucial to consider prospective payment system payers, such as Medicare, as compliance and reimbursement issues may arise.

Step 2: Review History and Physical, Emergency Department Report, and/or Consultant's Report

The next step involves a comprehensive review of the patient's history and physical (H&P) report, the emergency department report (if applicable), and any consultant's reports. The H&P report, usually dictated by the attending physician and transcribed by medical transcriptionists, contains subjective data collected from the patient, along with the provider's objective assessment. By analyzing these reports, coders can identify the chief reason(s) for admission and gain a deeper understanding of the possible principal diagnosis and secondary diagnoses.

Additionally, comorbidities and other diagnoses affecting patient care, as outlined in the Uniform Hospital Discharge Data Set (UHDDS) rules, should be noted. Emergency room reports and consultant reports also offer valuable insights and may provide additional details not found in the attending physician's H&P report.

Step 3: Review Operative Reports, Special Procedure Reports, and/or Pathology Reports

If applicable, coders must review operative reports, special procedure reports, and pathology reports.
reports. Operative reports, dictated by surgeons or physicians, provide information about operations or procedures performed, along with preoperative and postoperative diagnoses. It is important to recognize that these reports often exist as a set of linked forms, including anesthesia records, special consents for surgery, recovery room records, and pathology reports.

Coders should take note of any special procedures, such as cardiac catheterizations or biopsies, and ensure that the sequencing of procedure codes adheres to UHDDS rules. Pathologic diagnoses given for specimens removed during surgery should also be documented.

**Step 4: Review Physician's Progress Notes**

Physician's progress notes offer a detailed account of the patient's condition, progress, complications, response to treatment, and discharge instructions. Coders should thoroughly review these notes to identify significant diagnoses, findings, and the resolution of any problems or complications. Progress notes provide essential information that contributes to accurate coding and ensures that the patient's medical history is appropriately represented.

**Step 5: Review Laboratory, Radiology, and/or Special Test Reports**

Laboratory, radiology, and special test reports provide valuable insights into a patient's condition. Laboratory work encompasses various tests and analyses, including chemistry tests, cultures, and examinations of body fluids or substances. Coders should carefully review these reports, noting any abnormal results and clarifying treatments through physician documentation. Radiology reports, which include findings from x-ray studies, computed tomographic scans, and other imaging modalities, also play a crucial role in coding.

Similarly, special test reports, such as electrocardiograms and cardiac stress tests, provide additional diagnostic information. Coders must review these reports for any abnormal findings and consult with physicians if additional documentation is necessary.

**Step 6: Review Physician's Orders**

Physician's orders, whether written or oral, outline the treatments and medications prescribed for the patient. It is essential to review these orders to determine the treatments given and their corresponding diagnoses or conditions. In some cases, physicians may prescribe treatments without documenting the reasons for treatment.

Coders may need to query physicians to clarify a diagnosis for coding purposes and request
supporting documentation to be added to the patient's MR. Accurate diagnosis codes are crucial for establishing medical necessity and ensuring compliance.

Step 7: Review Medication Administration Record (MAR)

The Medication Administration Record provides a detailed account of the medications administered to the patient, including drug names, dosages, times of administration, and routes. Reviewing the MAR helps coders gain insight into the medications given and can help clarify or justify the diagnoses assigned by the physician. It is essential to ensure that the medications documented in the MAR align with the coding and diagnosis information.

Step 8: Review Discharge Summary or Clinical Résumé

The discharge summary (DS) is a comprehensive document that summarizes the patient's hospital course, condition on discharge, discharge instructions, and plan for follow-up care. Coders must review the DS for completeness and adherence to UHDDS reporting rules. The DS should include all final diagnoses, significant principal procedures, and any other relevant procedures.

Since physicians may not always be familiar with ICD-10-CM coding conventions and rules, it is the coder's responsibility to ensure the correct code assignment and sequencing.

Step 9: Assign Codes

Once all the relevant information has been reviewed and analyzed, coders can begin assigning codes. Utilizing the UHDDS and coding rules and conventions, coders should carefully assign the appropriate codes that accurately represent the patient's diagnoses, procedures, and conditions. It is essential to adhere to the guidelines and coding conventions to ensure consistency and accuracy in coding practices.

Step 10: Submit Physician/Coder Query/Clarification Form

In cases where further clarification is required, coders may need to submit a Physician/Coder Query/Clarification Form. This form serves as a communication tool between coders and physicians to seek clarification on proper code assignment for a patient care episode. While it is crucial to obtain necessary information through queries, coders should be mindful of potential coding-related issues, such as unintentionally leading physicians to add diagnoses that may affect reimbursement.
The form should explicitly state that the coder does not expect any specific response, emphasize the importance of supporting documentation, and be labeled as part of the permanent medical record.

To conclude, coding medical records is a meticulous and systematic process that involves multiple steps and careful review of various documents within the patient's medical record. The ten-step approach outlined in this article provides a comprehensive guide for coding professionals to ensure accurate and consistent coding practices. By following these steps, healthcare organizations can facilitate effective data management, streamlined billing processes, and enhanced patient care.

About Medical Billers and Coders (MBC)

**Medical Billers and Coders (MBC)** is a leading medical coding company known for its expertise in providing comprehensive coding solutions to healthcare organizations. With a team of highly skilled and certified coders, MBC ensures accuracy, compliance, and efficiency in medical coding processes.

Our extensive knowledge of coding guidelines and regulations, coupled with advanced technology and resources, enables us to handle complex coding tasks with precision.

MBC's commitment to excellence and customer satisfaction has earned us a reputation as a trusted partner in the healthcare industry. For further information about our coding services, please reach out via email at info@medicalbillersandcoders.com or by calling 888-357-3226.

Reference: [Medical Records: The Basis for All Coding](#)