



Coding External Cause of Injury Place of Occurrence

WITHOUT SUPPORTING DOCUMENTATION

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Scenario:

A chart is being coded in which the patient sustained an injury, and nowhere in the chart is the place of occurrence documented. What should a coding professional do? This article will explore CMS official coding guidelines and California state reporting regulations specific to this case scenario.

The CMS Official Coding Guidelines describe omitting the place of occurrence code altogether if it is not documented. If this guideline is followed, an edit requiring the "place of occurrence" might be triggered by the Office of Statewide Health Planning Department (OSHPD). OSHPD has turned off the edits for the use of "place of occurrence codes" as of January 1, 2016. However, according to OSHPD's Inpatient (97227) and Emergency Department and Ambulatory Services (97260) reporting guidelines, the place of occurrence code is required. Trend edits may occur if there is more than a 5% decrease in Principal External Cause codes reported, or the average number of Other External Cause codes per record drops significantly.

What is the current practice?

Some facilities choose to only follow the Official Coding Guidelines and not report the place of occurrence to OSHPD. Others inappropriately

ICD-10-CM Official Guidelines for Coding and Reporting¹

Chapter 20: External Causes of Morbidity (V00-Y99) 8.b. Place of Occurrence Guideline

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

OSHPD MIRCAl Reporting Guidelines²

97227 - Definition of Data Element for Inpatients – External Causes of Morbidity and Present on Admission Indicator

97260 - Definition of Data Element for ED and AS – External Causes of Morbidity

report the code Y92.89, other specified place, to avoid the OSHPD edit. OSHPD advises against this practice, as it is inaccurate. Some facilities are using the Y92.9, unspecified place, despite the direction given in the Official Coding Guidelines. Rarely do facilities make it a practice of querying the physician for this information, but that is certainly an option.

What is the best practice?

The coding professional may be tempted to report the code Y92.9, unspecified place, for discharges in the State of California to circumvent OSHPD edits. OSHPD advises coding professionals to follow the Official Coding Guidelines and avoid using Y92.9 until otherwise instructed by Coding Clinic. Each facility should clearly define the standard of practice for their coding department.

References

¹Centers for Medicare & Medicaid Services. (n.d.). ICD-10-CM Official Guidelines for Coding and Reporting FY 2016. Page 77. Retrieved from <https://www.cms.gov/medicare/coding/icd10/downloads/2016-icd-10-cm-guidelines.pdf>

²Office of Statewide Health Planning and Development. April 2016. OSHPD Reporting Manual, 7th Edition. Retrieved from <http://www.oshpd.ca.gov/HID/MIRCAl/IPManual.html>

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