

CHAPTER 24

Unit Health Record (UHR) Coding and Abstracting

I. POLICY

Health Record Services (HRS) staff shall establish systems to classify and abstract medical statistical information from the patient's UHR. The most recent edition of the International Classification of Diseases, Clinical Modification, shall be used to classify, abstract, and report medical statistical information for patients placed in an inpatient setting. Medical statistical information on patients who obtain services from the community facilities shall be reported. Abstracted information shall be reported to the Health Care Cost and Utilization Program (HCCUP) as mandated by that program.

HRS staff shall encode medical statistical information by using coding conventions and the California Department of Corrections (CDC) coding guidelines (once issued) to ensure accurate and consistent coding. The definitions, guidelines and mechanisms for reporting outlined in the HCCUP Inpatient Discharge Data Reporting Manual shall be followed.

All CDC inpatient and community hospital stays shall be reported. HRS staff shall verify the patient's conditions, or procedures treated at the community facility.

II. PROCEDURE

- A. Qualified HRTs who have demonstrated a working knowledge of medical terminology, and a basic understanding of disease processes shall:
1. Classify diseases, conditions, and procedures.
 2. Code cases, sequencing, the principal diagnosis first. This is the reason after study for admission to the inpatient level of care.
 3. Code daily, and abstract information as it becomes available, such as:
 - a. Additional diagnoses.
 - b. Complications.
 - c. Infections.
 - d. Other events which impact on the length of stay, and the services provided.
 - e. Use the coding conventions and guidelines.
 1. Abstract information using the most recent edition of the HCCUP Inpatient Discharge Data Reporting Manual for exact details.
 2. Enter the demographics as specified in the HCCUP manual.
 3. Submit all discharge data to the institution's HCCUP coordinator as indicated in the HCCUP manual.
- B. HRS staff, as part of the continuing quality improvement program shall:
1. Verify the accuracy of the coding of medical statistical information.
 2. Verify the accuracy of the abstracting of medical statistical information.
 3. Follow the HCCUP manual for correcting or amending previously submitted information.

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- a. Do not delay in submitting amendments.
- b. Submit amendments directly to the HCCUP contact in Sacramento.