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SCOPE: All personnel responsible for performing, supervising or monitoring coding of outpatient services including, but not limited to:

Corporate Regulatory Compliance Support
Facility Health Information Management
Case Management/Quality Resource Management
Registration/Admitting/ Scheduling/Patient Access
Ethics and Compliance Officers
External Coding Contractors
Service Centers
Hospital-Based Clinics
Parallon Business Performance Group

Administration
Resource Management
Emergency Department
Ancillary Departments
Laboratory Department
Radiology Department
Physician Advisors

This policy applies to diagnostic and procedural coding and reporting of the technical component of outpatient services. Examples of these services include, but are not limited to, outpatient visits and outpatient referrals for laboratory, radiology, cardiology, cardiopulmonary and other diagnostic testing; laboratory testing performed on referred specimens only; observation services; emergency care; clinic services; and ambulatory surgery performed in a hospital-based ambulatory surgery center (ASC). **For specific guidelines related to documentation requirements to complete test and service orders, refer to the Billing - Orders for Hospital Outpatient Tests and Services Policy, REGS.GEN.004.** This policy does not apply to physician office, freestanding ASC, freestanding imaging centers, physicians at teaching hospital (PATH) or home health services. For freestanding outpatient services and PATH services refer to REGS.OSG.001. For inpatient services, refer to the Coding Documentation for Inpatient Services Policy, REGS.COD.001. For Rehabilitation Services, refer to the Coding Documentation for Rehabilitation Facilities/Units Policy, REGS.COD.013.

PURPOSE: To ensure minimal variation in coding practices and the accuracy, integrity and quality of patient data, and improve the quality of the documentation within the body of the medical record to support code assignment.

The Company's commitment to data integrity is documented in Attachment A.

POLICY: The Company will follow the current guidelines for outpatient diagnosis coding and reporting published in the most current *ICD-10-CM Official Coding Guidelines for Coding and Reporting*.

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The Company will apply the Current Procedural Terminology (CPT) coding conventions and general guidelines as published by the AMA for surgical and diagnostic procedure coding. CMS mandates the utilization of Level I (CPT) and Level II (National Medicare) HCPCS codes for Medicare patients.

DEFINITIONS:

Non-Physician Practitioner (NPP): Individuals such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners and physician assistants who furnish services that would be physician services if furnished by a physician and who are operating within the scope of their authority under State law, within the scope of their Medicare statutory benefit and in accordance with hospital rules, regulations and by-laws.

Coding: Coding is a function by which there is an assignment of a numeric or an alphanumeric classification to identify diagnoses and procedures. These classifications or "codes" are assigned based upon a review of the source document (medical record). The classifications utilized for this purpose include: ICD-10-CM (International Classification of Disease – 10th revision – Clinical Modification); CPT (Current Procedural Terminology) or HCPCS Level II (Healthcare Common Procedure Coding System).

Authentication: An author's validation of his or her own entry in a document. Methods may include written signatures, faxed signatures or computer signatures depending on state law and medical staff bylaws. Only the physician or NPP ordering the test or service may perform authentication. State regulations and medical staff bylaws, rules and regulations specify whether NPP orders require countersignature by a physician.

Unique Payer Requirements: Unique Payer Requirements are defined as a specific requirement(s) described by the payer as being a situation in which the payer will be responsible for payment of a bill or invoice.

Generally, Unique Payer Requirements will meet some or all of the following criteria:
- Specific coding and/or billing instruction or requirements described by the payer (*e.g.*, Medicare, Medicaid, Blue Cross) for claims submitted by the provider.
- Variation(s) from official coding and/or billing guidance (*e.g.*, Coding Clinic, CPT Assistant, CMS Rules).
- Description of certain conditions in which the payer states a claim will be paid or considered for payment.
- Explanation of various coverage conditions (*e.g.*, medical necessity evidence and services excluded from coverage).
- Specific information can be found in the following documents:

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- Local Coverage Determinations (LCDs)
- Medicare National Coverage Determinations (NCDs)
- Medicare Administrator Contractors (MACs), Fiscal Intermediary (FI) or Payer newsletters
- Contract agreement between provider and payer

NOTE: Unique payer requirements are not intended to be coding guidelines. However, the payer may provide guidance that it requires codes to be reported in a certain manner.

Medicare billing guidelines may vary by MACs or FI and other payers may have different billing guidelines. Therefore, verbal guidelines must be obtained in writing. It is important to document all conversations held with the payer as an audit trail (this should include the date, the name of the person you spoke with, and the subject discussed). It may be helpful to send a certified letter to the payer seeking confirmation of your understanding of the Unique Payer Requirement and request that the letter be signed and returned to you.

Coding Validation Review: Validation of the appropriateness of HSC/HIM-assigned diagnosis code (ICD-10-CM), procedure code (CPT), E/M and infusion/injection codes (as applicable), and modifier validation review. This may include at a minimum ensuring code assignment is supported by documentation in the medical record based on company coding policy and/or current industry standard coding guidelines. These reviews must be performed by an individual who is qualified by job classification to assign codes.

Current Procedural Terminology (CPT): System of terminology provides a uniform medical language to accurately describe medical, surgical, and diagnostic services. It should be noted that inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

International Classification of Diseases - 10th revision- Clinical Modification (ICD-10-CM): A coding classification of diseases, injuries, adverse effects, and poisoning, which are grouped into appropriate chapters, sections, categories and sub categories.

ICD-10-CM is based on the tenth revision of the World Health Organization's ICD-10. The clinical modification adopted by the U.S. expands codes to facilitate more precise coding of morbidity. The uses of this classification in this country are for vital statistics reporting, mortality reporting, and for many third party reimbursement systems, including Medicare.

AHA Coding Clinic for ICD-10-CM: Coding Clinic is the official publication of ICD-10-CM coding guidelines and advice as designated by four cooperating parties: American Hospital Association

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(AHA), American Health Information Management Association (AHIMA), Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS).

AHA Coding Clinic for HCPCS: AHA Coding Clinic for HCPCS is a publication of the American Hospital Association (AHA) Central Office on HCPCS which provides coding advice on HCPCS coding for the institutional providers setting to coincide with Medicare instruction.

CPT Assistant: CPT Assistant is the official publication of the American Medical Association (AMA) designed to provide CPT coding advices to outpatient settings.

PROCEDURE: Acceptable sections of the medical record which contain physician documentation to support code assignment include, but are not limited to, the history and physical, emergency room record, physician progress notes, physician orders, operative reports, anesthesia notes and physician notations of intra-operative occurrences.

All individuals performing coding of outpatient services, including the above listed departments and facilities, must comply with the following:

1. **Diagnostic Coding and Reporting Guidelines for Outpatient Services**
   The appropriate code or codes must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting when an established diagnosis has not been diagnosed or confirmed by the physician. The documentation should describe the patient's condition, using terminology that includes specific diagnoses or the symptoms, problems or reasons for the encounter.
   The Company recognizes that there are unique payer coding and billing requirements. These requirements are addressed in Section 8 of this policy.
   a. Selection of first-listed condition. List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the service provided. In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease-specific guidelines take precedence over the outpatient guidelines.
   b. The appropriate code or codes from each code category must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
   c. For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all these.

    d. Codes from the section of ICD-10-CM for the classification of diseases and injuries (e.g., infectious and parasitic disease; neoplasms; symptoms, signs and ill-defined conditions) will frequently be used to describe the reason for the encounter.

    e. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the physician. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified contain many, but not all codes for symptoms.

    f. ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services (Z code range) is provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

    g. Level of Detail in Coding
        i. ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.
        ii. A three-digit code is to be used only if it is not further subdivided. Where fifth, sixth or seventh characters are provided, they must be assigned. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable. .

    h. List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the service provided. List additional codes that describe any co-existing conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

    i. Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," "compatible with," "consistent with," or "working diagnosis" Or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
        Please note: This differs from the coding practices used by hospital Health Information Management departments for coding the diagnosis for acute care, short-term, long-term care and psychiatric hospital inpatients.

    j. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

    k. **Code all documented conditions that coexist at the time of the encounter or visit and require or affect patient care, treatment or management**. Diagnoses that were previously treated and no longer exist should not be coded. Z codes may be used as

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secondary codes if the historical condition or family history has an impact on current care or influences treatment

l.   When only diagnostic services are provided during an encounter or visit, sequence first the diagnosis, condition, problem or other reason for encounter or visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter or visit. Codes for other diagnoses (*e.g.*, chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

m. When only <u>therapeutic</u> services are provided during an encounter or visit, sequence first the diagnosis, condition, problem or other reason for encounter or visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses. The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second..

n.   For patients receiving pre-operative evaluations only, sequence first a code from category Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-operative evaluation.

o.   For ambulatory surgery cases, code the diagnosis for which the surgery was performed. If the post-operative diagnosis is known to be different from the pre-operative diagnosis at the time the diagnosis is confirmed, select the post-operative diagnosis for coding, since it is the most definitive.

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p. For routine outpatient prenatal visits when no complications are present a code from category Z34, Encounter for supervision of normal pregnancy, should be used as first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.

q. For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

r. Patients Reason for visit – For unscheduled outpatient visits (emergency room, urgent care clinic or observation) code the ICD-10-CM diagnosis code(s) describing the patient's stated reason for seeking care (or as stated by the patient's representative) at the time of outpatient registration. This may be a condition representing patient distress, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report the first diagnosis code describing the patient's primary reason for seeking care first. There are two other diagnosis code fields to report additional reasons for the patient's visit for care.

2. **Company Evaluation and Management (E&M) Standardization**
Refer to REGS.GEN.008 policy on Hospital Evaluation and Management Services for guidelines and additional detail related to the standardized process.

3. **Outpatient Laboratory, Pathology, and Radiology Coding Issues**
The following information is intended to assist the coders and staff who perform the coding function to help clarify issues pertaining to outpatient laboratory, pathology and radiology coding issues:

a. In the outpatient setting, the pathologist or radiologist is a physician and if a diagnosis is made, it is appropriate to assign a code to identify the condition.

b. In the absence of physician interpretation of a test result or study, the coder should report the symptoms, signs or other reason for the visit.

4. **Minimum Documentation Requirements for Coding Purposes**
The following outlines the documentation to support coding of outpatient services. (Note: The patient types listed below may vary by facility in Meditech.

i. Outpatient Referrals (diagnostic lab, x-ray, etc.)
(a) Documentation may include, but should not be limited to, as appropriate to the service:
1. A diagnosis or reason for the service;
2. Test result, demographic information; and
3. Signed consent for services (if required).

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(b) **Referred Specimens**: Documentation for laboratory tests on referred specimens only, where there is no patient contact with the laboratory, may include, as appropriate to the service:
1. A diagnosis or reason for ordering each test; and
2. Demographic information (if required).

(c) This may be maintained either in a hard copy or electronic format in a centralized location such as the Health Information Management (Medical Records) Department or in a de-centralized location such as the laboratory. Refer to the Records Management Policy, EC.014.

ii. Outpatient Visits
(a) Documentation maintained may include, but should not be limited to, as appropriate to the service, an outpatient medical record that includes:
1. An initial evaluation or History and Physical;
2. Clinician visit notes or progress notes;
3. A diagnosis or reason for the service;
4. Test results;
5. Therapies;
6. A problem list;
7. Level of Detail in Coding
8. Medication list;
9. Demographic information;
10. Required consents; and
11. Procedure Reports.

(b) Coding of the diagnosis must be completed using the medical record that is completed by the provider except for diagnostic testing services.

(c) Documentation in the medical record must support the diagnosis and CPT codes assigned. (Note: ICD-10-CM is updated each October, while CPT is updated each January).

(d) The documentation or source document referred to by the coder should describe the patient's condition, using terminology that includes specific diagnoses as well as symptoms, problems or reasons for the service. Coders may assign diagnosis codes based on the reason for the referral. A specific diagnosis based on test results usually is not available and may not be available until after subsequent evaluations or physician visits.

(e) Documentation for the date of service for therapeutic services must clearly indicate the diagnosis for which the service is being provided. Coders should review the evaluation/treatment plan for the date(s) of service being billed and all other documentation from the provider that supports the date of service being

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billed (*i.e.*, order for the service, evaluation supporting the treatment plan for the service provided, treatment plan, progress notes).

iii. <u>Emergency Visits</u>
   (a) Documentation in the medical record to support diagnosis and CPT code assignment should reflect, an emergency medical record that includes:
      1. Encounter Form;
      2. Required consents;
      3. Physicians emergency documentation;
      4. Nursing notes;
      5. Test results;
      6. Demographic information; and
      7. Diagnostic and treatment interventions.
   (b) ICD-10-CM diagnosis codes and CPT codes must be assigned by the coder based on the diagnosis and treatment recorded by the physician or other NPP in the emergency room medical record.
   (c) The physician's or NPP's emergency medical record documentation and test results are reviewed to assist in code assignment.

iv. <u>Observation Visits</u>
   (a) Documentation may include but should not be limited to:
      1. A history and physical;
      2. Written progress notes, as appropriate;
      3. Clinical observations including the reason for observation services;
      4. Final progress note or summary that includes the diagnosis and any procedures performed and treatment rendered; and
      5. Discharge order by the physician that reflects the clock time by the physician (or in the absence of the clock time, it must reflect the time that the order is signed off on by the nurse).
   (b) The observation unit medical record is reviewed by the coder to assist in the code assignment process.

v. <u>Ambulatory Surgical or Diagnostic Procedural Services</u>
   (a) <u>As applicable, documentation maintained may include an ambulatory medical record that includes, but should not be limited to:</u>
      1. A history and physical examination (as required by hospital policy or Medical Staff Rules and Regulations/Bylaws);
      2. Results of previous diagnostic tests as related to this encounter;
      3. Operative/procedure report;
      4. Pathology report if applicable;

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5. Medication list;
6. Demographic information; and
7. Signed consent(s) for services.

(b) ICD-10-CM diagnosis codes and CPT codes must be assigned by the coder based on the diagnosis and treatment recorded by the physician or other NPP in the ambulatory medical record.

(c) The physician's dictated operative report, including review of the post-operative diagnosis, and any pathology report should be reviewed to assist in accurate code assignment.

vi. Investigational Services
a. Please refer to Billing for Investigational Devices in Clinical Trials, REGS.BILL.007 for guidance on investigational products and services.

5. **Query Process**

The coder is required to query the physician or NPP participating in the care of the patient once a diagnosis or procedure has been determined to meet official coding guidelines for reporting but has not been clearly stated within the medical record, or when conflicting or ambiguous documentation is present.

a. **Query Documentation**

The query documentation must include:
i. the name of the individual submitting the query;
ii. the patient's name;
iii. the patient's medical record and account numbers;
iv. the patient's encounter/discharge date
v. the date the query was submitted;
vi. an itemization of clinical findings pertinent to the condition/procedure in question including the source document(s) from the medical record supporting the query; and
vii. the statement of the issue in the form of a question.

b. **Query Format**

If a query is necessary to clarify ambiguous or conflicting documentation in the paper or approved electronic medical record in order to facilitate complete, accurate and consistent coding practices, the query should be documented in one of the following formats:
i. The physician or NPP can add an addendum to the medical record such as writing a late entry progress note. The addendum must be dated and signed and follow medical staff bylaws and/or rules and regulations.
ii. For queries pertaining to outpatient specific documentation requirements (*e.g.,* the excision of lesions or debridement), a coder should utilize the appropriate query form

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      determined upon the specific type of query that is being initiated. The approved outpatient query forms are available on the Company's intranet.

   iii. Approved inpatient query forms may be used when seeking clarification on outpatient documentation except for diagnosis/procedures that have specific outpatient query forms.

   iv. The yes/no query format may only be utilized on HCA Healthcare query forms that have the printed yes/no query responses. These query forms are to be used in the following circumstances:

      a. Substantiating or further specifying a diagnosis already present in the health record

      b. Establishing a cause and effect relationship between documented conditions

      c. Resolving conflicting documentation from multiple practitioners.

NOTE: Do not pose more than one unrelated question on the query form. It is appropriate to ask the physician multiple questions; however, each question must be on a separate query form.

  c. **Medical Staff Approval Process**
If the medical staff approval process is necessary, the Health Information Management (HIM) Director must submit the query forms for approval following the process outlined in hospital policy or medical staff bylaws or rules and regulations for adding forms to the medical record.

  d. **Query Form Maintenance**
   i. Preprinted query forms should include a statement that the form will be filed as a permanent part of the medical record.
   ii. Query documentation must be kept as a permanent part of the medical record.

  e. **Query Education**
   i. All facilities should educate their physicians and NPP on the query process.
   ii. Administration and medical staff leadership must support this process to ensure its success.

6. **Patient Coding Abstract**
In the Hospital Outpatient Departments the patient coding abstract should be either a system generated abstract or handwritten codes on the face sheet. The abstract must be stored (hardcopy, handwritten, or electronically) as a part of the permanent medical record. The electronic abstract that includes **all** HSC/HIM assigned codes (ICD-10-CM codes, CPT codes, modifiers and APCs as applicable) must be able to be re-printed upon request.

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The patient coding abstract should include a statement that the form will be retained as a permanent part of the medical record.

7. **Validation of Outpatient Coded Data**
Internal facility-directed (which includes coding supervisors) or certified external vendor (which excludes Corporate Regulatory Compliance Support and Internal Audit) or Parallon Business Performance Group - HIM coding validation reviews (as defined in the policy section) should be completed monthly (or more frequently as directed by company initiatives or facility/HSC leadership) by each facility or Parallon Business Performance Group^{SM} - HIM personnel. Validation reviews should include review of the medical record or available documentation to determine accurate code assignments as described in the policy section. If applicable, these reviews should incorporate review of any encounter forms in use.

8. **Unique Payer Requirements**
It is recognized that payers in various states may utilize coding guidelines that do not comply with those issued by the Cooperating Parties. See the Reference Section for description of Cooperating Parties.
   a. Each facility must maintain in writing documentation of coding requirements and instructions of a specific payer. Example: Medicare has special coding guidelines for Pap tests.
   b. Each facility must ensure that coders are oriented and aware of individual payer contracts/instructions that contain specific coding and reporting requirements. (see Unique Payer Requirements definition in the policy section)
   c. Coding and billing practices should also follow Medicare's policy regarding the 3-Day Rule before admission. (Refer to the Outpatient Services and Medicare Three Day Window Policies, PARA.HSC.COD.02 and REGS.GEN.009, and the Medicare - National and Local Coverage Determinations, REGS.GEN.011.)
   d. Written procedures must also outline how coding conflicts with payers are addressed. Since most facilities deal with many different payers who issue varied guidelines, coding issues with high volume payers should be addressed first.

9. **Review of Claim Rejections, Claim Denials, Claim Return to, Claim Suspension, Line Item Rejection and Line Item Denials Related to HIM-Assigned Codes**
In circumstances where there is a review of claim rejections, claim denials, claim return to, claim suspension, line item rejection and line item denials related to HSC/HIM-assigned codes, the review will be done by qualified coding employees.

10. **Payer Coverage/Medical Necessity For Services**
ICD-10-CM diagnosis and CPT procedure codes must be correctly submitted and will not be modified or misrepresented in order to be covered and paid.

DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Coding Documentation for Outpatient Services
PAGE: 13 of 14	**REPLACES POLICY DATED:** 7/14/97, 3/6/98, 4/16/99, 8/1/00; 6/1/02, 12/15/02, 6/1/03, 5/31/04 (HIM.COD.002), 3/6/06, 3/1/07, 8/1/09, 5/15/12, 9/1/15, 10/1/15, 8/1/16, 2/1/17, 2/1/19, 5/1/19
EFFECTIVE DATE: February 1, 2020	**REFERENCE NUMBER:** REGS.COD.002
APPROVED BY: Ethics and Compliance Policy Committee	

    a. Certain payers, specifically Medicare, have issued requirements for certain services which must have specific diagnoses for the service to be covered. Payment may be made only for services it determines to be "reasonable and necessary." Routine exams or screenings, tests for investigative or research use only and other services may not be covered.

    b. Medicare also maintains a listing of procedures that may be performed in an inpatient only setting.

    c. Each facility should have a process in place to identify appropriateness of services and/or coverage issues before a service is rendered.

    d. Refer to the Medicare - National and Local Coverage Determinations, REGS.GEN.011, and the Advance Beneficiary Notice of Noncoverage Policy, REGS.GEN.003, for additional information.

11. **Claims Adjustment**

A written policy must be developed which prohibits changing or resequencing of codes and/or HSC/HIM-assigned modifiers by facility, or Service Center personnel without review and approval by qualified coding personnel. Education and follow-up should be conducted with all coding professionals as applicable.

12. **Chargemaster/Encounter Form Maintenance**

Each facility has responsibility for maintaining and updating the chargemaster, and encounter forms on an annual basis to include new and/or revised codes (Note: ICD-10-CM is updated each October, while CPT is updated each January).

    a.   Each facility also has responsibility for implementing internal billing controls to assure correct use of chargemaster, or encounter form and accurate billing practices.

    b. Health Information Management should be involved in the review process.

13. **Compliance**

Compliance with this policy will be monitored during reviews by Corporate Regulatory Compliance Support and Parallon Business Performance Group.

    a. It is the responsibility of each facility's administration to ensure that all individuals involved in coding of outpatient services apply this policy.

    b. Employees that have questions about a decision based on this policy or wish to discuss an activity observed related to application of this policy should discuss these situations with the immediate supervisor to resolve the situation.

    c. All day-to-day operational issues should be handled locally. However, if confidential advice is needed or an employee wishes to report an activity that conflicts with this policy and is not comfortable speaking with the supervisor, employees may call the toll-free Ethics Line at 1-800-455-1996.

    d. For any questions regarding this policy please submit them to the Regs Helpline via the online Regs Helpline Interactive Tool at: http://trinisys.app.medcity.net/regshelpline.

REFERENCES:

1. ICD-10-CM Official Coding Guidelines for Coding and Reporting
2. Coding Documentation for Inpatient Services Policy, REGS.COD.001
3. Query Documentation for Clinical Documentation Improvement (CDI) and Coding – Compliance Requirements, REGS.DOC.002
4. Coding Documentation for Rehabilitation Services Policy, REGS.COD.013
5. Billing Continuing Education Requirements Policy, REGS.GEN.007
6. Hospital Evaluation and Management Services, REGS.GEN.008
7. Payment Window and Multi Visit Account Merge Manual Coding Process, PARA.HSC.COD.02
8. Licensure and Certification, CSG.QS.002
9. Billing for Investigational Devices in Clinical Trials, REGS.BILL.007
10. Medicare - National and Local Coverage Determinations, REGS.GEN.011
11. Advance Beneficiary Notice of Noncoverage – Outpatient Services, REGS.GEN.003
12. Billing - Orders for Hospital Outpatient Tests and Services, REGS.GEN.004
13. Outpatient Services and Medicare Three Day Window, REGS.GEN.009
14. Records Management Policy, EC.014 (applies to all clinical and business records**)**
15. Company E&M Standardization Tools
16. Company Observation Services Manual
17. Medicare Part B Policy Manual
18. Medicare Hospital Manual
19. CMS Pub. 10
20. AHIMA Defining the Core Clinical Documentation Set for Coding Compliance

ATTACHMENT A

Commitment to Data Integrity

One of the important philosophies of the Company is the commitment to conduct our business with integrity and always render our services on a highly ethical level.

This philosophy embraces the following principles related to coding:

1. We have great confidence in our employees and their commitment to collect, manage and report data in an unbiased, honest and ethical manner.

2. We believe that diagnosis and procedure coding should be governed by official coding guidelines and that all codes mandated by the guidelines should be assigned and reported. Adherence to guidelines will promote consistency and accuracy of coded data in individual facility and company databases. The Company policy is that ICD-10-CM diagnosis CPT procedure codes and modifiers must be correctly submitted, and will not be modified or misrepresented in order to be covered and paid. Diagnoses or procedures will not be misrepresented or mischaracterized by assigning codes for the purpose of obtaining inappropriate reimbursement.

3. We believe that the diagnosis reported by the physician or NPP as the reason for the encounter or visit and the codes reported must be consistent.

4. We believe that the procedural codes reported should accurately reflect the procedures performed during the encounter as documented by the physician or NPP.

5. We are committed to providing the support needed to effectively classify our patients. Support provided to the Company facilities includes coding seminars, training tools, group purchases of products at discounted rates, publications and nosology support.