<table>
<thead>
<tr>
<th>Regulatory Compliance Policy</th>
<th>No.</th>
<th>COMP.RCC 4.71</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong></td>
<td></td>
<td>Page: 1 of 12</td>
</tr>
<tr>
<td><strong>HIM DIAGNOSIS AND PROCEDURE</strong></td>
<td></td>
<td>Effective Date: 03-19-15</td>
</tr>
<tr>
<td><strong>CODE REPORTING</strong></td>
<td></td>
<td>Retires Policy Dated: 06-27-13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous Versions Dated:</td>
</tr>
</tbody>
</table>

I. **SCOPE:**

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest of greater than 50%; and (3) any hospital or healthcare entity in which an Affili ate either manages or controls the day-to-day operations of the entity (each, a “Tenet Entity”) (collectively, “Tenet”).

II. **PURPOSE:**

The purpose of this policy is to establish clear procedures, processes and practices regarding ICD-9-CM\(^1\), CPT/HCPCS and other UB-04 claim data elements coded and reported by Tenet HIM Coders and Clinical Documentation Specialists.

III. **DEFINITIONS:**

A. “AHIMA” means the American Health Information Management Association. AHIMA is the national organization for HIM professionals. In addition, AHIMA is one of the four “Cooperating Parties for the ICD-9-CM” along with CMS, NCHS and the AHA. The parties are responsible for establishing national ICD-9-CM coding guidelines.

B. “HIM Coding” means short-term or long-term acute hospital (“Hospital”) or ambulatory surgery center (ASC) based coding and abstracting services on behalf of a Tenet Entity for the purposes of claim submission. The Hospital/ASC HIM coding function includes assignment of any ICD-9-CM diagnosis (including the Present On Admission (POA) indicator) or procedure code, assignment of any CPT procedure code to represent the “technical component” between 10020 and 69990 (excluding designated codes in this range approved by Coding Compliance to be placed in the charge description master), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes.

C. “HIM Coder” or “Coder” means a Hospital, ASC, market, regional, or Home Office employee, contractor, subcontractor, agent, or other person who performs Hospital or ASC HIM coding. It also includes those employees or contractors involved indirectly, such as in a supervising or monitoring role, with the HIM coding.

D. “Clinical Documentation Improvement” or “CDI” means the entity-based process of reviewing patient records at the point of care and, as needed, working with treating physicians to assure that the clinical documentation in the entity medical record most accurately reflects the patient’s clinical condition and treatment provided.

---

\(^1\) References in this policy to “ICD-9-CM” shall be replaced with “ICD-10-CM”, “ICD-10-PCS”, or “ICD-10-CM/PCS” (as applicable) on the official ICD-10 effective date established by CMS.
E. “Clinical Documentation Specialist” or “CDS” means a Hospital, ASC, market, regional, or Home Office employee, contractor, subcontractor, agent or other person who performs clinical documentation improvement duties. It also includes those employees or contractors involved indirectly, such as in a supervising, assisting or monitoring role, with clinical documentation improvement.

F. “Official Guidelines” mean applicable portions of the following publications: International Classification of Diseases, 9th revision, Clinical Modification, including addenda, conventions and instructions, (ICD-9-CM); Current Procedural Terminology, including addenda, conventions and instructions, (CPT); ICD-9-CM Official Guidelines for Coding and Reporting; Coding Clinic for ICD-9-CM; Coding Clinic for HCPCS; and, the online CMS manual system. Each of the above publications is a CMS-approved reference for hospital inpatient and outpatient coding and reporting. CPT Assistant, while not an official CMS reference, provides additional nationally recognized guidance regarding CPT codes and shall be included as an “official guideline” by HIM Coders in areas not addressed by CMS-approved references.

G. “Outpatient Procedure” as used in this policy means any account with an HIM-assigned CPT procedure code to represent the “technical component” between 10020 and 69990 (excluding designated codes in this range approved by Coding Compliance to be placed in the charge description master), designated HCPCS Level II codes, designated HCPCS Modifiers, and designated CPT Category III codes. Note: accounts in this group are not limited to those procedures performed in the operating room.

IV. POLICY:

A. General Coding and Reporting Policies

1. Any individual involved in HIM Coding and/or CDI must at all times adhere to the AHIMA Standards of Ethical Coding, Official Coding Guidelines as well as applicable Tenet policies, and Coding Compliance Procedures, Processes, and Guidelines.

   a. The Coder must report any activity that appears to conflict with the above documents or any Tenet policy to his/her supervisor, designated Compliance Officer, a Tenet Coding Compliance Officer or the Tenet Ethics Action Line at 1-800-8-Ethics.

2. The Coder is expected to have and maintain specific expertise and demonstrate proficiency in the patient types and classification system for which she/he is responsible (i.e., ICD-9-CM and CPT/HCPCS). The Coder, likewise, has a responsibility to become proficient in ICD-10-CM/PCS (as indicated) by the ICD-10 implementation date.
3. The Coder must undertake a thorough review of applicable documentation to assess the quality of clinical documentation and determine the appropriate diagnosis and/or procedure codes to be reported, in conjunction with all applicable Official Guidelines.

   a. The Coder will utilize a computer-assisted coding application (as applicable) in compliance with Official Coding guidelines, and validate that any codes and POA indicators “auto-suggested” by the software are both accurate and reportable according to the Official Coding Guidelines.

   b. The Coder acknowledges that electronic documents interfaced to a computer-assisted coding software system are facsimile representations only.

      (1) The Coder should validate final code reporting against source documents in the entity’s officially designated legal medical record as needed to validate code assignment.

      (2) Any discrepancy potentially affecting code assignment regarding a document’s availability or display within the computer-assisted coding software must be immediately reported to a Coding Compliance Officer.

4. Consultation with a qualified peer, supervisor or a Tenet Coding Compliance Officer (CCO) is required whenever the Coder has a question regarding the appropriate and/or accurate reporting of a diagnosis or procedure code.

5. The Coder is to assign, sequence, and report ICD-9-CM diagnosis, procedure codes, and/or CPT/HCPCS procedure codes when supported by clinical documentation and authorized by Official Guidelines.

6. The Coder may report diagnoses that are not vague, incomplete or contradictory without physician query when documented by a physician involved with the care of the patient during the current stay (including residents, anesthesiologists or consultants).

7. The Coder must not report codes from previous encounters/coding summary sheets, non-physician or allied health practitioner documentation (except as allowed by Official Guidelines).

8. The Coder must not report diagnoses based on previous discharges/visits, charges, registration lists, system generated (e.g., “green-bar”) reports,
<table>
<thead>
<tr>
<th>Regulatory Compliance Policy</th>
<th>No.</th>
<th>COMP.RCC 4.71</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIM DIAGNOSIS AND PROCEDURE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CODE REPORTING</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

face sheets, electronic medical record nursing problem lists, or similar non-physician generated information.

9. The Coder must not report an abnormal finding unless the provider indicates its clinical significance.

   a. The Coder must not interpret an abnormal (non-diagnostic) finding on an ancillary report or non-invasive diagnostic test as a diagnostic statement.

   b. Similarly it is not appropriate for the Coder to report a diagnosis based on an up/down arrow or other symbol that does not directly and unambiguously correlate to a narrative ICD-9-CM code description. If indicated, the Coder or CDS may query the provider regarding the clinical significance of the finding and/or meaning of the symbol.

   c. A general guideline for Coders and CDS staff to follow is the finding, problem or diagnosis must be tested, treated, or clinically evaluated to be a reportable condition.

10. At the conclusion of the coding process, the Coder will generate a coding summary sheet, containing all reported ICD-9-CM and/or CPT/HCPCS codes as well as POA indicators and Modifiers as applicable.

   a. If the system-generated functionality is not available, the Coder must assure a copy of hand-written codes is entered into the record.

   b. Editing the narrative description of a diagnosis or procedure code is not appropriate.

11. *Coding Clinic for ICD-9-CM* provides instruction on reporting diagnoses and procedures in specific situations. The Coder must follow the guidelines published through the current issue *Coding Clinic for ICD-9-CM* as well as the most recently published *ICD-9-CM Official Guidelines for Coding and Reporting*.

12. The Coder may release for billing an account containing coding based on an unauthenticated source document (e.g. discharge summary, ancillary order, etc.) provided the Tenet Entity has a process defined to eventually obtain the authentication as required by state/federal law and/or entity policy.
B. Specific Inpatient Reporting Policies

1. For inpatient reporting, the Coder must at all times follow the Uniform Hospital Discharge Data Set (UHDDS) definitions for Principal Diagnosis, Additional Diagnoses and Principal Procedure. The Coder must specifically refer to Sections II and III of the ICD-9-CM Official Guidelines for Coding and Reporting for additional information for Official guidance on the selection of Principal and Secondary Diagnoses.

   a. The Principal Diagnosis is defined in the UHDDS as, “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

   b. Additional Diagnoses is defined in the UHDDS as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.” Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.

   c. Principal Procedure is defined by UHDDS as follows: “The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If two procedures appear to meet this definition, then the one most related to the principal diagnosis should be selected as the principal procedure.”

C. Specific Outpatient Reporting Policies

1. The term “First-listed” is used for outpatient reporting, in lieu of “Principal Diagnosis.” The Coder must specifically refer to Section IV of the ICD-9-CM Official Guidelines for Coding and Reporting for specific outpatient reporting guidance.

2. For an outpatient visit, the Coder must sequence and report first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for the encounter that is chiefly responsible for the service provided, as documented in the patient’s medical record. The Coder is then to report additional codes that describe any co-existing conditions.

3. Outpatient Diagnostic/Ancillary Accounts

   a. Coders must have a valid order/requisition indicating the reason for the test/service prior to coding and releasing for billing (excluding the limited circumstances where patients may self-refer).
b. Refer to Regulatory Compliance policies COMP-RCC 5.01 Orders for Outpatient Tests and Services and COMP-RCC 5.02 Outpatient Laboratory Requisitions for additional information, specific requirements and exceptions.

4. Outpatient NCCI Modifiers

a. The Coder is to assign applicable modifiers on outpatient services for federal payer accounts as well as those of commercial payers that request them.

b. The Coder will know that modifiers and NCCI logic is required when the charge codes appear when coding an outpatient visit.

c. A Coder, or other approved staff member must append modifier 25, 58, 59, or 91 to bypass an NCCI edit only when there is clear documentation of a separate, distinct service.

d. If a code pair triggers NCCI edit 19/20, the Coder is to remove the Column 2 (aka Component) code from the patient’s abstract. If the edit occurs on a department charge code, the Coder should refer the edit back to the charging department for removal.

e. If a code pair triggers NCCI edit 39/40, the Coder is to assess whether documentation supports modifier assignment.

(1) If yes, the Coder may assign the appropriate NCCI modifier to bypass the edit.

(2) If no, the Coder must remove the one of the codes triggering the edit prior to billing. This is most often, but not always, the designated “component” or “Column 2” code. Questions about which code to remove may be directed to a Tenet Coding Compliance Officer. If the edit occurs on a department charge code, the Coder should refer the edit back to the charging department for removal.

f. Coders must follow the requirements specified in all of the following documents: Tenet Procedure: HIM Modifier Assignment, and NCCI Policy Manual.
D. Certain Issues Requiring HIM Bill Hold

1. In all situations the Coder must use his/her expertise to determine whether a patient’s account is ready to be released for billing.
   a. When it becomes necessary to place an account on a billing-hold, the Coder may use the most appropriate “code hold” reason to document the reason chiefly responsible for the hold.
   b. The Tenet Entity should then take necessary action to resolve the deficiency(ies) in a timely manner.

2. At a minimum, a patient’s account must not be released for billing when any of the following conditions are met:
   a. When the Coder in conjunction with his/her supervisor (and, if needed, consultation by a Tenet CCO) determines that existing clinical documentation is illegible, incomplete, unclear, inconsistent or imprecise to the point where the Coder is unable to adequately assign a complete and accurate code set. Resolution: the Coder must generate a physician query consistent with the Tenet physician query procedure and request the account be placed on billing hold until the physician provides a response.
   b. When the Coder, in conjunction with his/her supervisor (and, if needed, consultation by a Tenet CCO) determines that there is an insufficient clinical documentation set and therefore the account cannot be coded completely and accurately.
      (1) For outpatient procedure accounts when the dictated or final operative note is not available to the coder, the clinical documentation set for that account is deemed insufficient and the account must be placed on bill-hold. See below for additional discussion regarding operative reports.
      (2) Resolution: the physician should be asked to provide the missing documentation through the Entity’s deficiency process.
      (3) See the AHIMA publication, “Defining the Core Designated Clinical Documentation Set for Coding Compliance” for additional guidance regarding a complete clinical documentation set.
   c. When, for Medicare inpatients, the patient’s medical record does not contain appropriate documentation to accurately determine the
patient’s discharge disposition status. Resolution: the account must be referred to the Director of Case Management, or designee, for documentation in the medical record.

d. When there is an inconsistency between the information in the medical record and in the patient accounting system regarding either admit/discharge dates or patient admission status (i.e., inpatient versus outpatient). Resolution: coders must refer conflicts to Case Management or Patient Access, as applicable, for clarification and system correction prior to releasing the claim for billing.

e. When pre-billing coding/data quality checks as required by Tenet Policy/Procedure (e.g., new-hire orientation and “CARDS” reviews) or as directed by a Tenet CCO (e.g., post-audit internal monitoring) have not been completed. Resolution: coder and/or supervisor complete quality checks; refer issue to a Tenet CCO as indicated.

E. Coding Guideline/Policy Interpretation

1. When a Coder or CDS staff member has a question/concern regarding interpretation or application of an Official Guideline, Tenet coding instruction, or patient-specific clinical documentation that is not able to be resolved at the hospital level, the Coder must direct the issue to a Tenet CCO for resolution.

2. A Coder or CDS staff member must obtain approval from a Tenet CCO prior to applying coding advice obtained from external sources (journal, seminar, vendor, website, etc.) to a Tenet patient’s account.

F. External Requests to Change HIM Coding

1. A Coder may comply with a patient’s payer’s instruction that conflicts with an Official Coding Guideline or a Tenet guideline/policy provided the instruction is obtained in writing prior to the account being coded/recoded.

2. The Coder must visually see a copy of the payer’s written instruction prior to making any coding changes.

3. The Coder may grant any other request to add, delete or change codes (such as those made via a business office, patient or physician) only when the change is supported by clinical documentation and either written payer coding policy and/or Official Guidelines.
G. Documentation-specific Coder Reporting Requirements

1. Physician Queries and Clinical Documentation Improvement

   a. The Coder and/or CDS is expected to engage in an appropriate physician query process when there is evidence of a diagnosis or condition within the medical record and the Coder/CDS is uncertain whether that diagnosis is valid because the documentation is vague, incomplete or contradictory, or when documentation is unclear regarding the appropriate Present on Admission (POA) indicator for an established diagnosis.

   b. Physician queries, whether initiated concurrently or retrospectively, and regardless of the credential(s) held by the one issuing the query, are to be compliant with Official Guidelines, Tenet policies and procedures, the Tenet Standards of Conduct and other applicable regulatory requirements.

   c. Any employee or contractor engaged in generating concurrent or retrospective physician queries must use only query forms approved by Tenet’s query forms committee. See Tenet Query Forms.

   d. Any employee or contractor engaged in generating concurrent physician queries is to strictly adhere to the AHIMA Ethical Standards for Clinical Documentation Improvement Professionals and the ACDIS Code of Ethics.

   e. Coders and CDSs must be oriented to the entity-specific process/procedure to address potentially unreliable physician documentation (e.g., refer to Hospital, market, or regional Physician Advisor, CMO, or other clinician). A physician query is inappropriate for potentially unreliable physician documentation.

2. Emergency Room Documentation

   a. When coding an Inpatient account, the Coder must not report a diagnosis documented solely by the Emergency Department physician unless confirmed by the attending or other physician involved with the care following the inpatient admission.

      (1) ER documentation is often provisional or differential in nature; conditions not substantiated during the inpatient stay are likely not clinically significant enough to be reported.
(2) If there is evidence of a condition tested, treated, or clinically evaluated, the Coder or CDS may generate an appropriately constructed physician query.

(3) An exception is permitted by Coding Clinic Q3 2012, page 22, when the patient expires immediately after admission and there is limited documentation from other physicians. In this unique situation the Coder may use the ED physician’s documentation to substantiate code assignment.

b. Procedures performed in the Emergency Department may be reported on the inpatient claim.

c. In general, the Coder is to report casting, splinting and strapping procedures ordered by a physician that involve specialized clinical training to apply.

(1) The application, fitting and adjustment of so called “off the shelf” supply items (e.g., an air cast or cervical collar) are not reported by Coders.

(2) Coders are to refer to the Tenet Coding Compliance intranet site for additional guidance on the coding and reporting of casting and strapping procedures.

3. Inpatient Discharge Summary

a. The Coder may release inpatient accounts for billing without a discharge summary.

b. When the patient’s payer reimburses based on DRG methodology (including APR-DRGs), the Coder is to follow the Discharge Summary Rerouting procedure for accounts originally coded without the discharge summary (where one is required by hospital/medical staff policy).

c. The Coder must understand the entity-specific process to “flag” an account for review once the summary becomes available.

d. If the information in the discharge summary necessitates a change in code assignment and the change affects payment, the Coder must submit the patient’s account for rebilling.
4. Operative Reports

a. As stated above, the Coder must not release an Outpatient Procedure account for billing until the dictated or written final operative note is available. The interim progress note is not sufficient as a source document for procedure coding.

b. A coder may release for billing an Inpatient account without a procedure report provided there is adequate documentation available to the Coder to assign an accurate ICD-9-CM procedure code.

c. Assigning an ICD-9-CM or CPT procedure code solely based on the procedure’s stated title, without reviewing the body of the report, is a violation of the AHIMA Standards of Ethical Coding and is prohibited.

5. Pathology Reports

a. The Coder may release for billing an inpatient or outpatient account without a pathology report at his/her entity’s discretion.

b. For inpatient coding, Coding Clinic for ICD-9-CM requires confirmation from a physician directly involved with the care of the patient prior to reporting a diagnosis documented by a pathologist.

V. PROCEDURE:

A. Implementation; Coding Compliance Intranet Site

In addition to the requirements stated in this policy, the HIM Coder or CDS (as applicable) along with the market and/or entity’s HIM executive, ASC administrator, or designee, must implement all applicable procedures and processes to assure effective coding. These documents are located on the Coding Compliance intranet site.

B. Responsible Person

The market or hospital HIM executive or ASC administrator is responsible for assuring that all individuals adhere to the requirements of this policy, that all applicable procedures and processes are implemented and followed at the Tenet Entity, and that instances of noncompliance with this policy are reported to the Compliance Officer and/or designated Tenet CCO. For any questions regarding this policy please contact Tenet Coding Compliance by the email address: TenetCoding@tenethealth.com.
C. Auditing and Monitoring

Tenet Compliance will audit adherence to this policy as part of its coding compliance audits.

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- AHIMA Code of Ethics
- AHIMA Standards of Ethical Coding
- Tenet Standards of Conduct
- NCHS Official ICD-9-CM Coding Guidelines (current FY)
- Tenet Coding Compliance intranet site