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 Affiliate 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 affirm Tenet’s commitment to ethical, complete, accurate and consistent HIM coding and documentation improvement.

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 36415), 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” will 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 36415, collection of venous blood by venipuncture), 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. HIM Coding is to be complete, consistent, accurate and compliant. Tenet Entities must strive to code every patient’s claim correctly and take reasonable and necessary efforts to achieve this outcome.

B. Any individual involved in HIM Coding and 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.

C. Each patient’s account is to be released, or re-released, for billing only when all of the following are met:

1. All ICD-9-CM and Outpatient Procedure CPT/HCPCS codes (including select modifiers) that are submitted for billing purposes under a Tenet Entity’s provider number must be assigned by an HIM Coder, who is adequately supervised, as well as trained and oriented, as appropriate, to the type of HIM Coding to be assigned.
2. All ICD-9-CM and Outpatient Procedure CPT/HCPCS codes to be reported on the patient’s claim are supported by legible, complete, clear, consistent, precise and reliable provider documentation.

3. A sufficient clinical documentation set exists in the patient record from which to assign a complete set of codes.

4. Diagnoses and procedure codes are assigned and sequenced appropriately according to Official Coding Guidelines.

5. Other claim elements including the discharge disposition code, admission status (inpatient or outpatient) and admit/discharge dates as recorded in the patient accounting system correlate with documentation in the patient’s medical record.

Accounts with identified discrepancies in one or more of the above areas must not be released for billing until the discrepancy is resolved and the account can be billed with a complete, accurate and compliant code set.

D. When a discrepancy is detected with the HIM Coding on a previously submitted claim, the Tenet Entity must undertake reasonable efforts to correct the deficiency and prevent the defect from reoccurring on future claims. Overpayments must be corrected and resubmitted to the payer within 45 days of identification. (See Regulatory Compliance policies COMP-RCC 4.35 Reporting of Overpayments to Federal Health Care Programs and COMP-RCC 4.34 Reporting of Overpayments to Commercial/Managed Care Plans.)

E. Each Tenet Entity shall have and maintain DRG and surgical APC coding accuracy rates of greater than 95.5% as measured by periodic independent/Home Office Coding Compliance audit. Each ASC shall have surgical CPT coding accuracy rates of greater than 95.5% as measured by periodic independent/Home Office Coding Compliance audit. Entities who do not achieve the accuracy rate on a Home Office Coding Compliance audit are subject to appropriate corrective action.

F. Under the direction of Tenet’s Chief Compliance Officer, the Sr. Director of Health Information Compliance (or designee) will develop and publish a document outlining Coding Compliance Program specifics including an annual Coding Compliance Workplan. All Tenet Entities that perform HIM Coding are required to implement applicable requirements of the plan, including Procedures and processes. Refer to the Tenet Coding Compliance Program and Workplan documents available on Tenet’s Coding Compliance intranet site.
G. General Coding Compliance Policies

1. Tenet adopts the AHIMA Standards of Ethical Coding as the foundation of its Coding Compliance program. All employees directly or indirectly involved in coding, clinical documentation and/or revenue cycle processes are required to abide by the AHIMA Standards of Ethical Coding. In addition all CDI initiatives are to be guided by the AHIMA Ethical Standards for Clinical Documentation Improvement Professionals and the ACDIS Code of Ethics.

2. Physician Queries and Clinical Documentation Improvement Programs

   a. Tenet Entities are to implement the requirements of the Tenet Coding Compliance Procedure Physician Queries. Entities shall further adhere to the AHIMA Practice Briefs: Managing an Effective Query Process and Guidance for Clinical Documentation Improvement Programs.

   b. Tenet Entities must implement a process/procedure for Coders and CDS staff to address potentially unreliable physician documentation (e.g., refer to hospital, market or regional Physician Advisor, CMO or other qualified clinician). A physician query is generally inappropriate for potentially unreliable physician documentation.

3. Upon request, the Tenet Entity must be able to produce all clinical documentation used to substantiate the HIM coding of any account.

4. Tenet Coding Compliance Officers

   The Coding Compliance Officers (CCOs) are members of the independent Home Office Ethics and Compliance Department and are available for consultation with any issue that may ultimately affect the accuracy of HIM Coding. When an issue/question involving the interpretation of an Official Guideline or other coding policy, procedure, practice etc., cannot be resolved at the local level, Tenet Entities are to escalate the question/issue to a Tenet CCO for resolution. See Tenet Procedure: Coding Guideline Interpretation.

5. Additional Compensation Plans

   Tenet will not have any compensation plan in place that adversely affects, or has the appearance of adversely affecting, consistent, complete and accurate HIM Coding. Any incentive/bonus pay plan for employed HIM Coders and Clinical documentation specialists require the advance written

6. HIM Coder Education and Training
   a. HIM Coders (and other pertinent staff as indicated) are required to complete training activities as indicated in the Coding Compliance Plan. Coders may be required to complete other educational activities not included in the annual plan from time to time, as directed by Tenet Compliance.
   b. Tenet coders are required to complete coursework for ICD-10-CM/PCS preparation. Periodic deadlines have been established to ensure coders are making sufficient progress prior to the implementation date announced by CMS. Failure to meet these deadlines may result in disciplinary action. An HIM Coder, including a contract coder, will not be permitted to final code ICD-10-CM/PCS accounts until proficiency can be demonstrated.
   c. See Tenet Procedure: Coder CE Requirements.

7. Home Office Compliance Audits
   Tenet Hospitals and ASCs will receive independent audits for coding accuracy. At the conclusion of the audit, investigation as to the causes of any coding discrepancies, remediation of potential claims made in error, education regarding trends identified, if any, and appropriate disciplinary action are to occur under the direction of a Tenet CCO. Entities are required to implement the corrective action tasks assigned by the CCD at the conclusion of the audit. See the annual Tenet Coding Compliance Workplan for specifications.

8. Internal Coder Monitoring
   a. Tenet Hospitals will have an effective ongoing coding internal quality monitoring process for each applicable coder with results compiled and reported to the Compliance Officer and Tenet CCO on a quarterly basis, at minimum. Individual HIM coders who do not achieve designated quality targets on the internal monitoring must likewise receive appropriate and measured corrective action. See Tenet Procedure: HIM Coder Quality Monitoring.
   b. Each applicable Tenet Entity must analyze PEPPER data to identify potential coding (as well as case management) quality issues.
9. CARDs-Rules Review

a. All short-term acute inpatient discharges must be screened through the CARDs-Rules system within PBAR. Accounts with pending rules are not to be released for billing until a sufficient review has occurred and notes addressing the rule have been documented in the CARDs system. See Tenet Procedure: Review of CARDs Rule Exceptions.

b. A short-term acute-care facility not on the PBAR abstracting platform must implement a similar coding compliance monitoring process approved by a Tenet CCO.

10. The HIM Director/ASC administrator, or designee, must assure all new HIM Coders (including newly hired and new contract coders) are provided orientation and training, including a review of Tenet Compliance policies, procedures and processes. Additionally Tenet Hospitals must assure that pre-bill coding reviews are conducted until acceptable coding quality can be demonstrated. See: Tenet Procedure: New HIM Coder Orientation and Monitoring.

11. Tenet permits final coding of inpatient accounts without a discharge summary. When the patient’s payer reimburses based on DRG methodology (including APR-DRGs), an account originally coded without the discharge summary (where one is required by hospital/medical staff policy) must be returned to a Coder to determine whether the summary supports a change to the final ICD-9-CM code set. See Tenet Procedure: Discharge Summary Rerouting.

12. Tenet Coding Compliance maintains an intranet site for official communication including compliance-related procedures and processes, coding compliance training requirements and code-assignment recommendations. At least one individual from each Tenet Hospital must be designated to receive system-generated alerts for the purpose of reviewing updates to the site and to communicating these to coding and other relevant staff on a minimum weekly basis. Individuals from freestanding ASCs are likewise encouraged to subscribe to the alerts where system access permits. Coding Compliance will assure pertinent updates are shared with ASC coding staff on a periodic basis. See https://sharepoint.etenet.com/sites/Compliance/Coding.
13. Contract Coding Arrangements

a. Approval by a Tenet CCO is required before engaging a new consultant/vendor in the area of coding.

b. The Tenet Entity is ultimately responsible for the accuracy of work produced by a contract coder. It is recommended that the contract have provisions to reduce payment or terminate the contract if any contract coder’s individual coding error rate of less than 4.5% is not achieved.

c. Individual HIM Coders from non-employee vendors who directly perform HIM Coding for billing purposes are to be reimbursed on a per-hour or per-day basis. Arrangements that include a base or additional “per chart” coder compensation structure are not appropriate.

14. External Coding Consultants

Engaging an external consultant/vendor to review patient accounts with the goal of assessing the quality/completeness of coding and/or clinical documentation, including Computer-Assisted Coding Software products, requires the prior written approval of a Tenet CCO or the Senior Director of Health Information Compliance. (See also Administrative policy AD 2.23 Authorized Financial Approval Limits for Outside Consulting Agreements.)

15. External Clinical Documentation Consultants

Engaging an external consultant/vendor to assist in the development, implementation or day-to-day duties of a concurrent HIM coding or medical staff documentation improvement program requires the prior written approval of Tenet’s Chief Compliance Officer. (See also Administrative policy AD 2.23 Authorized Financial Approval Limits for Outside Consulting Agreements.)

16. Coder-specific reporting requirements and other compliance-related performance expectations are delineated in the Regulatory Compliance policy COMP-RCC 4.71 HIM Diagnosis and Procedure Code Reporting.
V. PROCEDURE:

A. Implementation; Coding Compliance Intranet Site

In addition to the requirements stated in this policy, the Tenet HIM Director/ASC administrator, or designee, is to implement all applicable procedures and processes to assure effective coding. These documents are located on the Coding Compliance intranet site.

B. Responsible Person

The hospital HIM director 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 Coding Compliance will audit Tenet Entity 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)
- Regulatory Compliance policy COMP-RCC 4.71 HIM Diagnosis and Procedure Code Reporting

- Administrative policy AD 2.23 Authorized Financial Approval Limits for Outside Consulting Agreements

- Tenet Coding Compliance intranet site