CORPORATE POLICY

Manual/Library Name: Ethics and Compliance	**No**: EAC.08.01
Title: Coding Compliance Program	**Effective Date:** 09/15/22
	Previous Versions: 03/20/18, 01/12/17, 02/01/15, 06/27/13, 09/27/11, 0/10/10
	Approved By: Executive Leadership Team
	Approval Date: 09/14/22

I. Scope:

This policy applies to Tenet Healthcare Corporation and its subsidiaries and affiliates other than Conifer Holdings Inc. and its direct and indirect subsidiaries (each, an "Affiliate"), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any 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:

To outline controls in place to ensure an effective risk-based coding compliance program and to affirm Tenet's commitment to ethical, complete, accurate, and consistent Health Information Management (HIM) coding and clinical documentation improvement.

III. Definitions:

See Exhibit A for Glossary of Definitions.

IV. Policy Statement:

Tenet Coders (Coders) shall code consistently, accurately, and completely for the purpose of claim submission in accordance with Official Coding Guidelines, relevant laws and regulations, and Tenet Healthcare Corporation's Quality, Compliance and Ethics Program Charter.

V. Procedure:

A. General

1. Coders shall comply with all applicable laws, regulations, and coding guidelines. Coders shall strive to code every patient encounter correctly.
2. Any Coding leader and Coder shall always adhere to the AHIMA Standards of Ethical Coding, the Official Guidelines for Coding and Reporting, CMS 1995/1997 Documentation Guidelines for Evaluation and Management Services as well as applicable Tenet policies.

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3. In addition, all CDI and provider query initiatives must be consistent with the AHIMA Ethical Standards for Clinical Documentation Improvement Professionals and the ACDIS Code of Ethics. Individuals with American Academy of Professional Coders (AAPC) credentials should also follow the AAPC Code of Ethics. CDI must obtain prior written approval from Tenet Legal and Compliance for all substantive changes to Tenet's CDI program.

4. Coding leaders and Coders shall have and maintain coding accuracy rates at = 95.0% or greater, as measured by risk-based Coding Compliance audits. Any Coding leaders or Coders who do not achieve the required accuracy rate on a Coding Compliance audit will be subject to appropriate corrective action.

5. Coding Compliance leaders and auditors must be employees who are independent from Tenet's operational departments that perform coding services. Coding Compliance is available for consultation or escalation of issues that may ultimately affect the accuracy of Coding. If a Coder has a question or concern involving the interpretation of an Official Guideline or other coding policy, procedure, practice, directive or request, that cannot be resolved with his or her leader, the Coder or leader must escalate the question or concern to Coding Compliance for resolution.

6. Coding Compliance leaders must develop an annual, risk-based Coding Compliance Audit Plan ("Audit Plan") outlining specific auditing and monitoring activities, error/accuracy rate thresholds, and required educational initiatives. The Audit Plan must:

   a. Appropriately address risks identified through the Enterprise and Compliance Risk Assessment processes, or through consultation with Tenet Legal as needed;

   b. Require reporting of applicable metrics on a periodic basis;

   c. Include review of all Tenet Coders;

   d. Take into account facility or practice specific risks, compliance initiatives and obligations (e.g., external audit corrective action plans, corporate integrity agreements, non-prosecution agreements, etc.);

   e. Be reviewed and updated on at least a quarterly basis, to address and re-prioritize

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issues arising from new and emerging compliance risks; and

f. Be approved by designated Coding, Compliance and Operational stakeholders.

7. Coding Compliance will perform independent risk-based audits, including PEPPER audits, which may from time to time be directed by Tenet Legal under attorney-client privilege as needed.

   a. Coding Compliance leaders (or their designees) will provide a copy of the Executive Summary Report and mitigation plan, if applicable, to appropriate stakeholders. 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 must occur under the direction of a Tenet Coding Operations Leader and/or Tenet Legal.

   b. When mitigation is necessary, Coding Compliance must initiate and develop the mitigation plan, in consultation with or under the direction of Tenet Legal if needed. Coding Compliance will develop the mitigation plan in conjunction with Coding Operations, and Coding Operations must fully carry out the mutually agreed upon plan.

   c. For Coding Compliance audits that fall out of audit thresholds, a follow-up audit must be conducted.

8. Any coding compliance concerns, including suspected non-compliance with the requirements of this policy, should be reported to Ethics and Compliance in accordance with COMP-RCC 4.21, Internal Reporting of Potential Compliance Matters.

9. Any selection and engagement of Vendors to support coding services must comply with relevant Tenet vendor oversight policies and procedures.

B. Coding Compliance Training and Education

All Coders, Edit Coders, CDI Specialists and Auditors must complete appropriate initial and refresher job-specific coding compliance training in accordance with HR.ERW.15, Ethics and Compliance.

C. Coder Credentials

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Coding and coding audit professionals must have Health Information Management (HIM) or coding credentials through the American Health Information Management Association (AHIMA) or the American Academy of Professional Coders (AAPC) and be qualified to perform their duties on day one of employment at Tenet Coding Quality.

D. Coding Quality

Controls established within Tenet's Coding Quality Program exist to ensure that only appropriately qualified Coders, Edit Coders and Auditors are put into production, and that consistent coding quality is sustained during a Coder's tenure with Tenet. Anomalies identified through Tenet's Coding Quality Program should be escalated to Coding Compliance in accordance with COMP-RCC 4.21 Reporting of Potential Compliance Matters.

E. Additional Compensation Plans

Tenet Enterprise will not compensate any Coder in a manner that adversely affects, or has the appearance of adversely affecting, consistent, complete and accurate Coding. All compensation plans must be consistent with other relevant compensation practices within Tenet.

VI. 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.

VII. References:

FIN.07.01 General Coding Operations
COMP-RCC 4.21 Reporting of Potential Compliance Matters
AHIMA Code of Ethics
AHIMA Standards of Ethical Coding ACDIS CDI Code of Ethics

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AHIMA Ethical Standards for Clinical Documentation Improvement Professionals AAPC Code of Ethics

VIII. Exhibit A: Glossary of Definitions

American Academy of Professional Coders (AAPC): A national credentialing organization for medical coding.

Association for Clinical Documentation Improvement Specialists (ACDIS): A national credentialing organization for CDI Specialists.

American Health Information Management Association (AHIMA): The national organization for HIM/Coding professionals. In addition, AHIMA is one of the four Cooperating Parties for the ICD-10 CM/PCS, along with Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS) and the American Hospital Association (AHA), which are responsible for establishing national ICD-10 CM/PCS coding guidelines and leading the development of information governance principles for healthcare.

Ambulatory Payment Classification (APC): The assignment of codes for reimbursement of certain outpatient services by the Medicare program. All Patient Refined Diagnosis Related Group (APR-DRG): The assignment of subclasses, based on severity of illness and risk of mortality, to coding in accordance with the basic DRG methodology.

Claim: A claim to a payer for reimbursement of health care services on forms mandated by HIPAA, including electronic claims on the current HIPAA-mandated version of the Accredited Standards Committee (ASC) X12 and paper claims on the CMS-1500.

Clinical Documentation Improvement (CDI): The process of reviewing patient records at the point of care and, as needed and appropriate, working with treating physicians and extenders to ensure that the clinical documentation in the medical record most accurately reflects the patient's clinical condition and treatment provided.

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Clinical Documentation Specialist (CDS): An employee who performs clinical documentation integrity reviews for overall coding and quality reporting. It also includes those involved indirectly, such as in a supervising, assisting or monitoring role, within the department.

Coder: A person who has been employed or retained by Tenet to perform Coding Operations or functions which involve support to or oversight by Coding Operations (e.g., supervising, assisting or monitoring of Coders' activities and production, or management of a third-party vendor relationship). A Coder must possess the knowledge and qualifications to evaluate providers' medical documentation of patient encounters and procedures, and use that information to assign numeric codes that represent those diagnoses and procedures reflected in the documentation. Diagnosis and procedure coding assignments must also comply with applicable regulations with respect to medical record documentation. Coders are placed in a healthcare facility or provider setting, or as applicable in remote settings, for the sole purpose of performing Coding Operations.

Coding Accuracy Rates: The percentage of records that were coded correctly as part of the overall number of records reviewed, determined in accordance with applicable policy. The coding accuracy rates are calculated on the audit spreadsheet as follows:

A. *Chart accuracy rate* is the total number of charts without countable errors divided by number of charts reviewed.

B. Chart accuracy rates with respect to professional fee coding services are calculated as the total number of points assessed divided by the total number of points for the audit.

a. Each chart will be assigned a point value based on the possible number of coding outcomes for each chart.

b. Potential coding outcomes include a combination of:

   i. Accurate assignment of E/M codes;

   ii. Accurate assignment of one or multiple CPT procedural codes; and

   iii. Accurate assignment or non-assignment of one or more applicable modifiers.

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C. *Diagnosis accuracy rate* is calculated as the total number of diagnoses audited minus the total number of diagnosis errors identified, divided by the total number of diagnoses audited.

D. *Procedure accuracy rate* is calculated as the total number of procedures audited minus the total number of procedure errors identified, divided by the total number of procedures audited.

E. *Overall coding accuracy rate* is calculated as the total number of diagnoses, E/M services and procedures audited minus the total number of diagnosis, E/M and procedure errors identified, divided by the total number of diagnoses, E/M services and procedures audited.

F. *Disposition accuracy rate* is only calculated on inpatient and IRF PAI reviews and is defined as the total number of discharge dispositions reported minus the total number of discharge disposition errors identified, divided by total number of discharge dispositions.

Coding Operations: Hospital, other facility or professional service coding and abstracting services to support claim submission.

Hospital Coding Operations: Coding and abstracting services performed on behalf of a facility to support submission of claims for hospital or facility inpatient and outpatient services. The Hospital Coding Operations function includes assignment of applicable ICD-10-CM/PCS diagnosis or procedure codes, Current Procedural Terminology (CPT) procedure codes to represent the “technical component” of applicable services, designated Healthcare Common Procedure Coding System (HCPCS) Level II codes, designated CPT and HCPCS Modifiers, and designated CPT Category III codes. Professional Coding Operations: Coding performed on behalf of a facility or professional group to support submission of professional medical and surgical services in all settings. The Professional Coding Operations function includes assignment of applicable ICD-10-CM diagnoses, any CPT procedure codes to represent the "professional component" of applicable services, designated HCPCS Level II codes, designated CPT Category III codes, and designated CPT and HCPCS modifiers.

Current Procedures Terminology (CPT): Includes CPT Category I, II, and III code sets published by the American Medical Association (AMA). These five-digit sets of codes describe procedures and services performed by physicians and other health care professionals or entities.

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Diagnosis-Related Group (DRG): A method of classifying facility patients by diagnosis, average length of hospital stay, and therapy received, which is used to by certain payers to determine reimbursement amounts for future procedures and services, primarily for inpatient care.

Official Guidelines: Publications by authoritative organizations, as mutually designated by Tenet Coding Operations and Compliance, that provide instructions and definitions for assignment of coding]; including, but not limited to, applicable portions of the following publications: International Classification of Diseases (ICD), 10th revision Clinical Modification (CM) for diagnosis reporting and Procedure Classification System (PCS) for hospital inpatient procedure reporting, including addenda, conventions and instructions (ICD-10-CM/PCS); Current Procedural Terminology (CPT), including addenda, conventions and instructions, ICD-10-CM/PCS Official Guidelines for Coding and Reporting; Coding Clinic for ICD-10-CM/PCS (and applicable guidance from Coding Clinic for ICD-9-CM); Coding Clinic for HCPCS; CMS Risk Adjustment Coding including HCC coding 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 Coders in areas not addressed by the CMS-approved references. From time to time, Coders and others may be asked to review, validate, and potentially resubmit accounts coded in accordance with prior versions or guidelines that are no longer effective. When this occurs, the reviewer must consult with Coding Compliance and apply the appropriate classification, conventions, instructions and Official Guidelines that were effective as of the patient’s discharge or visit date.

Patient Types: Classifications, based on clinical setting or other categories identified in accordance with facility services and licensing, including, but not limited to, the following:

A. IP - Inpatient
B. OBS - Observation
C. SDS - Same Day Surgery
D. ED - Emergency Department
E. ANC - Ancillary

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F. ProFee - Professional Fee Services (includes all types of diagnostic, medical and surgical services in all settings)
G. HCC – Hierarchical Condition Category
H. IVR - Interventional Radiology
I. IRF PAI - DRG change on UB04 Portion and Impairment Group, Etiologic Diagnosis, Comorbid Condition, or Complication change on UDS Abstraction Portion Countable Error:

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