DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Coding and Documentation for Non-Hospital Entities
PAGE: Page 1 of 11	**REPLACES POLICY DATED:** 10/1/99, 9/1/02, 6/1/03 (HIM.PHY.001), 3/1/06 (GOS.OSG.001), 3/6/06, 10/1/10, 10/1/15, 2/1/17, 12/1/20
EFFECTIVE DATE: September 1, 2023	**REFERENCE NUMBER:** REGS.OSG.001
APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE:

All colleagues responsible for performing, supervising or monitoring coding or claims processing for Non-Hospital entities, including, but not limited to:

- Administration
- Advanced Practice Professionals (APPs)
- Ambulatory Surgery Division (ASD)
- Coding/Billing
- Employed and Managed Physicians
- Ethics and Compliance Officers (ECOs)
- Freestanding Imaging Centers
- Freestanding Radiation Oncology Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Nursing Staff
- Office Staff
- Ordering/Referring/Rendering Physicians
- Parallon
- Physician Services Group (PSG)
- Physician Service Center (PSC)
- Shared Service Center (SSC)

This policy applies to diagnostic and procedural coding and reporting of services.

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. Our commitment to data integrity is documented in Attachment A.

POLICY:

Diagnoses will be coded utilizing the International Classification of Diseases Tenth Revision, Clinical Modification (ICD-10-CM). HCA Healthcare will follow the Official Guidelines for Coding and Reporting diagnoses published in AHA Coding Clinic for ICD-10-CM and the Centers for Medicare and Medicaid Services (CMS) coding and reporting requirements for coding and billing and all required ICD-10-CM coding and reporting requirements as published in the current ICD-10-CM edition issued by the Department of Health and Human Services.

HCA Healthcare will follow the CPT coding guidelines published by the American Medical Association and the Centers for Medicare and Medicaid Services for coding. Services and procedures will be coded utilizing the Current Procedural Terminology (CPT) and/or HCPCS Level II coding system.

HCA Healthcare will follow the coding guidelines for Physicians at Teaching Hospitals (PATH) outlined in Supervising Physicians in Teaching Settings guidelines published by the Centers for Medicare and Medicaid Services (CMS) in Chapter 12, Section 100 of the Medicare Claims Processing Manual or the most current guideline issued by CMS.

CMS mandates the utilization of Level I (CPT) and Level II (National Medicare) HCPCS codes for Medicare Patients.

HCA Healthcare

DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Coding and Documentation for Non-Hospital Entities
PAGE: Page 2 of 11	**REPLACES POLICY DATED:** 10/1/99, 9/1/02, 6/1/03 (HIM.PHY.001), 3/1/06 (GOS.OSG.001), 3/6/06, 10/1/10, 10/1/15, 2/1/17, 12/1/20
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PROCEDURE:

All individuals performing coding/claims processing must comply with the following:

A. **Basic Coding**

1. **Basic ICD-10-CM**

The appropriate ICD-10-CM 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 a related definitive diagnosis has not been established (confirmed) by the physician or APP. The documentation should describe the patient's condition, using terminology that includes specific diagnoses or the symptoms, problems or reasons for the encounter.

We recognize that there are unique payer coding and billing requirements. These requirements are addressed in Section D of this policy.

a. **The diagnosis, condition, problem, symptom, injury or other reason for the encounter or visit which is chiefly responsible for the services provided is the primary diagnosis.** This diagnosis is listed first for reporting purposes. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions.

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

c. Z Codes may be used to code encounters for circumstances other than disease, symptom, problems or injury. For additional guidance on the use of Z Codes, refer to the ICD-10-CM Official Guidelines for Coding and Reporting.

d. Codes must be reported using the maximum number of characters required for that code. A three-character code is only to be used if it is not further subdivided. 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.

e. Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis". 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.

f. When only diagnostic services are provided during an encounter or visit, sequence first the symptom, sign, condition, problem or other reason for encounter/visit shown

in the medical record to be chiefly responsible for the services provided during the encounter/visit.

i. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

ii. 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.

g. When only therapeutic services are provided during an encounter or visit, sequence first the diagnosis, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided during the encounter/visit.

i. The only exception is that the appropriate Z code is listed first for patients receiving chemotherapy or radiation therapy followed by the problem or diagnosis.

ii. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

h. For patients receiving preoperative evaluations only, sequence first the Z code that describes the pre-op services and code the reason for the surgery as an additional diagnosis. Code also any findings related to the preoperative evaluation.

i. For routine and administrative examinations (general check-up, school exam, child check, etc.), list first the appropriate Z code for the examination. If a diagnosis or condition is discovered, it should be coded as an additional code.

j. For surgery cases, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, code the postoperative diagnosis.

Follow written payer coding guidelines if they differ from above. (See the Unique Payer Requirements section of this policy).

2. **Basic CPT Coding**

a. Services and procedures will be coded utilizing the current year edition of the CPT manual. The *CPT Assistant* publication will be referenced for additional coding guidelines and definitions as a supplement to the CPT current year manual.

b. Medical services and supplies will be coded utilizing the current edition of the HCPCS Level II manual.

B. **Minimal Documentation Requirements for Coding Purposes**

1. **Required Standards of Documentation**

   Each entity should follow documentation standards that communicate complete patient care information in a clear and effective format by ensuring that all entries must:

   a. Contain the author's signature on all notations.

   b. Be legible to someone other than the author.

   c. Be accurate and concise.

   d. Utilize only abbreviations approved for use in the practice or center. A current list must be maintained on-site.

   e. Record incidents requiring specific follow-up, including a time frame for each follow-up action.

   f. Record all unusual events.

   g. Contain the date for all encounters.

   h. Have errors identified by one single line drawn through erroneous statements, with initials and date of entering person.

   i. Not contain erase marks or correction fluid.

   j. Orders for tests and services must be reduced to writing.

2. **Patient Visits**

   a. Documentation maintained must include but should not be limited to, as appropriate to the service, a medical record that includes:

      i. An authenticated physician or APP order for services,

      ii. Clinician visit notes including history and physical as applicable for the presenting problem,

      iii. A diagnosis, reason for visit, or rationale for any service that was ordered,

      iv. Request for consultation as applicable,

      v. Test results,

      vi. Therapies,

      vii. A problem list,

      viii. Medication list,

ix. Demographic information,

x. Required consents.

b. Coding of the diagnosis must be completed using the medical record or encounter form that is completed by the provider at the point of service.

c. Documentation in the medical record must support the diagnosis and procedure codes marked on the encounter form, super-bill, etc.

d. It is important to review and update the ICD-10-CM and CPT, HCPCS Level II codes on these forms at least annually. (Note: ICD-10-CM is updated each October, while CPT and HCPCS Level II are updated each January).

e. Each practice must establish a system for retention of the required documentation, including documentation necessary to substantiate coding/billing of the service. This should be maintained in the patient's medical record. Refer to the Records Management Policy, EC.014.

C. **Validation of Coded Data**

Internal (or external) coding validation reviews should be completed on a regular basis for each entity. Validation reviews should include review of the medical record to determine accurate code assignment with subsequent comparison with the claim form, the corresponding encounter form, and the corresponding remittance notice, to determine accurate coding. Findings from these reviews must be utilized to improve coding and medical record documentation practices and for provider and staff education, as appropriate.

D. **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.

1. Each organization must develop and maintain, in writing, policies and procedures that document the coding guidelines or coding requirements of a specific payer.
2. Each entity must state in their written policies and procedures how coders will be oriented about and made aware of individual payer contracts that contain specific coding and reporting requirements.
3. Written procedures must also outline how coding conflicts with payers are addressed. Since most entities deal with many different payers who issue varied guidelines, coding issues with high volume payers should be addressed first.

E. **Review of Denials**

Documentation should be maintained on claims denied in part or total due to discrepancies in coding. Written policy and procedures must require that all claims denials are reviewed

and areas for additional coding education to reduce denials are identified.

F. **Payer Coverage/Medical Necessity for Services**

ICD-10-CM diagnosis codes and CPT and HCPCS procedure codes must be correctly submitted and will not be modified or misrepresented in order to be covered and paid.

1. Certain payers, specifically Medicare, have issued requirements for "certain cardiopulmonary, radiology and laboratory tests" which must have specific diagnoses for the service to be covered. Payment may be made only for services the payer determines to be "reasonable and necessary." Routine exams or screenings, tests for investigative or research use only and other services may not be covered.
2. Each entity should have a process in place to identify the appropriateness of services and/or coverage issues before a service is rendered.

G. **Charge Document Coding**

The charge documents should be completed at the time of service. Charges must be identified using the appropriate procedure codes, diagnosis codes, and codes for patient supplies and drugs.

Code assignments may be selected by a qualified coder based on the documentation in the medical record.

"Qualified" means the person:

1. has obtained his/her coding certification from one of the national accrediting coding organizations, and/or
2. has completed the required number of organization-sanctioned Coding Training hours, or
3. is being trained, and is under the supervision of a qualified coder until training hours are completed.

Incorrect, incomplete or illegible charge documents should be returned to the provider promptly for correction so that timely charge entry can be performed.

For surgical procedures the codes on the claim should be submitted after review of the pathology report.

Physician and APP office providers should select the appropriate level of evaluation and management.

Surgical cases may be coded but not billed based on preliminary information (e.g., surgery schedule) available at the end of the month to accommodate business office requirements. The codes must be validated once all the source documentation (e.g., handwritten or

transcribed operative report) is available and prior to the claim being billed. For surgical cases which are billed based on unauthenticated operative reports, the facility should have a process to monitor/review for any edits made by the physician upon final authentication.

H. **Query Process**

The coder/appropriate office staff should query the physician or APP participating in the care of the patient once a diagnosis or procedure has been determined to meet the official coding guidelines for reporting but has not been clearly stated within the medical record, or when conflicting, or ambiguous documentation is present. It is not necessary to query the physician or APP when documentation that already exists in the medical record was not appropriately forwarded to the billing staff.

1. **Query Documentation**

A form which contains these elements must be used for the query process:

a. the name of the individual submitting the query;

b. the patient's name;

c. the patient's medical record number

d. the patient's account number;

e. the date the query was submitted

f. an itemization of clinical findings pertinent to the condition, or procedure in question including the source document(s) from the medical record that support the query; and

g. the statement of the issue in the form of a question.

2. **Query Format**

If a query is necessary to clarify ambiguous or conflicting documentation in the medical record in order to facilitate complete, accurate and consistent coding practices, the query should be documented in one of the following formats:

a. The physician or APP can add an addendum to the medical record such as a late entry progress note. The addendum must be dated and signed following the medical bylaws and/or rules and regulations. A copy of the addendum must be attached to the query with coding changes noted and returned to the billing office for accurate billing purposes.

b. The query can be documented on a separate query form. This documentation must be kept as a permanent part of the medical record and must include the patient's name, the patient's medical record number, the name of the individual submitting the query, the date the query was submitted, and a clear communication of the issue in

the form of a question. The completed form must contain the physician's or APP's coding response to the query and signature.

c. The query can be documented on the approved General query form for inpatient services as defined in the Query Documentation for Inpatient Services Policy, REGS.COD.012. The approved query form includes all of the required query elements and is attached to this policy. (See Attachment B). For specific instructions on the appropriate use of this form, refer to REGS.COD.012. It must be signed and dated by the physician or APP. A copy of the query must be forwarded to the billing office to validate the coding changes for accurate billing purposes.

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

d. If the physician or APP does not update the medical record documentation to reflect coding changes, this query must be maintained as a permanent part of the medical record to support the final code assignments.

e. The health care provider can correct, change or add information directly onto the encounter form as long as the correction, change or addition is authenticated by the provider and is supported in the medical record documentation.

3. **Medical Practice Approval Process**

   It is required that the Regional Practice Manager or Business Office Manager ensure that any query form has been officially approved by the health care provider and any facility to be included as a permanent part of the medical record.

   a. Preprinted query forms should include a statement that the form will be filed as a permanent part of the medical record if the physician or APP uses it to add an addendum or make a coding change that is not reflected in the body of the medical record.

   b. Follow the process outlined in the medical practice policy for adding forms to the medical record.

   c. If an entity is affiliated with a hospital or clinic, follow the facility by-laws and rules for adding new forms to the medical record.

   All health care providers should be aware of the importance of concurrent documentation within the body of the medical record to support complete, accurate and consistent coding.

4. **Communication**

   Communication should be provided to the health care providers that coders, billing office staff or other assigned staff, would query providers when there are questions regarding documentation for code assignment. This query will be documented and will require provider signature.

5. **Process Support**

   Administration and medical staff leadership must support this process to ensure its success.

I. **Computer System Maintenance**

Each entity has responsibility for maintaining and updating the computer system on an annual basis to include new, revised and/or deleted codes.

DEFINITIONS:

Advanced Practice Professional (APP): 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.

Ambulatory Surgical Center (ASC): A distinct legal entity which operates exclusively for the purposes of furnishing outpatient surgical services to patients. An ASC is either independent (i.e., not part of a provider of services or any other facility) or owned or controlled by a hospital (i.e., under the common ownership, licensure or control of a hospital). This policy and other REGS.OSG policies will apply to the former type. ASCs owned or controlled by a hospital provider and which are paid by CMS under Ambulatory Payment Classifications (APCs) are to follow the REGS.COD series of policies.

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). Note: CPT is considered HCPCS Level I in the Healthcare Common Procedure Coding System.

Cooperating Parties: The cooperating parties consist of Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), American Health Information Management Association (AHIMA) and National Center for Health Statistics (NCHS).

DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Coding and Documentation for Non-Hospital Entities
PAGE: Page 10 of 11	**REPLACES POLICY DATED:** 10/1/99, 9/1/02, 6/1/03 (HIM.PHY.001), 3/1/06 (GOS.OSG.001), 3/6/06, 10/1/10, 10/1/15, 2/1/17, 12/1/20
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Evaluation and Management Codes: Each healthcare provider providing evaluation and management services must adhere to the Evaluation and Management (E/M) guidelines published by CMS and the AMA.

Freestanding Outpatient Center: An entity that provides outpatient tests/services that is not a department or remote location of a hospital, satellite facility or provider-based entity. Examples include Independent Diagnostic Testing Facility (IDTF) and Ambulatory Surgery Center.

Independent Diagnostic Testing Facility: A facility that is not a physician's office or hospital which performs only diagnostic testing and may be a fixed location or a mobile unit.

Health Care Provider: The term Health Care Provider, for the purpose of this policy, includes physicians and APPs.

Medical Record: The medical record today is a compilation of pertinent facts of a patient's life and health history, including past and present illness and treatment, written by the health professionals contributing to that patient's care. The medical record must be compiled in a timely manner and contain sufficient data to identify the patient, support the diagnosis or reason for health care encounter, justify the treatment, and accurately document the results. *Health Information Management, Huffman, 10th Edition.*

Modifiers: Modifiers are two digits (alpha and/or numeric) used to identify circumstances that alter or enhance the description of a service or supply. There are two levels of modifiers. Level I (CPT) modifiers are two digit numeric or alphanumeric (e.g., -25 – significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) published by the American Medical Association in the CPT book. Level II (HCPCS II) are national modifiers, which consist of two digit alpha and alphanumeric digits (A1-VP) and are updated annually by CMS.

Physicians at Teaching Hospitals (PATH): According to Chapter 12, Section 100 of the Medicare Claims Processing Manual, a teaching physician is a physician (other than another resident) who involves residents in the care of his or her patients. The teaching physician practices at a teaching hospital which is a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

REFERENCES:

1. 2021 CPT® Evaluation and Management Code and Guideline Changes (Office or Other Outpatient and Prolonged Services – Developed by the AMA.
2. 2023 CPT® Evaluation and Management (E/M) Code and Guideline Changes – Developed by the AMA.
3. Evaluation and Management Services Guide (Medicare MLN006764)

4. CPT® – Current Procedural Terminology, published by the AMA, used for reporting healthcare services in a numeric format.
5. CPT® Assistant – Procedural coding guidelines published by the AMA as a supplement to the CPT code book, published monthly**.**
6. HCPCS Level II – Healthcare Common Procedure Coding System is a national coding system of codes that consist of a single alpha letter (A through V) with the exception of S followed by four numeric digits. This coding system was initially developed to report medical services and supplies not found in CPT to Medicare and Medicaid patients.
7. Category III Codes – A temporary set of codes for emerging technologies, services, procedures, and service paradigms. If a Category III code is available, this code must be reported instead of a Category I unlisted code.
8. ICD-10-CM Official Guidelines for Coding and Reporting – International Classification of Disease, Tenth Revision, Clinical Modification used for reporting diagnoses, symptoms, status or other reason for a health care encounter in a numeric and/or alphanumeric format.
9. ICD-10-CM AHA Coding Clinic – Diagnosis coding guidelines published quarterly by the AHA.
10. Medicare Publication 100-04 Claims Processing Manual – A manual available to Medicare providers and contractors. It contains instructions for processing and payment of Medicare claims, preparing reimbursement forms, billing procedures, and Medicare regulations. As processes and regulations change, CMS issues revisions to the manual. Each entity is responsible for maintaining access to a current copy of the Medicare Claims Processing Manual.
11. National Correct Coding Initiative (NCCI) – CMS developed the NCCI program to promote national correct coding of Medicare Part B claims. CMS owns the NCCI program and is responsible for all decisions regarding its contents. Edits are updated quarterly and the manual is updated annually.