EPIC MANAGEMENT, L.P.
BEAVER MEDICAL GROUP, L.P.
EPIC HEALTH PLAN

ADMINISTRATIVE POLICY AND PROCEDURE
COMPLIANCE

SUBJECT: Documentation, Coding, and Billing Compliance	
DRAFTED BY: Sherry Miller, CCO	**DATE:** 8/17/2020
REVIEWED BY:	**DATE:**
REVISED BY:	**DATE:**
APPROVED BY: Compliance Committee	**DATE:** 8/17/2020
BOARD APPROVAL DATE: N/A	
EFFECTIVE DATE OF POLICY: 9/1/2020	

1. **PURPOSE:** This EPIC Documentation, Coding, and Billing Compliance Policy sets forth EPIC's requirements for ensuring the accuracy, integrity, quality, and consistency of coding practices and that code assignments are supported by the documentation within the body of the medical record.**ATTACHMENTS:** N/A. **DEFINITIONS:**

   a. All capitalized terms used but not defined in this Policy shall have the meaning attributed to them in the EPIC Compliance Program Definitions Policy.

   b. In addition, the following capitalized terms shall have the following meanings for purposes of this Policy:

      i. "Coding Staff" refers to Personnel in EPIC's PFS Department who are certified coding specialists (as further described in this Policy), who perform medical coding and billing for professional services furnished to EPIC patients by physicians and other applicable health care professionals.

      ii. "Coding Guidelines" refers broadly to the following sources of potentially applicable authorities, among others:

         (1) CPT coding guidelines published in the current edition of the CPT manual maintained by the American Medical Association and/or its monthly publication, CPT® Assistant;

(2) HCPCS coding guidances and instructions promulgated by CMS;

(3) National Correct Coding Initiative (NCCI) Policy Manual published by CMS;

(4) Coding guidance for anesthesia services published and maintained by the American Society of Anesthesiologists;

(5) ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, as adopted by CMS;

(6) AHA Coding Clinic® for ICD-10-CM and ICD-10-PCS, a quarterly publication of the American Hospital Association; and/or

(7) Applicable payor-specific coding instructions pertaining to a given patient, plan, item, or service.

iii. "CPOE" refers broadly to computerized provider order entry platforms and processes, pursuant to which physicians and Advanced Practice Practitioners enter orders and related clinical documentation and treatment instructions into a patient's electronic medical record.

iv. "CPT" refers to the Current Procedural Terminology (CPT®) medical coding system developed and maintained by the American Medical Association.

v. "Encounter Form" refers to an itemized invoice submitted by a physician or Advanced Practice Practitioner to the Coding Staff, to provide necessary information about a given patient encounter for coding and/or billing purposes when the encounter at issue has not been documented in an electronic medical record.

vi. "ICD" refers collectively to the International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10-CM") diagnosis coding system, and the International Classification of Diseases, Tenth Revision, Procedure Coding System ("ICD-10-PCS") for coding of inpatient procedures, each of which is developed and maintained by the U.S. Department of Health & Human Services.

vii. "HCPCS" refers to the Healthcare Common Procedural Coding System developed and maintained by the Centers

for Medicare & Medicaid Services, within the U.S. Department of Health & Human Services.

viii. "Medical Code(s)" refers individually and collectively to the applicable CPT, HCPCS, and/or ICD codes pertaining to a given item, service, or patient encounter.

ix. "Medical Necessity" and "Medically Necessary" refer to health care items and services that, in the independent, good faith medical judgment of the physician or other qualified treating practitioner, are reasonable and necessary for the diagnosis or treatment of a patient's medical condition, illness, injury, or disease, and/or its symptoms, and that meet accepted standards of medical practice in EPIC's locality.

x. "PFS Department" refers to EPIC's Patient Financial Services Department.

4. **POLICY:** Personnel may only code professional services claims or encounters in a manner that accurately and reliably reflects the services provided and fully documented within the patient medical record. EPIC follows applicable Federal Health Care Program and other payor-specific rules and requirements pertaining to medical procedure and diagnosis coding and billing for professional services of physicians and other applicable health care professionals. This Policy applies to all professional services provided or billed by Personnel, including but not limited to professional services furnished in connection with inpatient, outpatient, physician office, and/or skilled nursing facility care, and ancillary services.

5. PROCEDURE:

a. Medical Record Documentation

i. Medical record documentation of professional services must communicate complete patient care information in a clear and effective format.

ii. Medical record documentation maintained with respect to each patient encounter must include the following elements, as appropriate to the applicable patient and service:

(1) Identification of the patient;

(2) Medical history of the patient;

(3) Report of relevant physical examination;

(4) Orders for applicable diagnostic and therapeutic services;

(5) Evidence of appropriate informed consent;

(6) Clinical observations, including the results of therapy, as appropriate;

(7) Reports and results of any procedures and tests;

(8) Conclusions at termination of hospitalization, evaluation, or treatment; and

(9) Condition of the patient upon discharge, including instructions given to the patient and/or family.

iii. All medical records must, at a minimum:

(1) Record the date for each medical record entry/notation and for the applicable patient encounter;

(2) Contain the author's handwritten or electronic signature on all notations;

(3) Be legible to someone other than the author;

(4) Be accurate and concise;

(5) Utilize only standard and other organization-approved abbreviations;

(6) Record incidents requiring specific follow-up, including a timeframe for each follow-up action;

(7) Record all unusual events;

(8) Include error corrections that are (for paper charts) identified only by one single line drawn through erroneous statements (i.e., no erasures, blacked-out text, or correction fluid), which strikeout and correction must be dated and signed by the entering person; and

(9) Include all necessary attestations and/or addenda (signed and dated) to supplement or otherwise correct any omissions or inaccuracies in prior entries.

iv. Items and services should be completely, accurately, and consistently documented in the medical record concurrently

with the item and/or service provided, or as soon afterwards as is practicable, and should be authenticated within forty-eight (48) hours following the applicable patient encounter.

b. **Coding and Billing**

i. Once the physician or Advanced Practice Practitioner has fully documented applicable items and services furnished during a patient encounter, the encounter is submitted (either electronically or via an Encounter Form) to the Coding Staff for coding and claims processing.

(1) Documentation of items and services must be complete and authenticated prior to submission of an encounter for claims processing.

ii. All claims for professional services must be coded utilizing the appropriate recognized coding conventions and applicable Coding Guidelines with respect to CPT, HCPCS, and/or ICD coding systems.

(1) Physicians and Advanced Practice Practitioners are responsible for selection and assignment of CPT codes for evaluation and management (E/M) services furnished to patients, which codes are subject to limited review by the Coding Staff.

(2) Physicians and Advanced Practice Practitioners utilizing an electronic medical record are responsible for selection and assignment of additional billable Medical Codes for a given patient encounter, which code assignments undergo a second-level quality review by the Coding Staff prior to claim submission.

(3) For items and services furnished by a physician or Advanced Practice Practitioner that are not documented in an electronic medical record, for which the physician or Advanced Practice Practitioner submits an Encounter Form, the Coding Staff validates and/or selects and assigns appropriate Medical Codes, consistent with information and documentation in the medical record.

iii. Incorrect, incomplete, or illegible medical record documentation or CPOE/charge capture documents provided to the Coding Staff in connection with an encounter that has been submitted for claims processing may be returned to the applicable physician or Advanced Practice

Practitioner for correction, annotation, and/or supplementation, so that timely and accurate coding and claims filing or encounter data submission can be completed.

(1) Similarly, if conflicting or ambiguous documentation is present in the medical record that prevents definitive assignment of Medical Codes, the Coding Staff shall follow up with the applicable physician or Advanced Practice Practitioner for clarification, correction, or supplementation of the medical record prior to billing.

iv. All billed claims shall be supported by sufficient documentation that clearly demonstrates:

(1) The billed items and services were Medically Necessary;

(2) Items and services were provided in accordance with properly approved protocols and/or pursuant to order(s) of the patient's physician(s) or Advanced Practice Practitioner(s), as appropriate; and

(3) The level of services coded and submitted to the patient or third-party payor for payment aligns with the services rendered during the applicable encounter.

v. Medical Codes and applicable billing modifiers, if any, must be faithfully and correctly submitted for payment in an unbiased and ethical manner, based on available documentation in the medical record for Medically Necessary items and services, and shall not be misrepresented in any way in order to achieve coverage and payment, or to avoid a payor edit, rejection, or denial.

c. **Coder Qualifications and Arrangements**

i. Each member of the Coding Staff shall:

(1) Possess, at all times, one or more of the following current and valid professional coding certifications from the American Academy of Professional Coders ("AAPC") or the American Health Information Management Association ("AHIMA"), as applicable:

(a) Certified Professional Coder ("CPC");

(b) Certified Outpatient Coder ("COC");

(c) Certified Coding Specialist (“CCS”);

(d) Registered Health Information Technician (“RHIT”); and/or

(e) Certified Coding Specialist – Physician-based (“CCS-P”).

(2) Receive the required continuing coding education each calendar year to maintain their certification;

(3) Attend initial orientation training and all compliance trainings provided and/or required by the Corporate Compliance Officer (or their designee) on coding-related compliance topics; and

(4) Be subject to periodic validation reviews including a sufficient number and type of charts to determine the quality of their coding, in accordance with the PFS Department’s standard operating procedures. The PFS Department shall report findings from these periodic validation reviews to the Corporate Compliance Officer (or their designee).

ii. No Coding Staff or other subcontracted third-party billing or coding entity shall be compensated on a contingency or percentage-of-collections basis. Such arrangements may not be entered into.

iii. Subcontractors engaged to perform billing or coding services are required to have effective compliance programs and codes of conduct, and must demonstrate the necessary skills, quality control processes, systems, and appropriate procedures to ensure that all billings for Federal Health Care Program and commercial insurance programs are accurate and complete.

(1) Note. All such third-party billing or coding entities, contractors, subcontractors, and/or preferred vendors must be approved in advance in writing by the Corporate Compliance Officer.

d. **Coding Validation and Correction**

i. Coding and billing accuracy shall be periodically validated and corrected, as necessary, in accordance with the following additional EPIC Compliance Program Policies, as applicable:

(1) Procedure Code Reviews and Corrective Actions;

(2) Risk Adjustment Internal Validations and Reviews; and

(3) Risk Adjustment HCC Diagnosis Code Follow-Up Review and Deletion.