1. PURPOSE

1.1. Conscientious goals for accurate coding and documentation are critical to health of business. As such, the following standards are intended to support compliant documentation and coding.

2. SCOPE

2.1. This standard is applicable to all Associates of Catalyst Health Group and subsidiaries. For purposes of this standard, this Policy shall collectively refer to this group as "Catalyst Associates."

2.2. Intended for all employees (office-based and remote workers), contractors, consultants, BPO (business process outsourcing), third parties, and others affiliated with Catalyst Health Group.

3. ACRONYMS AND DEFINITIONS

3.1. Acronyms and definitions found in all policies are listed in *CHG-102 Acronyms and Definitions.*

4. ATTACHMENTS

4.1. Not Applicable

5. REFERENCES

5.1. American Health Information Management Association Standards of Ethical Coding {2016 Version}

5.2. AHIMA House of Delegates. "American Health Information Management Association Standards of Ethical Coding [2016 version]" (AHIMA, December 2016)

5.3. Complying with Medical Record Documentation Requirements CMS MLN909160 March 2024 (Services, 2024)

5.4. Documentation Guidelines for Evaluation and Management (E/M) Services: Reminders and Updates, CGS April 9, 2024, (A/B, 2024)

5.5. Complying with Medicare Signature Requirements MLN905364 April 2024 (CMS, 2024)

5.6. Proper use of Modifier 59, E, XP, XS & XU CMS MLN1783722 February 2024

5.7. Evaluation and Management Services Guide CMS MLN006764 August 2024

6. PROCEDURE

6.1. Revenue Cycle Coding and Billing Specialist

6.1.1. Coding and Billing Specialist will support the importance of accurate, complete, and consistent coding practices to produce quality healthcare data.

6.1.2. Coding and Billing Specialist will adhere to the ICD-10-CM (International

Classification of Diseases, 10th revision, Clinical Modification) coding conventions, official coding standards, the CPT (Current Procedural Terminology) rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets.

6.1.3. Coding and Billing Specialist will use their skills, their knowledge of the currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes and modifiers for claims that fail to pass internal and external claim review systems.

6.1.4. Coding and Billing Specialist will only assign and report codes that are clearly and consistently supported by documentation in the health record.

6.1.5. Coding and Billing Specialist will consult dictating provider for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.

6.1.6. Coding and Billing Specialist will not change codes or the narratives of codes so that the meanings are misrepresented.

6.1.7. Coding and Billing Specialist, as members of the healthcare team, will assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity and the occurrence of events.

6.1.8. If requested, Coding and Billing Specialist may provide counsel in the development of facility coding policies to ensure that coding policies complement, not conflict with, official coding rules and guidelines.

6.1.9. Coding and Billing Specialist will maintain and continually enhance their coding skills, as they have a responsibility to stay abreast of changes in codes, coding guidelines, and regulations.

6.1.10. Coding and Billing Specialist will strive for the optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines

6.2. Clinical and Administrative Support Staff

6.2.1. Procedure and diagnosis codes are assigned by the clinic staff during the documentation process at the time service is rendered.

6.2.2. Documentation and coding should be performed daily, 80% completion on the same day and 100% within three business days of the rendered service.

6.2.3. Diagnosis coding is performed, determining relativity to procedures performed/coded and ascertaining that the code has been carried to the highest level of specificity.

6.2.4. Documentation should be specific to the patient and the situation at the time of

the encounter. This includes the patient's name, date of birth, and conditions.

6.2.5. Documentation should accurately reflect the services performed and coded. Documentation must support the necessity for those services. This includes symptoms, physical findings, diagnostic test results, and how the disease affects the patient's daily activities and health.

6.2.6. Clinical staff should provide a clear rationale for the chosen treatment or service, explaining why it's necessary for the patient's care and how it meets medical necessity criteria.

6.2.7. Documentation should clearly identify who performed the services and assessments, the author of each note or entry, and the date and time the entry was made. The provider's signature, credentials, and date must be legible to someone other than the writer.

6.2.8. Delayed entries may be acceptable within a reasonable time frame (80% completed same day and 100% completion with in three business days) for clarification, error correction, or if unusual circumstances prevented the note from being generated at the time of service.

6.3. Evaluation and Management

6.3.1. Documentation must include clearly defined chief complaints or reason for visits.

6.3.1.1. Coding based on medical decision-making should:

6.3.1.1.1. Include an assessment with a clear description of all problems managed, evaluated and/or treated on the date of service, as well as the severity and acuity of those problems.

6.3.1.1.2. Include the "status" of chronic conditions using terms like stable, unstable, exacerbated, etc. Include notes on the chronicity for conditions that are not inherently chronic.

6.3.1.1.3. A description of the data ordered, reviewed or interpreted plus any relevant analysis.

6.3.1.1.3.1. Include the source and speciality of any material received for review.

6.3.1.1.3.2. Include the name and relationship for independent historians that provide history on behalf of the patient.

6.3.1.1.4. Documentation of any interpretation of data that occurred during the evaluation including who provided the interpretation.

6.3.1.1.5. A clear plan for each problem being managed. Or possible management options that were considered but ruled out. All considerations that impact the level of medical decision making.

6.3.1.1.6. The number and complexity of problems addressed listed individually.

6.3.1.1.7. Any discussions with external party including the specialty of the external party and how the discussion played a role in decision making.

6.3.1.1.8. Risk factors and their severity.

6.3.1.1.9. Prescriptions and over the counter medications that impact the outcome or decision making.

6.3.1.1.10. Any diagnosis or treatment significantly limited by social determinants of health must indicate how.

6.3.1.2. Coding based on time should include:

6.3.1.2.1. Documentation of the exact and total time spent by the provider or other qualified health care professional on the date of the encounter. Including both face to face and non-face to face time.

6.3.1.2.1.1. Including time spent preparing to see the patient, revising the history, preforming the examination, counselling or educating patient/ family or caregiver, ordering medications, test or procedures, referring and communicating with other health care professionals, documenting clinical information int eh electronic record, communicating or interpreting results not separately reported and care coordination.

6.3.1.3. Preventive Annual and Physical documentation must include:

6.3.1.3.1.1. Comprehensive, age and gender appropriate history and exam, counselling/anticipatory guidance, risk factor reduction, laboratory and diagnostic procedures in asymptomatic individuals and performed in the absence of patient complaints

6.3.1.3.1.2. Be focused on checking current overall health and a patient's ability to adhere to recommendations based on social determinants.

6.3.1.3.1.3. Risk factor reduction documentation should include but is not limited to recommended lifestyle changes, preventive care plan and community-based interventions taking into consideration the patients' social determinants.

6.3.1.3.1.4. Anticipatory guidance documentation should include disease prevention and developmental guidance tailored to the patients age and gender.

6.3.1.3.1.5. Comprehensive Physical Exam

6.3.1.3.1.6. Should include bloodwork and other screening test that may occur.

6.3.1.3.1.7. Immunizations if they occur.

6.3.1.4. Separately Reported Services

6.3.1.4.1. Documentation for separately reported services must include:

6.3.1.4.1.1. Indication that the conditions treated required a significantly

separate identifiable evaluation and management service.

6.3.1.4.1.2. A modifier 25 must be utilized to identify the separate evaluation and management.

6.3.1.4.1.3. A modifier 25 must be used when annual wellness exam is performed with evaluation and management the modifier 25 must be appended to the evaluation and management code.

6.3.1.4.1.4. A modifier 25 must be used when evaluation and management and annual wellness visits are performed with vaccine or drug administrations. The modifier must be appended to the evaluation and management and the annual wellness code.

6.3.1.4.1.5. A modifier 25 cannot be used to elicit payment when the separately identifiable service is not clearly documented in the notes.

6.3.1.4.1.6. Procedures billed requiring a modifier 25 without proper documentation must be returned to the documenting physician for correction.

6.3.1.5. Distinct Procedural Service modifier 59

6.3.1.5.1. Is used to identify procedures or services that are not usually reported together but are appropriate in certain circumstances.

6.3.1.5.2. May not be used unless the documentation of the distinct procedural service include notes about separate incision/excision, separate lesions, separate injury.

6.4. Coding Disputes

6.4.1. All coding related disputes should be routed to the Revenue Cycle Coding team for review by a certified coder. Any recommendations on coding will be routed back to the rendering provider for review.

6.4.2. We do not routinely or systematically up code or downcode medical services at the patients request without a review of the documentation by the certified medical coding team.

6.5. All Catalyst Health Group associates are required to maintain in compliance with the laws and regulations

6.5.1. Violations of this policy may result in disciplinary action in accordance with the Employee Handbook.

7. REVISION HISTORY

Document Number	Document Title	Version Number	Date of Revision	Description of Change
CHG-509	**Documentation and Coding Standards**	1.0	N/A	N/A Initial

CHG-509	**Documentation and Coding Standards**	2.0	10/16/2025	Added 6.4. Updated 8.0, 9.1

8. AUTHOR OF CURRENT VERSION

Name	Title. Department	Signature and Date
Sara Brown	Senior Director Revenue Cycle	Signed by: B5CAF9DC5992484... 10/16/2025

9. APPROVALS

9.1 Department Approval

Name	Title. Department	Signature and Date
Kathy Rismiller	Chief Financial Officer	Signed by: Kathy Rismiller 08EE7636E2AC43B... 10/16/2025