Hospital Auditing Now and with ICD-10

HCCA Regional Conference
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Speaker

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    • Regional Managing Director HIM
    • Revenue Cycle, Kaiser Foundation Health Plan
      – Oakland, CA
  – The opinions and comments expressed during this presentation are those of the speaker and not of Kaiser Permanente.
Disclaimer

• This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner.
• The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
• Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.
• Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

Goals and Objectives

• Review the importance of coding audits
• Discuss coding risk areas
• Share auditing and reporting processes
• Understand Auditing Considerations with ICD-10
• Action Steps to take
• Questions/Answers
Healthcare Compliance

• Be “Proactive”
• Seven Basics:
  – Written policies and procedures
  – Compliance professionals (i.e. officer, compliance committee)
  – Effective education and training
  – Effective communication (incl. hot line)
  – Internal auditing & monitoring
  – Enforce your standards
  – Respond to issues

Compliance Definitions

• Abuse- actions resulting in unnecessary costs, services that fail to meet standards, medically unnecessary.
• Fraud- knowingly and willingly executing a scheme to obtain money from a health care program.
• Waste- over utilization or other practices that result in unnecessary costs, misuse of resources.
And the Golden rule ...

• “If it’s not documented by the physician/provider, it didn’t happen.”

— Before MS-DRGs and after ... In compliance and in coding, there is no deviation from this principle. We can’t code it if it isn’t documented, and we can’t bill for it.

AHIMA and AAPC Standards of Ethical Coding

• Following a standard for ethical coding
  — Demonstrates coding professionals’ commitment to integrity during the coding process, regardless of the purpose for which codes are being reported
AHIMA Ethical Coding

Coding professionals should:

1. Apply accurate, complete, and consistent coding practices for the production of high-quality healthcare data.
2. Report all healthcare data elements (e.g., diagnosis and procedure codes, present on admission indicators, discharge status) required for external reporting purposes (e.g., reimbursement and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.
3. Assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines.
4. Query providers (physicians or other qualified healthcare practitioners) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator).
5. Refuse to change reported codes or the narratives of codes so that meanings are misrepresented.
6. Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.
7. Facilitate interdisciplinary collaboration in situations supporting proper coding practices.
8. Advance coding knowledge and practice through continuing education.
9. Refuse to participate in or perform unethical coding or abstraction practices or procedures.
10. Protect the confidentiality of the health record at all times and refuse to access protected health information not required for coding-related activities (examples of coding-related activities include completion of code assignment, other health record data abstraction, coding audits, and educational purposes).
11. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

Auditing Basics

- Coding is one of the core ambulatory setting and HIM hospital/facility functions
- Complex regulatory requirements affect the health information coding process
- Coding professionals are frequently faced with ethical challenges
- Auditing is an important function
Auditors Need to be Qualified

- Be sure those who perform coding audits are qualified
- Ask for resumes of the auditors
- Make sure the credential fits the setting of the audit: hospital CCS

Inpatient Targets

- RAC, MACs, CERT, etc
- MS-DRG’s
  - Coding Dx and Procedures
  - POA
  - HACs
- One and two day stays
- Medical Necessity
  - Ensure that the diagnosis and that patient status/treatment are fully supported and delineated.
- Discharge Disposition (or PACT)
Audit and Profile Your Data

- **Inpatient Case Mix Questions to Ask:**
  - How do you compare with other hospitals in your geographic area?
  - Knowing the services you provide, are you where you think you should be?
  - Complication and comorbidity (CC)
  - Do the CC rates appear overly aggressive compared with other hospitals in your geographic area?
  - Do the CC rates suggest a potential for improved reimbursement through more accurate and complete coding?
  - DRG Pairs
  - Compared with MEDPAR data, how do you compare to national numbers?
  - What are the variance rates?

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**RAC Stats April through June 2012**

<table>
<thead>
<tr>
<th>Medicare Fee for Service National Recovery Audit Program</th>
<th>Region A: DCS (Diversified Collection Sves)</th>
<th>Region B: CGI (CGI Federal)</th>
<th>Region C: Connolly</th>
<th>Region D: HDI (Health Data Insights)</th>
<th>Nationwide Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overpayments Collected</td>
<td>$133.7</td>
<td>$90.9</td>
<td>$223.8</td>
<td>$208.8</td>
<td>$657.2</td>
</tr>
<tr>
<td>Underpayments Returned</td>
<td>$22.3</td>
<td>$3.8</td>
<td>$5.3</td>
<td>$12.7</td>
<td>$44.1</td>
</tr>
<tr>
<td>Total Quarter Corrections</td>
<td>$156.0</td>
<td>$94.7</td>
<td>$229.1</td>
<td>$221.5</td>
<td>$701.3</td>
</tr>
<tr>
<td>FY to Date Corrections</td>
<td>$357.6</td>
<td>$232.5</td>
<td>$575.2</td>
<td>$611.6</td>
<td>$1,776.9</td>
</tr>
</tbody>
</table>

(Figures provided in millions)
Medicare Fee for Service National Recovery Audit program
Top Issues Per Region
Based on collected amounts through June 30, 2012

<table>
<thead>
<tr>
<th>Region</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td><strong>Cardiovascular Procedures</strong>: (Medical necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.</td>
</tr>
<tr>
<td>Region B</td>
<td><strong>Cardiovascular Procedures</strong>: (Medical necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.</td>
</tr>
<tr>
<td>Region C</td>
<td><strong>Cardiovascular Procedures</strong>: (Medical necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.</td>
</tr>
<tr>
<td>Region D</td>
<td><strong>Minor Surgery &amp; other treatment billed as Inpatient</strong>: (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.</td>
</tr>
</tbody>
</table>

RAC Recovery through August 2012

<table>
<thead>
<tr>
<th>Recovery Audit National Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 2010</strong></td>
</tr>
<tr>
<td>Overpayments Collected</td>
</tr>
<tr>
<td>Underpayments Returned</td>
</tr>
<tr>
<td>Total Corrections</td>
</tr>
</tbody>
</table>
MS-DRGs for Review

- January 1: MS-DRG 312 SYNCOPE & COLLAPSE
- March 1: MS-DRG 069 TRANSIENT ISCHEMIA
  MS-DRG 377 G.I. HEMMORHAGE W MCC
- May 1: MS-DRG 378 G.I. HEMORRHAGE W CC
  MS-DRG 379 G.I. HEMORRHAGE W/O CC/MCC
- July 1: MS-DRG 637 DIABETES W MCC
  MS-DRG 638 DIABETES W CC
  MS-DRG 639 DIABETES W/O CC/MCC

October 2011: Volume 2, Issue 1

RAC auditing finding

- Validation of MS-DRG with ventilator support of 96 or more hours
  – Also on 2013 OIG Work plan
  – Run a report with vent procedure code

- Improper coding:
  – MS-DRG 853, 231, 233, 235, 100, 101, 840
Medical Necessity Target Example

Audit Transient ischemia attack (TIA)

What proportion of TIA (MS-DRG 69) claims are being billed at an inpatient level of care that can be treated in a lesser setting (e.g., as outpatient observation)?

MS-DRG 069

MS-DRGs 061 - 069

Data Comparison

• Summary of an organization's paid Medicare claims for each target:
  – The volume of discharges
  – The percentage of cases based on target definition
  – How each target ranks by percentile compared to other organizations
  – Associated total value of paid claims (sum of payments)
Key Targets for Particular Areas

• Utilization review
  – One-day stay MS-DRG targets
    • Any part of an inpatient stay that occurs before midnight is counted as one day
  – Two-day stay MS-DRG targets
    • These are new targets as many organizations are slow at discharging patients extending their stay beyond one day without significantly changing the treatment plan or demonstrating the initial acuity of the patient

Physician Query & CDI

• Providers should be queried whenever there is conflicting, ambiguous, or incomplete information in the health record regarding any significant reportable condition or procedure.

• An inappropriate query— such as a form that is poorly constructed or asks leading questions -- or overuse of the query process can result in quality-of-care, legal, ethical and compliance concerns.
Physician query/clarification forms

- Queries should improve documentation of unique clinical situations and provide assurance that if codes are assigned, the documentation in the record supports them
- Excessive use of queries may indicate trends of poor documentation that should be addressed
- The query can list “all clinically reasonable choices regardless of the impact on reimbursement or quality reporting” and give physicians a space to write “other” or “unable to determine.” (AHIMA 3/2010)

AHIMA Guidance

- A Practice Brief on physician query forms titled “Developing a Physician Query Process” was published in the October 2001 Journal of the American Health Information Management Association (AHIMA). – industry standard
- October 2008—AHIMA “Managing an Effective Query Process” – industry standard
  – Note: This practice brief updates the 2001 practice brief “Developing a Physician Query Process,” with a continued focus on compliance.
Clinical Documentation Improvement

• A process whereby clarification is obtained for incomplete, conflicting, contrasting or missing clinical documentation.
• Traditionally achieved through the HIM Coding query process, which is at the time of coding or after discharge, this is also CDI.
• Now the main stream approach is “Concurrent” CDI work, while the patient is still in the hospital
• Other settings? Sure SNF, Rehab, etc. and for Medicare Part C ... HCCs

Tracking your CDI physician querying concurrent, prebill or retro

• Track query usage by physician, positive/negative responses, diagnoses or MS-DRG, etc., for trends.
• Review queries for content and appropriateness in terms of the medical record documentation.
• Identify problematic questions or otherwise poorly constructed queries. Also, review for legibility.
• Follow up on trends by determining the cause and addressing it through improvement and/or education.
Audit CC/MCC Capture

• Although CDI departments are about more than the money, the CC/MCC capture rates also reflect severity (Medicare severity diagnosis-related groups = MS-DRG), so monitoring the CC/MCC capture trends can demonstrate the positive impact of CDI or the impact of a process change, as well as provide an opportunity for improvement if the trend turns negative.

Compliance

• “Always review all payers so you can see how patients stack up against national payers. IF you’re only looking at Medicare, you skew your data.”

• Walter A. Wade, Esq
Bayview settles claims case for $2.75 million

By Tricia Bishop
Baltimore Sun reporter
July 1, 2009

Johns Hopkins Bayview Medical Center Inc. has agreed to pay $2.75 million to settle allegations that it filed false claims to federal health benefits programs for nearly two years, the U.S. attorney for Maryland announced Tuesday.

From July 2005 though February 2007, Bayview employees claimed that patients were treated for secondary diagnoses:

Essentials of Hopkins Case

- Bayview employees were assigned to work in the coding department to assist in clinical documentation.
- They reviewed charts relating to inpatient hospital stays to determine if there was any way for the hospital to increase reimbursement by increasing the severity of the secondary diagnoses recorded for certain patients.
- The employees allegedly focused on lab test results which might indicate the presence of a complicating secondary diagnosis such as malnutrition or respiratory failure, and advised treating doctors to include such a diagnosis in the medical record, even if the condition was not actually diagnosed or treated during the hospital stay, in violation of billing rules adopted by federal health benefit programs.

Source: Department of Justice
Audit CDI & Query Process

- Review the CDI P&P
- Query P&P
- Review forms used
- Review educational materials
- Leading vs nonleading
- Verbal or written
- retrievable or in the medical record
- Tracking CDI results?
- Risk areas: Sepsis, Malnutrition, Respiratory Failure, Renal Failure

Audit 3-Day Window Rule

- Outpatient to inpatient
- Three-day rule defines certain preadmission services as inpatient operating costs, meaning they are bundled and billed as part of the inpatient claim and payment is made as part of the applicable DRG payment for the case.
- Whether an outpatient service is subject to bundling to the inpatient admission is dependent on three things:
  - The relationship of the inpatient and outpatient provider
  - The nature of the service: diagnostic or nondiagnostic
  - The date the outpatient service was rendered
3-Day Window Rule (con’t)

• The rule a three-day rule.
• Wholly owned means the hospital is the sole owner. Wholly operated means the hospital has exclusive responsibility for conducting and overseeing the entity’s operations.
• Note that the hospital does not need to have sole policy-making authority over that entity; it simply has to be responsible for conducting the everyday operations of the facility.

3-Day Window Rule (con’t)

• The payment window is applied differently to diagnostic and nondiagnostic services. Diagnostic services are defined by revenue code and in some cases HCPCS Code.
• CMS publishes a list of these codes in the Claims Processing Manual.
• Services subject to the payment window:
  – All **diagnostic** services on the day of and three days before admission
  – All **nondiagnostic** services on the day of admission
  – Related **nondiagnostic** services three days before admission
3-Day Window Rule (con’t)

• The hospital and hospital units subject to the 1-day payment window policy (instead of the 3-day payment window) are psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children’s hospitals and cancer hospitals.

• Condition code 51 is only used by the hospital when they bill separately for unrelated outpatient non-diagnostic service claims. The modifier PD would not be appended to an unrelated non-diagnostic service furnished in a wholly owned or wholly operated physician practice (or other Part B entity). The absence of the modifier PD would serve as the attestation that the hospital that wholly owns or wholly operates the physician practice believes that the non-diagnostic service was unrelated to the hospital admission.

3-Day Window Audit and Establish Processes

• Run a report using medical record #, list encounters and IP admissions
• Identify those within three days of the admission
• Audit to see if the account should be combined
  – Not the medical record
• Check your “systems” to see if they are combining accounts automatically
PACT Rule

• PACT stands for Post Acute Care Transfer rule……we often refer to is as Discharge Disposition or patient status.

Post Acute Care

• The PACT payment policy was based on the belief that it was inappropriate to pay the sending (transferring) hospital the full MS-DRG payment for less than the full course of treatment.
  – Meaning when they are discharged prior to the geometric mean length of stay (GMLOS) being met for the transferring DRG... this is key.
Patient Status Codes

• It is considered to be a post acute transfer when the patient is transferred to one of the following:
  – 03 Skilled nursing facility
  – 05 Another type health care institution not defined elsewhere
  – 06 Home health
    • Within 3 days following discharge
  – 62 Inpatient rehabilitation
    • Includes distinct part unit of a hospital
  – 63 Long term care hospitals
  – 65 Psychiatric hospital
    • Includes distinct part unit of a hospital

RAC FOCUS....

Internal Auditing and Validation is key

• Validation of the patient status is complex but not a complex review, via data mining
• Incorrect patient status code is a compliance issue
  – You are at risk for overpayment
    • PFS services has received take backs from the FI/MAC
  – You are at risk for underpayment
    • We are entitled to appropriate reimbursement based on supporting documentation, nothing more, nothing less
    • RAC is monitoring
      – #1 provider underpayment identified in RAC pilot program in CA and FL
        » $19.6 million
        » 8500 claims
• Audit and Validation is time consuming
Compliance Specifics to Home Health

- Incorrectly reporting the post-acute care discharge as “home” is a compliance risk.
- There is a 3-day window for initiating post-acute care home health services after discharge, that applies and ideally validated before billing.
- A specific billing condition code is required on the billing side (UB-04) which tells the FI (CMS) that the HH was not within the 3-days.

Audit PACT

- Internal or external resources
- Data mining can help
- Common Working File (CWF)
- Home health is problematic
### Outpatient Audits

**Application of Dermabond®**

- After cleaning the wound, the physician or trained healthcare professional applies DERMABOND® in thin layers with a light brushing stroke while holding the edges of the wound together. A strong, flexible bond is created in < 3 minutes.

  - Prior to CY 2006, the tissue adhesive product was reported with HCPCS code G0168, but now it is packaged and Medicare does not generate any separate payment for it
    - Now the cost associated with HCPCS G0168 must be reported by hospitals on outpatient claims in one of two ways:
      - Either by reporting the tissue adhesive as a supply item using a supply revenue code and reporting the dollar charge or
      - By building the cost of the tissue adhesive product by incorporating it into the cost of the procedure charge

### Audit Outpatient:

**CPT Guidelines/Rules**

- As of May 1999, CPT coding instructions state that the codes in the Repair (Closure) section should be used to “designate wound closure utilizing tissue adhesives.”

  - Generally, tissue adhesive closure used alone is considered a "simple" closure technique (CPT codes 12001 – 12021). However, CPT guidelines should still be applied regarding the use of the intermediate repair codes.

  - Single-layer closure of heavily contaminated wounds that have required extensive cleansing or removal of particulate matter constitutes intermediate repair.” (AMA CPT Assistant, May 1999).
### Laceration Repair - Definitions

- **Simple Repair**: is used when the wound is superficial involving the dermis, epidermis or subcutaneous tissue without significant involvement of deeper structures. This is a one layer closure and includes local anesthesia, chemical or electrocauterization of wounds not closed.

- **Intermediate Repair**: involves layered closure of one or more of the deeper layers of the subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single layer closures that require extensive cleaning or debridement prior to closure are also considered intermediate repairs.

- **Complex Repair**: requires more than layered closure. Includes extensive debridement of traumatic lacerations or avulsions; scar revision; extensive undermining, stents or retention sutures. Necessary preparation may include creation of a defect for repairs (scar revision).

### Review:

**CMS Observation**

- CMS said: “We define observation care as an active treatment to determine if a patient’s condition is going to require that he or she be admitted as an inpatient or if the condition resolves itself and the patient is discharged. The currently required diagnostic tests reflect that an active assessment of the patient was being undertaken, and we believe they are generally medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and aid in determining the appropriate disposition of the patient following observation care.”

- In the 2010 OPPS Final Rule, CMS clarified that Observation is a service and not a patient status.

- Observation may be separately payable or packaged depending on whether criteria is met, but in either case, there must be an “order” for observation, documentation, and adherence to all coding and billing rules, just like for all other outpatient therapeutic services.
Observation Services and the News...

- **November 04, 2011: Patients sue over hospital 'observation status':**
  
  *Plaintiffs file first class-action lawsuit challenging the Medicare policy*

- A group of patients filed a lawsuit challenging a Medicare policy that allows hospitals to place patients under "observation status" for days without admitting them.

- Hospitals’ use of observation status has increased from 828,000 claims in 2006 to more than 1.1 million in 2009. CMS data show claims for observation stays greater than 48 hours increased by nearly 300% in this same period.

- The American Hospital Association wrote a letter to CMS last year warning that the agency's policies were driving hospitals to place patients under observation status instead of admitting them.

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Observation Services and the News...

- **Beneficiaries challenge policy:** The Center for Medicare Advocacy (CMA) filed a lawsuit this week in a U.S. district court in Hartford, Conn., against HHS Secretary Kathleen Sebelius on behalf of seven Medicare beneficiaries and their families in Connecticut, Massachusetts, and Texas.

  According to CMA, the observation status policy "is denying thousands of beneficiaries of their Medicare coverage rights, even though they are inpatients in hospitals." The lawsuit notes that observation status is not mentioned CMS statutes, and is "applied in an ad-hoc fashion to Medicare beneficiaries who for all practical purposes are hospital inpatients."

  The lawsuit asks the court to block Sebelius from allowing Medicare outpatient classifications using observation status. According to Stein, Sebelius has the authority to establish Medicare criteria and determine the appropriate use of the designation.
Review of Reporting Observation Time/Hours

- **Observation time...no changes!**
  - Physician order required and clinical criteria must be met for the appropriate level of care
  - Start time begins with the beneficiary's admission to an observation bed
  - Ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient to be released or admitted as an Inpatient
  - If observation spans more than 1 calendar day, all hours of observation must be included on a single line and the date of service for that line is the date that observation care begins.

Review of Reporting Observation Time/Hours (cont)

- **CMS guidance on “counting” time in observation**
  - Hospital Manual Section 290.2.2 - Reporting hours of observation; (Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)
    - Hospitals should round to the nearest hour. For example, a patient who was placed in an observation bed at 3:03 p.m. according to the nurses’ notes and discharged to home at 9:45 p.m. should have a “7” placed in the units field of the reported observation HCPCS code.
    - Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services.
Injection/Infusions... still confusing?

- Include in your OP audits
- Providers must continue to follow CPT guidelines, parenthetical notes, and the hierarchy
- Documentation, charges and coding

EHR Risk

- Areas of EHR risk for coding and documentation:
- Internal vs external auditing and monitoring activities
  - Patient Problem Lists: old information, not current
  - Copy and Paste practices
  - Diagnostic pick lists
  - Physician query process: facility and professional services; clinical documentation improvement queries
  - Documentation to support diagnosis assignment
Comprehensive Error Rate Testing

• The terms “admitting” diagnosis and “principal” diagnosis are not necessarily the same, warns Noridian Administrative Services, LLC., Medicare Administrative Contractor for Jurisdiction F, in a August 17 memo to providers.
• Recent Comprehensive Error Rate Testing (CERT) reports indicate providers are not coding the principal diagnosis and procedure to the highest level or specificity or are not selecting the most appropriate codes for the inpatient service.
• When the inappropriate code is selected auditors may deny the claim or refuse to pay for inpatient care based on the lack of medical necessity.
• “Whenever possible the medical documentation should provide sufficient evidence of the actual underlying cause of the inpatient admission not the just symptoms... Coders should review the complete medical record for the appropriate principal diagnosis, the condition known to have caused the admission once all pertinent diagnostic testing is complete.”

ICD-10 Implementation & Planning

– ICD-10 Coding Assessment and others – PHASE I
– Awareness education for others – PHASE I & II
– ICD-10 Prerequisite Education (Coding Staff) – PHASE II
– ICD-10 Code Set Training & Practice (Coding Staff) – PHASE III
– Go-Live for Coding and All – PHASE IV
– Post Go-Live – PHASE V
Coding Assessment Audit

- Help prepare for ICD-10
- Conduct assessment audits
- Review 20-25 charts from each member of your coding staff
- Look at all payers
- Assessment the health science knowledge
- Assessment Coding guidelines
- Assessment Coding skills

ICD-10 Documentation Assessment Audit

- Conduct a documentation assessment
  - 50 to 100 charts for each setting
- Feeder to your specific education and training plan and content
- Run some specific reports
  - NOS and NEC Dx & Procedure codes
  - Identify your top 20 by volume
- Physician query trends today… compare to ICD-10 codes
  - Report on your current query patterns and volumes
    - Identify your top 10 queries (Dx/Procedure
ICD-10: Audit the Impact

- Some guidelines have changed, this will result in different MS-DRGs “shift”
- Audit/assessment for ICD-10 implementation
- Plan to take action... educate, awareness, etc.

ICD-10: Education & Training to Meet Compliance

- Continue to provide education and training
- Audit and audit more when ICD-10 comes
  - Assessment competency and readiness
- Include time to practice
PEPPER Action

• Use your PEPPER...
• The Program for Evaluation Payment Patterns Electronic Report (PEPPER) is a report developed and maintained by the TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services.
  – http://www.pepperresources.org:80/
• Its purpose is to provide comparative data reports to hospitals and to Medicare Administrative Contractors/Fiscal Intermediaries
• To reduce Medicare fee for service improper payments
• PEPPER was previously distributed to hospitals by state Quality Improvement Organizations.
• QIOs are no longer providing these reports.

PEPPER

• PEPPER Reports flag when a hospital is at or above the 80th percentile in a risk area. That hospital is submitting a higher percentage of claims for that target than 80% or more of all hospitals in the reporting jurisdiction. This may represent overcoding.

• PEPPER Reports identify hospitals when their percent of claims in a risk area is lower than 20% of hospitals in the reporting jurisdiction. This may represent undercoding.

PEPPER does not identify the presence of payment errors, but it can be used as a guide for auditing and monitoring efforts. A hospital can use PEPPER to compare its claims data over time to identify areas of potential concern:
• Significant changes in billing practices
• Possible over- or under-coding
• Increasing length of stays
Complacency is Not Compliance

- Develop Action Plans and next steps
- Make sure that your findings have related action and list accountable person and timeline

Auditing Tips

- During the medical record review, the certified coder should specifically check for:
  - The service was provided in an acceptable level of care, matching to the MD order
  - Dates of services match the claim
  - A provider signature, time date, is on each note from which codes were assigned.
  - Acceptable documentation is provided, thorough and complete
  - Documentation supports the code assignment
  - Physician querying was appropriate
  - Discharge disposition was correct
Keep this Quote in Mind

• *The time is always right to what is right!*

  • Martin Luther King Jr.

Summary

• Audit annually
• Select your sample size and process
• Target risk areas
• Report finding and determine action plan and next steps
• Completion of action plan
Questions

Resources/References

• National Center for Health Statistics (NCHS)
• www.cdc.gov/nchs
• MedLearn Matters
• National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual
Resources/References

- http://www.pepperresources.org/
- Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Sections 90.7 and 90.7.1.
- RAC@cms.hhs.gov
- http://go.cms.gov/cert-demos