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CODING COMPLIANCE SYNERGY WITH INTERNAL AUDIT AND COMPLIANCE

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Internal Audit, Risk, Business & Technology Consulting

CONTENTS

1. **Introduction**
2. **Brief Overview of Coding Function**
3. **Role of Coding Compliance Audits**
4. **Synergies with Internal Audit Function**
5. **Best Practices for Developing Coding Audit Work Plan**
   - **Leverage Data**
   - **Review Hot Topics**
6. **Contact and Questions**

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BRIEF OVERVIEW OF CODING FUNCTION

WHAT IS MEDICAL CODING?

Provider Clinical Documentation

Providers document in the medical record what was wrong with the patient (diagnoses) and what services were provided (procedures). Providers typically document in clinical terminology.

Coded Record

A team of medical record coders read the medical record and assign each diagnosis an ICD-10 CM code out of over 68,000 codes and 8,800 CPT codes for outpatient services or 87,000 ICD-10 PCS codes in inpatient environment.

Coding Regulations And Guidelines

- **CMS:** CMS issues guidance on a regular basis concerning documentation, coding, and billing requirements, and payors typically follow CMS guidance. Documentation and coding requirements come from CMS Final Rule as well as periodic CMS transmittals.
- **Additional regulations/guidelines:** Coders follow guidance from resources: ICD-10-CM Official Guidelines for Coding and Reporting, ICD-10-CM code book; ICD-10-PCS Official Guidelines for Coding and Reporting; ICD-10-PCS code book; the AHA's Coding Clinic, the Physician's Current Procedural Terminology (CPT) book, AMA's CPT Assistant, Correct Coding Initiative Edits, and national Medicare guidelines.

W61.62XD: Struck by duck, subsequent encounter.

V97.33XD: Sucked into jet engine, subsequent encounter.

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CODING OVERVIEW

Objectives and Functions

- Review the patient's medical record (e.g., operative report) for the purpose of assigning International Classification of Diseases (**ICD-10**) diagnosis and Current Procedural Terminology (**CPT**) codes.

- Coding cannot take place until the **physician** has dictated their report into a formal, **signed document** known as the **operative report**, that will become part of the **patient's legal medical record.**

- Coding has to be completed to reflect the **most specific procedure** rendered and has a direct implication in revenue generation.

    - Unlisted CPT codes may be required if a specific code does not exist for the procedure performed or the physician's dictation lacks specificity.

- Standards and **regulations** exist to monitor "upcoding."

    - "Upcoding" occurs when a healthcare provider submits codes for more serious (and often more expensive) diagnoses or procedures than the provider diagnosed or performed. This practice is not legal.

Key Risks

- Clinical coding may be incorrect and/or incomplete which can lead to delayed or decreased reimbursement.

- Lack of medical necessity may lead to denials when specific procedures don't meet the required payer policy stipulations.

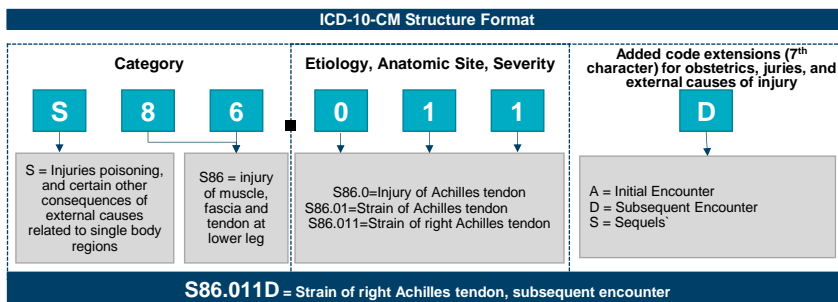- Unauthorized access to records may occur, which would violate internal and CMS policies.

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CODING – DIAGNOSTIC CODING

- When a patient is seen in a medical setting anywhere around the world, the provider assigns a medical reason (diagnosis) with the same alpha numeric coding system.

    - Every disease, disorder, injury, infection, and symptom has its own ICD-10 code.

    - ICD-10 codes are used for everything from processing health insurance claims to tracking disease epidemics and compiling worldwide mortality statistics.

    - The current coding system utilized is **ICD-10**, which includes over **68,000 codes**.

- **ICD-10: alpha numeric sequence 2 - 7 characters long**. The first 3 characters are a category classification, followed by a decimal. The 4th digit is the cause, 5th digit is the location, 6th digit is the laterality identifier, and the 7th digit is the extension. For example: *S86.011 D or "Strain of Right Achilles Tendon, Subsequent Encounter."*

ICD-10-CM Structure Format		
Category	**Etiology, Anatomic Site, Severity**	**Added code extensions (7th character) for obstetrics, juries, and external causes of injury**
S **8** **6**	**0** **1** **1**	**D**
S = Injuries poisoning, and certain other consequences of external causes related to single body regions S86 = injury of muscle, fascia and tendon at lower leg	S86.0=Injury of Achilles tendon S86.01=Strain of Achilles tendon S86.011=Strain of right Achilles tendon	A = Initial Encounter D = Subsequent Encounter S = Sequels`
S86.011D = Strain of right Achilles tendon, subsequent encounter		

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PATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS)

The Inpatient Prospective Payment System

- Amount paid to a hospital for inpatient care is based on prospective (or predefined) set rates. Hospitals are required to manage toward a set payment amount, as opposed to simply billing actual charges.
- Implemented in 1983 using DRGs - Diagnostic Related Groups - that were developed at Yale for all types of patients.
- Responsibility for maintenance of DRGs rests with CMS.
- DRGs classify patients into clinically cohesive groups that demonstrate similar consumption of hospital resources and length of stay patterns.
- DRGs have two functions:
  1. **Evaluate quality of care**
     - Treatment protocols
     - Related conditions
     - Demographics distribution
     - Critical pathways are then designed
     - Benchmarking and outcome analysis
     - Quality reviews
     - Ongoing education of physicians and nurses
  2. **Evaluate utilization of services**
     - Each DRG represents average resources needed
- Developed and implemented MS-DRGs on October 1st, 2007 to better account for severity (Medicare Severity Diagnosis Related Groups).

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HOW INACCURATE CODING AND DOCUMENTATION EFFECTS REIMBURSEMENT AND PERCEIVED QUALITY

Example of Payment Calculation

Reimbursement

DRG	Relative Weight	X	Hospital Specific Blended Rate	=	Payment for Inpatient Visit*
684: Renal Failure **w/o** CC/MCC	0.6181	X	$6,500	=	$4,018
683: Renal Failure w/ CC	0.9191	X	$6,500	=	$5,974
682: Renal Failure w/ MCC	1.4989	X	$6,500	=	$9,743

Quality Rankings

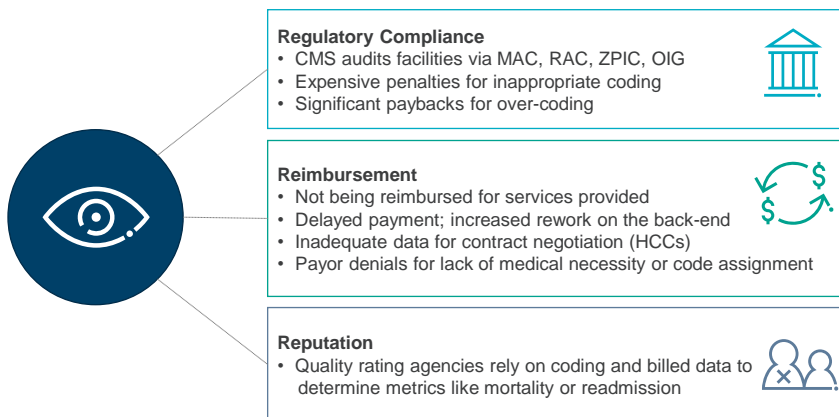| MS-DRG	Description	Weight (CMI)	GMLOS	Exp. Mort. Rate	Severity
331	Major Small and Large Bowel Procedures w/o CC or MCC	1.6623	4.0	0.11%	Low
330	Major Small and Large Bowel Procedures w/ CC	2.5405	6.8	0.50%	Medium
329	Major Small and Large Bowel Procedures w/ MCC	4.9612	11.3	9.99%	High

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ROLE OF CODING COMPLIANCE AUDITS

COMPLIANCE IMPLICATIONS OF INAPPROPRIATE CODING

Regulatory Compliance
- CMS audits facilities via MAC, RAC, ZPIC, OIG
- Expensive penalties for inappropriate coding
- Significant paybacks for over-coding

Reimbursement
- Not being reimbursed for services provided
- Delayed payment; increased rework on the back-end
- Inadequate data for contract negotiation (HCCs)
- Payor denials for lack of medical necessity or code assignment

Reputation
- Quality rating agencies rely on coding and billed data to determine metrics like mortality or readmission

California's Prime Healthcare to pay $65 million to settle Medicare fraud lawsuit

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DIFFERENT TYPES OF CODING AUDITS TO CONSIDER

Coding compliance audits go beyond just coder and billing accuracy, but can have different goals, with the overall mandate of ensuring integrity of medical record

Coding Accuracy
- Audit of coders work to ensure coder accuracy and types of education needed.
  - Accuracy includes ICD-10 CM codes, ICD-10 PCS Codes, CPT/HCPCS Codes, Present On Admission (POA), Discharge Disposition, Modifiers
- Consider auditing second-level reviewers or coding auditors to determine if they are effectively identifying coding accuracy opportunities and are fully aware of most recent coding guidelines.

Provider Coding Accuracy
- Audit provider coding to identify instances in which coding does not align with regulations or with documented provider services in professional fee environment (clinics and physician practices). For example: telehealth, Evaluation and Management (E/M), use of modifiers, appropriate ICD-10 CM code selection, Medicare allowable services.
  - In clinics, providers typically code their records but are often ill-equipped to do so given it is not their typical mandate (i.e. providing patient care).

Documentation Accuracy
- Audit medical record documentation in IP/OP/Profee to determine if documentation in the record was accurate and allowed for optimum reimbursement.
- Identify provider query opportunities: both for documentation gaps and for compliance (e.g., clinically unsupported diagnoses).

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CODING COMPLIANCE AUDITS GO BEYOND HOSPITALS

OIG and other governmental enforcement agencies increasing scrutiny on post-acute care documentation, coding, and billing

Inpatient Behavioral Health Facilities: Focus on documentation which meets CMS requirements for inpatient stay (e.g., cert/recert, plan of care) as well as diagnosis and procedural coding accuracy.

Skilled Nursing Facilities (SNF): Identifying documentation and coding opportunities as well as complete documentation of comorbidities under new CMS Patient Driven Payment Model (PDPM) as well as compliant documentation and coding of Therapy Time.

Inpatient Rehabilitation Facilities (IRF): Audit assignment of Case Mix Groups (CMG) to ensure reimbursement accuracy, diagnosis code accuracy, as well as IRF-PAI completion.

Physician Groups and Clinics: Evaluating professional fee coding accuracy, such as assignment of Evaluation and Management (E/M) codes, diagnosis codes, Annual Wellness Visits (AWVs), and use of modifiers.

Home Health Documentation and Coding: Audit to ensure full documentation of principle diagnosis and comorbid conditions under new CMS Patient-Driven Groupings Model (PDGM) as well as functional status and Admission Source (i.e., Institution or Community).

Pediatric and Neonatal Care: Review coding and documentation of inpatient and outpatient care for accuracy, including assignment of APR-DRGs.
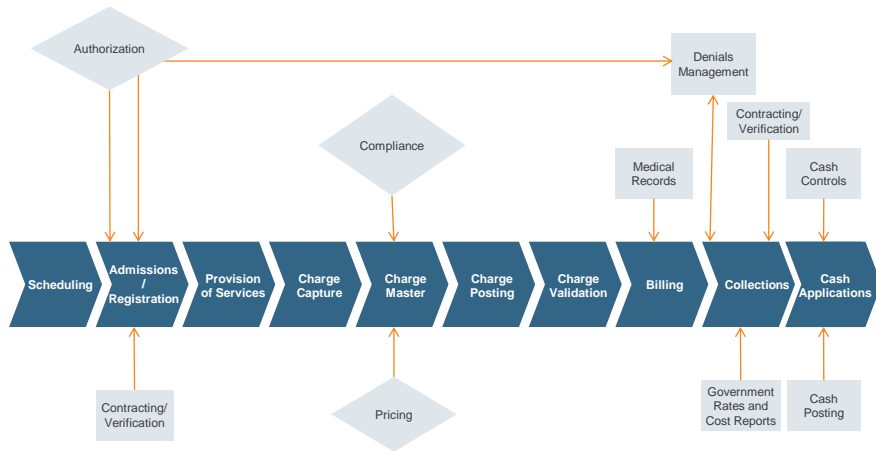
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SYNERGIES WITH INTERNAL AUDIT FUNCTION

BENEFITS OF INTERNAL AUDIT PARTNERSHIP WITH CODING AUDITS

- Often coding quality audits are siloed in Health Information Management (HIM), and only focus on one topic, such as POA status or procedural coding, sometimes with an informal connection to compliance.

- Internal Audit is uniquely positioned to provide valuable insights concerning compliance risks or operational effectiveness opportunities throughout the organization and revenue cycle which should trigger a medical record review.

- Medical record reviews can reveal a wealth of information concerning risks that require remediation or processes that can be optimized.

  o Example: if a review notes frequent cases in patients are leaving Against Medical Advice (AMA) there is probably an opportunity to incorporate measures to ensure a more effective and safe discharge.

- Optimal practice that provider organizations leverage a non-biased, third-party auditor to conduct audits of fellow coders. Coding auditors or second-level reviewers may be unintentionally biased towards frontline coding counterparts when auditing.

  o Internal coding auditors are often also in charge of coder teams and want their teams to look good.

  o Internal coding auditors may be very familiar with the coders and therefore may not be able to be completely objective in review.

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CODING AUDITS IDENTIFY ISSUES ALONG REVENUE CYCLE

Effective coding audit programs utilize data and observations from medical record reviews to assist all functions of the revenue cycle. Additionally, Internal Audit, which is often tasked with auditing components of the revenue cycle should leverage findings from revenue cycle audits to determine where a medical record review is needed.

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EXAMPLE AUDIT ANALYTICS

Inpatient Statistics*			
Finding Type	**Total Assigned**	**Total Errors**	**Accuracy Rate**
MS-DRGs	146	5	96.58%
APR-DRGs	1	0	100%
ICD-10-CM Codes	2043	82	95.99%
ICD-10-PCS Codes	214	5	97.66%
All ICD-10 Codes	2257	87	96.15%
Discharge Disposition Codes	147	1	99.32%
Present on Admission Indicators	1254	4	99.68%

Outpatient Statistics*			
Finding Type	**Total Assigned**	**Total Errors**	**Accuracy Rate**
APCs	39	1	97.44%
ICD-10-CM Codes	899	60	93.33%
CPT / HCPCS Codes	63	2	96.83%
Modifiers	23	1	95.66%

- Principal diagnosis
  - Sequencing of conditions such as Sepsis, Acute Respiratory Failure and Pneumonia
  - Sequencing of a definitive condition rather than symptom code
  - Hypertension diagnosis vs. Hypertensive crisis or Hypertensive urgency
- First-listed diagnosis
  - Opportunity for greater specificity in first-listed diagnosis
  - Seventh character application for injury codes – character 'D' vs. character 'A'
  - Use of OB codes over codes from other chapters in OB cases

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BEST PRACTICES FOR DEVELOPING CODING AUDIT WORK PLAN

LEVERAGE DATA TO IDENTIFY CODING COMPLIANCE RISKS

TRADITIONAL COMPLIANCE WORK PLAN
RESOURCES VS. LEVERAGING CLAIMS/BILLING DATA

- Compliance programs often utilize traditional sources outlining risk and/or regulatory changes such as:
  - o OIG work plans
  - o Internal/external audits
  - o RAC activity
  - o PEPPER reports

- Only using these sources may limit program effectiveness, as they do not shed insight into own operational gaps and opportunities.

- Claim level detail (837/835s) and data analytics identifies operational gaps and quantifies potential financial and compliance risk/s including:
  - o Coding and billing errors
  - o Patterns with documentation and coding
    - ▪ New physician documentation challenges
    - ▪ New coder/practice learning curves
    - ▪ New service lines
    - ▪ New guidelines/requirements

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BENEFITS OF DATA ANALYSIS
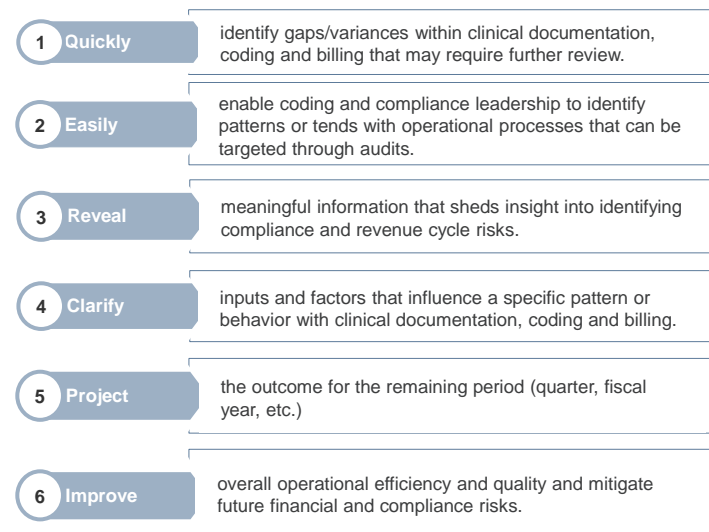
1 Quickly	identify gaps/variances within clinical documentation, coding and billing that may require further review.
2 Easily	enable coding and compliance leadership to identify patterns or tends with operational processes that can be targeted through audits.
3 Reveal	meaningful information that sheds insight into identifying compliance and revenue cycle risks.
4 Clarify	inputs and factors that influence a specific pattern or behavior with clinical documentation, coding and billing.
5 Project	the outcome for the remaining period (quarter, fiscal year, etc.)
6 Improve	overall operational efficiency and quality and mitigate future financial and compliance risks.

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HEALTHCARE DATA ANALYTICS EXAMPLE

Regional Healthcare Organization – 835/837 Coding Diagnostic

Scenario

Post electronic medical record (EMR) implementation, a large hospital system immediately began experiencing a significant negative impact to their discharged not final billed days (DNFC) and revenue. The organization was virtually blind to the impact of the changes attributed to the EMR implementation and began to experience delays in billing and denials. These issues began to adversely affect overall patient satisfaction and prompted the organization to begin to access the compliance and financial risks.

Development and Delivery

With a goal to better understand the increasing compliance and financial risks, the organization began developing claim level reporting and dashboards based on raw 835 data directly from their governmental and commercial payers. With this investment into data, the client was quickly able to compare claims level detail before and after EMR implementation to identify when, where, and why deviations occurred. The provider quickly noted several significant shifts and variances in their coding denials.

Results and Review

After leveraging claims level data and analytics, the provider conducted a focused audit on these coding denials and quickly determined that the majority of the denials were due to coding staffs' challenges navigating through new components of the newly implemented EMR to identify supporting clinical documentation. Once the root cause of the issue was identified, additional training and education was provided to coding staff to streamline processes, allowing the organization to reduce their coding related denials by 50% and attain leading practices in DNFC targets.

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MAP DENIALS CODES TO IDENTIFY DENIAL TYPES

True Denial Non Payment Reasons with Remit Codes

- ➤ Revenue Cycle analytics and dashboards provide healthcare organizations with an overall assessment of the compliance and financial health of the organization.

- ➤ Dashboard and reporting can help identify operational gaps, human error and inefficiencies.

- ➤ Trend data by service lines/modalities, DRG, physician, coder, procedure or diagnosis code.

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IDENTIFY AND PRIORITIZE HOT TOPICS

REVIEW EXTERNAL AUDIT AGENCY PLANS

Organization Type	Name	Example Target Audit Topics
Medicare Administrative Contractor (MAC)	National Government Services (NGS) – Medicare A/B	• Ultra-High RUG (IP rehab facilities) • Tissue Debridement • Cardiovascular Nuclear Medicine • DRG Validation 853/854 (Infectious and Parasitic Diseases in OR Procedures) • Ultra-High Resource Utilization Group (RUG) levels
CMS Enforcement Agency	Office of Inspector General (OIG)	• Critical Care Coding • End Stage Renal Disease (ESRD) Treatment Documentation and Coding • Documentation and Coding of Malnutrition • Documentation and Coding of Sepsis • Home Health Documentation and Coding Compliance • Cardiac and Pulmonary Rehabilitation Service Coding and Billing
Recovery Auditor	Cotiviti Inc.	• Evaluation and Management (E/M) with Same Day as Dialysis Treatment • Annual Wellness Visit (AWV) Billed Sooner Than 11 Whole Months Following the Initial Preventative Physical Examination (IPPE) • Complex Cardiac Pacemaker Documentation and Coding Review • Documentation and Coding of Provider Services in Hospice Period
Medicare Quality Improvement Organization (QIO)	StratisHealth	• Home Health Documentation and Coding • Highly Weighted MS-DRGs (e.g., Sepsis, Transplants, etc.)

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INTEGRATE GOALS AND AUDIT PLAN REVISION PROCESS INTO CODING AUDIT CHARTER

Charter establishes a system wide standardized coding compliance auditing process to reduce variances in coding practices and ensure compliance with Official Coding Guidelines.

Key Components of Charter

- ✓ **Program goals:** ensure coder accuracy, ensure integrity of coded medical record, develop proactive defense against external audit findings

- ✓ **Program Oversight:** Both medical and operational leadership, representation from HIM, CDI, Revenue Integrity, system and facility leadership, Compliance

- ✓ **Audit Scoring Methodology:** consider coder accuracy methodology (.e.g, coded over code or reimbursement), audit error rate, what is included in accuracy methodology or structure.

- ✓ **Audit Sample Methodology**: Selection per coder, per facility, per provider, etc.

- ✓ **Audit Plan Development:** Review frequency, sources to review, communication of audit plans to external stakeholders, use of patient data

- ✓ **Communication and Action Items:** Reporting to governing body, education to coders and providers, follow-up audits, metrics to utilize and communicate to leadership

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CONTACTS AND QUESTIONS

CONTACT INFORMATION

Do not hesitate to contact us with any questions, thoughts, or interest in learning more:

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