The value of a complete coding quality audit program

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TRUE OR FALSE: One coding audit a year based on a random sample of 30 charts per coder is sufficient to ensure accurate documentation and coding practices within a health care organization.

If you answered TRUE, please read on, because you will be surprised to learn that one coding audit of 30 records per coder per year utilizing a random sample chart selection method is by no means a complete coding quality audit program, with today's increasing scrutiny on accurate reporting and reimbursement. While the breadth and depth of a coding quality audit program will vary depending on the needs of the organization, as a general rule, frequent audits that use a variety of chart selection methodologies will result in the most complete, well-rounded compliance program and will yield additional benefits, including accurate reimbursement in a more timely fashion and valuable education to coders.

Auditing acronyms

RAC	Recovery Audit Contractor
OIG	Office of Inspector General
ZPIC	Zone Program Integrity Contractors
MIC	Medicaid Integrity Contractor
MAC	Medicare Administrative Contractor
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PQRS	Physician Quality Reporting System

Why perform coding audits?

With increasingly complex government legislation, regulations and investigations, health care organizations continue to struggle to ensure complete and accurate documentation and coding practices. One way to minimize risk and regulatory exposure, receive appropriate reimbursement and assure a complete and accurate database is to perform periodic coding and documentation audits. The focus on achieving a complete and accurate database is often overshadowed by the reimbursement element. A complete and accurate database leads to:

- Accurate case mix index (CMI) and reimbursement
- Accurate reflection of severity of illness (SOI)/risk of mortality (ROM)
- Support of medical necessity for services rendered
- Support of decision to admit/medical necessity for inpatient status; correct place of service status
- Adherence to compliance regulations
  - Wards off government and payor scrutiny in the form of RAC, OIG, ZPIC, MIC, MAC, etc.
- Improved comparison studies and profiling/scorecards
  - e.g., HealthGrades, Leapfrog, state comparison studies, PEPPER reports, PQRS
- Support of resource consumption and length of stay
- Support of contract negotiations (payors for managed health care)
- Decreased number of rejections and denials, including Hospital Acquired Condition/Present on Admission concerns and discharge disposition issues
- Assistance with research, outcomes analysis, quality of care, critical pathway development and wellness initiatives

- Reduced penalties related to 30-day readmissions; the excess readmission ratio includes adjustments for factors that are clinically relevant, including comorbidities
- Accurate planning for population management and accountable care data analytics

All health care organizations should maintain a robust coding quality compliance plan with ongoing monitoring and evaluation, strong coder feedback and education to promote consistency in complete and accurate reporting of a facility's patient population.

Planning and preparing for a coding audit

There are many components to a complete coding quality compliance program including the frequency of audits, the detailed scope, the volumes to be reviewed, the chart selection methodology and if to be pre-bill or post bill.

1. **Determine the frequency of audits:** daily pre-bill, monthly, quarterly, semi-annual, annual

   Daily: Pre-bill targeted inpatient reviews through MS-DRG validation

   Quarterly reviews:
   - Random selection of inpatients from the top MS-DRGs by volume, with outpatient random reviews
   - Random selection of inpatients from all MS-DRGs with outpatient random reviews
   - Targeted sampling based on high-risk DRGs as identified from prior review results, PEPPER reports, OIG and RAC targets

   By alternating random and targeted chart selection for each quarterly review, organizations can then compare the auditing results from year to year within each quarter and achieve a well-rounded coding compliance program.

2. **Consider the scope:**

   Inpatient:
   - Total data quality (validation of all codes) or DRG validation only?
   - MS-DRG and/or APR-DRG?

   Outpatient:
   - Which outpatient service types are to be included? Emergency department, same day surgery, endoscopy, observation, wound care, ancillary/diagnostics, recurring such as physical therapy, occupational therapy, chemotherapy, blood transfusions, interventional radiology, clinics, etc.
   - Will the review include only HIM coding or also Charge Description Master (CDM)-assigned CPT codes?
   - Will the review include validation of injection and infusion services?
   - Will the review include validation of facility-reported E/M levels?
   - Will medical necessity for tests performed and services rendered against Local Coverage Determination (LCD) and National Coverage Determination (NCD) be included?

   Professional Fee:
   - Which specialties are to be included?
   - Which providers are to be included?
   - Will medical necessity for tests performed and services rendered against LCD and NCD be included?

3. **Determine the volumes for review:** Specific volume per DRG, per coder, per coder per service type coded (for cross-trained coders)

4. **Choose a chart selection method:** Random, random from top MS-DRGs or APR-DRGs, targeted by MS-DRG or APR-DRG or specific code, targeting of specific records

5. **Determine if the review will be concurrent or retrospective**

6. **Decide which payors are to be included:** All payors versus specific payor types, such as Medicare only

7. **Decide which dates of service are to be included:** Most recent dates of service, dates of service from a specific quarter (Jan-Mar/Apr-June/July-Sept/Oct-Dec), etc.

8. **Decide where the audit will be performed:** Remotely or on-site

9. **Plan time for the review:** Avoid scheduling audits during high vacation times; ensure coders have adequate time set aside to participate in the coding audit process for reviewing the recommendations and responding to the auditor(s)

Choosing a coding audit vendor

A trusted vendor partner can be invaluable in helping your organization develop and maintain a complete coding quality compliance program. When choosing a vendor partner to perform coding audits, consider the following:

- **References** – Talk to other organizations about their experience with various vendors and find out which ones they recommend and which ones they don't.
- **Range of services** – Choose a partner with the ability to perform a wide variety of audit types, not just one specific type such as MS-DRG validation only.
- **Versatility** – Choose a partner that is experienced with both on-site and remote audits, small and large facilities and individual and multiple-facility audits.
- **Reporting capabilities** – Make sure the vendor will offer statistical findings that will help identify patterns and trends in coding and documentation, and identify specific areas of educational needs with the ability to offer the education needed.
- **Audit process** – Discuss the vendor's audit process to ensure it includes a strong coder involvement in the audit process, allowing for coder comments and chart-specific discussions.
- **Auditor training** – Request information about the vendor's audit staff in terms of their experience, credentials, education, tenure and training.
- **Quality Assurance (QA) program** – Ensure that the vendor has an internal quality check and internal QA program for its auditors.

The complete coding quality compliance plan

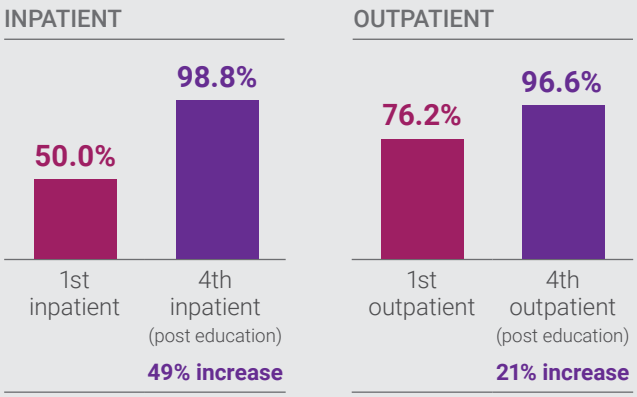
In considering the various components of a complete coding quality compliance plan, it is clear that the best plan should involve frequent reviews to offer continuous and timely support and feedback to the coding staff, allow for a variety of chart selection methods and include a process that supports coder education and consistent, complete and compliant reporting of coded data. A trusted vendor partner can go a long way in assisting your organization in developing the best coding audit compliance plans based on your specific needs.

Compliance spotlight

Improve coded clinical data

After the ICD-10 implementation, a 122-bed client in Missouri wanted to understand how well the coders were coding and where they needed additional education. nThrive was brought in to perform coding reviews. There were four audits on inpatient and outpatient records. Based on the findings, coders were provided with supplemental education. The improvements are substantial:

Coding accuracy rate



Increase reimbursement while mitigating risk

During one year, nThrive auditors reviewed nearly 20,000 inpatient records during 83 audits at 53 individual hospitals. While 7.8 percent of the records revealed failure to report the most appropriate DRG based on the patient's clinical condition, the resulting increase in DRG totaled more than $1.6 million of lost revenue, while the resulting decrease in DRG reflected a compliance risk of approximately $980,000.

"Auditing the auditor" uncovers need for education and process improvement

University-affiliated teaching institution improves coding accuracy rates and sustains high performance

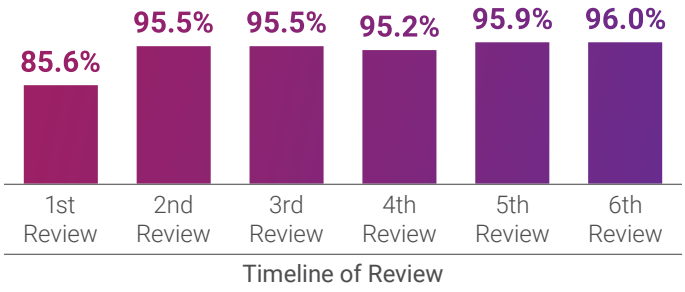
Large teaching institutions typically see a high volume of very complex cases. In turn, this increases the complexity of coding. A large Midwestern teaching facility had relied on an internal QA resource to monitor the accuracy of its coding, and when this resource left, decided it was a good time to bring in an external resource to measure the work.

nThrive* was engaged to perform the external audit. The first audit review of 250 Medicare records showed an 85.6 percent accuracy rating, a number almost 10 percent below industry standards. Education on coding and specific DRGs followed, along with Q&A sessions and the availability of ongoing support for the staff. In addition to the immediate application of education to increase the coding accuracy, nThrive and the hospital developed a new internal compliance plan that included an additional internal layer of auditing prior to submission of records to billing and bi-annual external audits. The hospital's coding policies were updated, and a new practice of conferring with the medical staff on DRG impact factors was initiated.

The bi-annual audits focused each time on a different type of record. After each audit, education was provided that addressed the errors or issues uncovered by the audit. Before long, the institution was realizing accuracy levels just above 95 percent, the industry standard. The bi-annual audits and subsequent education extended the learning process and ensured that the accuracy rates would be sustained.

Now, five years after the initial audit, the hospital is consistently realizing coding accuracy ratings above industry standards. Outpatient records have been added to the audit mix, and the hospital is achieving high accuracy marks in this arena as well.

DRG accuracy rates trended



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From Patient-to-Payment,℠ nThrive empowers health care for every one in every community.℠

*Disclaimer: References to nThrive in these instances refer specifically to experiences with the legacy MedAssets-Precyse organization (previously known as MedAssets Net Revenue Systems, LLC and Precyse Solutions, LLC).