Auditing Across the Continuum: One Size Doesn't Fit All

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All coding professionals have been involved in coding audits, in one form or another. Many hear the term "coding audit" and expect it to be a quality audit. While coding quality audits are a standard part of every coding department, the scope of audits continues to evolve, reviewing many facets related to documentation and coding. One size no longer fits all.

New healthcare reimbursement models have been a major focus for healthcare organizations over the past few years. Coding professionals have spent hours educating and preparing for these new methodologies for compensation. It is now time to assess organizational compliance and audit plans to ensure adequate risk assessment for the complexities of coded data. Facilities need to review audit plans with a critical eye to ensure that the scope is assessing coding accuracy and critical quality indicators for all encounter types that impact reimbursement and quality reporting. An assessment may reveal that a major overhaul is necessary or that minimal revision and expense is needed to improve risk assessment.

First, let's review some common audit types and the minimum scope to be considered as audit plans are reviewed.

Coding Quality Audits

These audits review all codes reported and identify those codes to be added, deleted, or revised and are typically conducted post-bill. Coding quality reviews should be conducted on all encounter types (Inpatient, Outpatient Surgery, Clinics, Emergency Department, and Physician-based) under the jurisdiction of health information management (HIM) for all coding professionals. In addition, ensure that coded data generated outside of the HIM professionals' scope—such as hard coded and physician- or system-assigned codes—are assessed. Auditors need to be skilled in assigning ICD-10-CM/PCS and CPT procedural coding, as well as communicating with coding staff regarding audit findings. Designing and delivering educational feedback is a critical component of a well-designed coding audit plan.

At a minimum, inpatient audits should measure and validate the following:

- Accurate identification of principal and secondary diagnoses and procedures in accordance with official and facility coding guidelines
- Review of secondary diagnoses impacting SOI/ROM, as applicable
- Accurate MS-DRG or APR-DRG assignment
- Accurate present on arrival (POA) indicator assignment for all non-exempt codes
- Accurate discharge disposition assignment

Outpatient quality audits should measure and validate the following:

- Accurate identification of primary and secondary diagnoses
- Accurate CPT/HCPCS code assignment, including modifiers, for coder-assigned procedure codes
- Accurate APC/EAPG assignment
- Accurate Evaluation and Management (E&M) code assignment

Coding quality audits should provide the following data:

- Accuracy rate by coder for:
    - Principal/primary diagnosis selection
    - Accuracy for all diagnoses assigned
    - Principal procedure selection
    - Accuracy for all procedures (ICD-10-PCS or CPT/HCPCS) assigned

- E&M accuracy rate
- MS-DRG/APR-DRG or APC/EAPG accuracy rate
- POA and Discharge Disposition accuracy rate

While coding quality audits must include all encounter types, there are several considerations that should be reviewed when defining these audits. As healthcare organizations and the services they provide continue to evolve, audit plans must adapt accordingly in order to effectively evaluate risk and internal expertise. The following three sections discuss things to consider when it comes to developing audit plans.

Sampling Methodology

Options for the audit plan's sampling methodology include random or focused sample selection, keeping in mind there are a multitude of options for focused sampling. A random sample will represent an unbiased selection of cases for an individual coder. The main advantage of this method is identifying a new or unknown problem. A focused sample will audit specific charts at the highest risk for coding errors. This method reviews high-risk encounters for errors.

Focused sample audits may include:

- MS-DRG/APR-DRG
- APC/EAPG
- Single CC or MCC
- RAC or OIG target areas
- Previously identified coding issues

Depending on the frequency and types of audits being performed, a combination of the two methods may be the ideal choice.

Frequency of Audits

The most common timeframes for audits include monthly, quarterly, biannually, and annually. A review of literature indicates that biannual or annual coding audits are no longer adequate given the complexity of ICD-10 coding and reimbursement.

At a minimum, audits should be performed quarterly with a transition plan to achieve monthly coding audits. There are several advantages to performing monthly audits:

- Risks are identified earlier, diminishing any potential negative financial impact.
- Many payers, including Medicare, have a time limit for corrected bill submission. Remember that rebilling of previously submitted claims should be completed according to the organizational compliance plan.
- Coding professionals receive feedback more frequently and consistently, which allows for immediate corrective action and monitoring that reduces the negative impact of identified errors.

Internal vs. External Audits

External audits are a critical component of any audit plan but should be utilized wisely to get the best return on investment. Given the increased importance of coding quality on reimbursement, examine how external expertise can supplement and support an internal staff's proficiency and availability to conduct audits.

Internal audits should be assessed to determine if collaborative interdisciplinary audits can be incorporated to enrich the data collected and improve risk assessment. In other words, audits should not occur in silos.

Pre-bill (Concurrent) Coding Audits

Concurrent coding audits can often cause operational difficulties, as additional staff may be required to complete these second-level reviews during a short timeframe. However, identifying any potential issues, prior to billing, alleviates potential quality issues found in a retrospective rebill process.

Concurrent coding audits should be limited in scope to address specific areas that impact quality reporting and reimbursement or have been identified in previous risk audits as problematic. There are vendor tools available to provide specific focus to concurrent audits, which identify potential documentation and coding issues prior to billing. Timeliness of pre-bill audits is critical because these accounts are held for additional review prior to releasing the bill. Turnaround time should be short (for example, 48 hours) to release cases in a timely manner with a minimal impact to discharged not final billed (DNFB) daily goals.

Organizations should consider pre-bill coding audits for high-risk areas such as:

- Medicare cases
    - Develop a second-level review process
- Patient safety indicators (PSIs) and hospital-acquired conditions (HACs)
    - Review for validation, accuracy of coding, accuracy of POA assignment, and clinical documentation opportunities
- DRG mismatches between clinical documentation and coding
- Office of the Inspector General target areas, as well as other high-risk DRGs
- Mortality cases
    - Second-level review, particularly for those cases with SOI/ROM of 1 or 2

HCC Audits

The increased scrutiny on hierarchical condition categories (HCCs) has necessitated the need for focused auditing in this area. The HCC/risk adjustment calculation is determined, in part, by coding of chronic medical conditions. While this focus on secondary diagnoses is not new in the hospital setting, the new attention on secondary chronic conditions is not necessarily standard practice in the physician office setting.

Providers are becoming more aware of the need for complete documentation for the capture of appropriate HCC conditions. With this increased awareness there is a risk of inaccurate identification and coding of secondary diagnoses. In this audit process, care should be taken to ensure all identified diagnoses satisfy "MEAT" criteria—monitoring, evaluation and/or education, assess/address, and treatment—for reporting. The focus of HCC audits is on the patient and all qualifying encounters during a calendar year should be audited. HCC auditing should include the following:

- Review of all applicable encounters for each patient
    - HCC capture is applicable for a patient for each calendar year
    - Each applicable diagnosis must be documented and coded at least once during each year and code sequencing does not apply
    - Beware of problem lists and copy/paste documentation, both of which may not be applicable to the encounter being reviewed
    - Qualifying encounters must be face-to-face from specific, approved physicians and clinically trained non-physicians (NP, PA, etc.)
    - Qualifying healthcare settings include hospital inpatient, hospital outpatient, and physician office visits
    - The following setting and services are not valid for HCC capture: freestanding ambulatory surgery centers, skilled nursing facilities, hospice, home health, ambulance, lab, radiology, durable medical equipment, prosthetics, orthotics, and supplies
- Application of MEAT criteria to each encounter
    - Only one element of MEAT is required to support a diagnosis
- HCC auditing should include a standard practice of identifying both addition and deletion of diagnosis codes

New Audit Methods for a Changing Landscape

While there is nothing new about the concept of coding audits, there is now a greater variety of them, which requires different skill sets to successfully manage risk assessment. As each type of audit has different parameters, coding auditors have different skill sets for completing these reviews. Correct staff assignment to coding audit projects is crucial to the success and accuracy of each type of audit.

Before evaluating your current audit plans for specific items related to risk assessment, review them from a conceptual perspective and evaluate the following:

- How has your organization structure changed? Coding and billing for new service lines should be given high priority to identify and correct any issues as early as possible. Do you have the internal expertise necessary to audit internally?
- Can interdepartmental audits improve risk assessment and increase audit efficiency?
- How should you blend the use of random and focused audits to optimize risk assessment?
- Assess your current staffing. Is there a gap between expertise needed and what staff currently possess? Do supervisory job descriptions allow time for audit responsibilities and staff education?
- How can external audits be utilized to support internal auditing practices? What weaknesses were identified in your staffing analysis that can be addressed with external audits?
- What internal processes impact risk assessment? For example, evaluate all areas in the organization where diagnoses and procedures are captured.

Industry guidance will continue to evolve, and HIM professionals have a responsibility to continue the review of relevant guidance and participate in the development of industry best practices related to auditing.

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