Audits Offer Fix for Poor Coding Compliance, Lagging Reimbursement

By Hammerman, RHIA, CPHQ

The ever-increasing complexity of healthcare is driving the need for coding quality and compliance programs. Given the transition to ICD-10, advancements in treatments and procedures, a move to quality reporting, and evolving regulations with potentially lofty penalties, the lost reimbursement at stake as the result of poor coding is driving more providers to intensify their coding audit programs.

The trend among large providers is a wave of both random and targeted audits at varying stages of the revenue cycle—from pre-bill to post-bill analysis of key issues ranging from denials to specifics such as transfer DRGs.

Audits help uncover potential problems and issues, such as coder knowledge deficiencies and workflow and documentation hiccups, which could be quietly chipping away at reimbursement and patient care.

Random and targeted audits certainly have their place. Identifying the purpose or goal of the audit is key to determining the most effective approach. Random audits offer a strong, unbiased approach to evaluating where general weaknesses and educational needs exist and may identify new issues each time they are conducted.

Data analysis of random audits, Recovery Audit Contractor (RAC) findings, PEPPER reports, and denials allow for targeted audits of both coders and specific DRGs to truly improve overall compliance and coding accuracy. Unfortunately, finding time and resources to coordinate the random sampling of records is a big enough challenge for many providers. Addressing issues raised in a random audit with an education program, and then measuring the effectiveness of the remedy through a targeted re-audit effort, requires even more resources and commitment.

Considering how much is riding on coding in today's complex healthcare market, however, it is hard to justify not investing in audits and education to boost accuracy and compliance. Coding provides a window into a healthcare organization's operation. No longer just a mechanism for mining data or patient population studies, coding is the primary tool for measuring current and even future reimbursement, with many providers eyeing compliance goals beyond the traditional target of 95-98 percent. Audits and education programs vary as much as the healthcare systems conducting them. Let's explore some examples of organizations that have embraced compliance.

Embracing Compliance to Drive Excellence

Dekalb Medical, a hospital system based outside Atlanta, GA, is evolving their coding compliance program to drive excellence. Dekalb's internal compliance team recently worked with a vendor to complete a baseline review of the accounts coded by hospitalists and clinic physicians. Initial audit results were reviewed with providers in individual and group educational sessions aimed at improving the hospitalists' and physicians' ability to accurately code.

Physicians will often say, "I'm here to treat patients, not to do paperwork." But the hospitalists and doctors at Dekalb Medical, like the vast majority of physicians across the US, are very engaged in stepping up their documentation.

Conducting coding audits will unveil provider coding trends. For example, providers assign E/M codes based upon three components: the exam, patient history, and medical decision-making. Hospitalists tend to under-document patient history during exams. Because they see a patient every day of their hospital stay, they may leave out history details and other documentation. Often it's as simple as noting the patient history has not changed from the day before. Any over- or under-reporting, as it relates to the exam or the physician's medical decision-making, can have a negative impact on charges by as much as two or more levels of service.

The results of baseline audits of Dekalb Medical's 37 hospitalists demonstrated similar tendencies. Subsequent audits reflected improvements in documentation and coding following the initial educational sessions. While the baseline review revealed that Dekalb Medical's hospitalists and physicians were coding at various levels of compliance, the first round of education improved accuracy and overall compliance by an average of 15 percent.

Of the providers who started out with scores below the national goal of 95-98 percent coding accuracy, one has achieved 100 percent compliance and several are over the 95 percent mark, while others are consistently in the 90-94 percent range and continue to improve because of monthly reviews.

Another recent example involves a leading organization that worked with a vendor to conduct a coding professional performance improvement program. Performance-based audits focus on gaining insight into key areas of risk and opportunity through frequent, intensive reviews using a more concurrent approach. This approach ensures findings can be addressed quickly in the coding process.

Baseline audits were completed on every coding professional to identify current quality levels and performance challenges. Based upon the initial audits, coding professionals received feedback and targeted education. Focused audits followed, helping to ensure that coding professionals retained the information and applied it in production coding. The ongoing cycle of audit, education, and assessment resulted in significantly higher performance levels across the entire team. It is an approach that often results in education being delivered far more cost effectively because the primary focus is on individual coaching and development. Group education is only conducted when there is an identified trend among the entire team.

While still early in this engagement, DRG accuracy improved from 92.8 percent to 95.5 percent, and it resulted in an immediate impact on reimbursement by reducing both over- and under-coding. Additionally, the capture of MCC/CCs demonstrated improvements from 87.1 percent to 93.2 percent and 87.3 percent to 94.9 percent, respectively. Improvement was noted in all other areas of the audit as well, including diagnoses, procedures, and hospital-acquired conditions. This type of improvement impacts not only the financial wellbeing of an organization, but data quality and reporting as well.

Beyond the numbers, perhaps the biggest takeaway from health systems focused on compliance is that education makes a significant difference in the audit process.

What Nine Out of 10 Organizations are Missing from an Audit Program

Many organizations complete audits and review the findings, but they are unable to accomplish more due to competing priorities and limited resources. Often, results are just shy of the 95 percent goal of coding accuracy, allowing the organization to focus on more critical priorities with the expectation of focusing on the audit later. But then it's suddenly time for the next quarterly or annual audit, for example, and the previous audit has still not been addressed. New issues may be identified while old issues remain, and though coding quality may not be worse overall, it likely hasn't improved, resulting in lost revenue and continued compliance risks.

Often, audits demonstrate significant opportunities for the improvement of coding professionals' performance and the optimization of reimbursement. For instance, a random two percent sample of inpatient records at a large hospital system found recurring DRG errors that reflected $74,000 in lost revenue in a single quarter. Audit findings reflected repeated errors of incorrect principal diagnosis or procedure, as well as a lapse in capturing all comorbid conditions, which resulted in underweighted DRGs and costly underpayments.

Coding performance and documentation accuracy have never been more important and critical to an organization's compliance and financial health. Organizations that invest in compliance audits can improve their return on that investment by adding education and focused audits that can result in better data and optimized revenue capture.

Resource constraints can certainly be a hurdle to compliance improvements. Given the risks of taking zero action, however, even small steps toward a performance-based program will have a positive impact on an organization's overall coding quality and compliance. As these programs progress, organizations may consider taking even more creative and cutting-edge steps in compliance, such as implementing pre-bill audits for high-risk DRGs and automation of the pre-bill scrubbing process. Until then, leading organizations are arming their coders with inventive tools, such as tip sheets and targeted education, to boost knowledge and accuracy.

There is often a fine line between successful audits and missed opportunities on the heels of audits, but the difference can have a major impact on reimbursement and overall patient care.

Julia Hammerman (jhammerman@himaginesolutions.com) is director of compliance and education for himagine solutions.

Article citation:
Hammerman, Julia. "Audits Offer Fix for Poor Coding Compliance, Lagging Reimbursement." *Journal of AHIMA* 89, no.6 (June 2018): 28-30.