Coding Audits Evolve with ICD-10: Industry Experts Define New Benchmarks and Best Practices

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From privacy and security risk assessments to perennial health plan record reviews, HIM departments are inundated with audits. The move to ICD-10-CM/PCS adds another layer of audit complexity and requirements as hospital and health systems step up their coding quality review processes, procedures, and partners.

Beyond coding audit modifications at provider organizations, the industry's outsourced coding vendors and healthcare payers have published new coding audit best practices, performance metrics, and key performance indicators (KPIs) to assess progress in ICD-10. One example is the Centers for Medicare and Medicaid Services' (CMS') new ICD-10 resources: an ICD-10 KPI infographic and their Next Steps Toolkit, both available online at www.cms.gov/Medicare/Coding/ICD10. HIM professionals can also turn to their outsourced coding partners for advice as these companies become the "experts' experts" for ICD-10 coding accuracy.

In March 2016, four leading outsourced coding services companies and one large academic medical center came together via a virtual roundtable to discuss the shifting dynamics of coding audits in ICD-10. This article summarizes updated policies and procedures for auditing ICD-10 code quality and accuracy. New best practices gleaned from these four coding industry experts can be applied to all hospital-based coding audit programs.

Beth Friedman, BSHA, RHIT, founder of Agency Ten22: Briefly describe your ICD-10 code auditing process. Who performs the audits and what is the focus?

Dina Nedorost, RHIT, CCS, AHIMA-approved ICD-10 trainer, director of coding and data operations, HIM, at Thomas Jefferson University Hospital: Thomas Jefferson University Hospital is a top Pennsylvania hospital and ranks second in the Philadelphia, PA metro area, according to *U.S. News & World Report*. Our organization recently received the Healthgrades Distinguished Hospital Award for Clinical Excellence for 2016. We have five primary care locations and 951 licensed acute care beds. We rely on four consultant groups for retrospective audits and second-level reviews. Internally, we conduct the following coding audits using the same processes and procedures we had in place for ICD-9:

- Daily pre-bill second level review of all Medicare cases, hospital-acquired conditions (HACs), and mortalities
- Third-level risk adjusted clinical review for mortality cases (performed by clinical documentation improvement (CDI) specialists)
- Review of all PSIs [patient safety indicators] for validation, coding, and clinical opportunities daily by coding and CDI teams

Lisa Crow, MBA, RHIA, AHIMA-certified ICD-10 trainer, director of auditing services at TrustHCS: In addition to internal coding audits like those mentioned above, we see increasing requests to conduct external ICD-10 coding audits for our hospital clients—both retrospective and concurrent. The focus and process for these ICD-10 audits varies depending on each individual hospital's requirements.

Some of our hospital clients request 100 percent of a selected coder's cases for review while others prefer a set number per coder. From a focus perspective, some hospitals are focused on auditing high-risk and/or high-volume DRGs while others ask us to review coding accuracy for specific service lines. All information gleaned from auditing efforts is incorporated within a final report and educational session for the client.

Julie Boomershine, RHIA, CCS, CTR, AHIMA-approved ICD-10 trainer, manager of coding operations at HRS: As a remote coding services provider, our internal audit process is performed using a team approach by employed audit experts—who have all received extensive training in ICD-10-CM/PCS. New coders, or coders assigned to a new client, undergo concurrent review of 100 percent of their cases until the coder has achieved an acceptable accuracy rate. Once optimal accuracy is achieved, the coder is placed on a routine audit schedule and audits are conducted retrospectively based on percentage of randomly selected records coded in the previous period.

For the concurrent portion of our audit process, we limit the number of individual coders having concurrent auditing performed simultaneously for any client. We coordinate closely with our clients regarding coding turnaround time to ensure we release cases from review in a timely manner, respecting and meeting each client's discharged not final billed (DNFB) targets.

The focus of ICD-10 coding audits performed for our hospital clients has centered on unspecified codes with three goals in mind: identify trends, uncover the root cause for code assignment issues, and ascertain when clinical indicators are missing to justify a specific diagnosis.

Cassie Milligan, RHIT, CCS, manager of coding quality improvement at H.I.M. ON CALL, Inc.: Our coding reviews are performed by two separate internal teams of trained ICD-10-CM/PCS resources: coding supervisors and our quality improvement (QI) department. The coding supervisors perform concurrent reviews while the QI department conducts retrospective audits. The QI department currently does a random sample of 20 cases per coder every month. Concurrent QI on cases is performed within 48 hours per our coding turnaround-time commitments.

We also combine these traditional efforts with data from an online coder assessment software application. The software measures coder productivity and accuracy via real test cases providing additional coder-specific performance results. All of our coders spend time every week using the application to practice on test cases and garner additional experience on specific service lines.

Friedman: How do your ICD-10 code auditing practices differ from those in ICD-9?

Nedorost: Our internal auditing process didn't change dramatically with the transition to ICD-10. We still audit the same types of cases and have the same procedures. For the remainder of 2016 we will continue with the same type of audits to establish a solid benchmark. Next year we may shift to DRG-specific audits or something similar, reassessing as we go. However, with ICD-10 the quarterly audits we do with our vendor now target more documentation-specific deficiencies such as CC/MCC capture and DRG shifts.

Crow: For TrustHCS, the selection of records and reporting of results has changed since the implementation of ICD-10. Records are being selected based on high volume, high dollar, or areas of coder concern—not just by random selection. We are also able to report out trends based on the ICD-10-PCS character that may be incorrect. We expect to see a bigger trend toward auditing cases of denial or underpayment, where reimbursement received varies from the expected payment.

Boomershine: We have increased the frequency of audits with ICD-10 and added auditors to our team. Initial ICD-10 audits were focused on a higher-level view to prioritize validation of correct DRG assignment. This allowed us to quickly identify any coding issues that impacted the DRG and immediately provide feedback and education—to both our own coders and our clients' teams.

Now that we are eight months into ICD-10, the focus for coding audits has shifted to more detailed code-level review and in-depth discussions for challenging cases. Each audit HRS performs delivers new insights that we incorporate into a continual process improvement loop for coders—including web-based educational sessions that are recorded and posted on our internal learning management system for ongoing coder reference.

Milligan: The biggest change we see is in volume. More code audits are being performed in ICD-10 versus ICD-9 and we have hired additional QA resources. Overall, we now have a stronger audit team in place. Another notable difference is audit focus. In ICD-9 we conducted more focused DRG reviews. In ICD-10, we are looking at all types of cases to ensure correct coding across the board until coders feel comfortable with the new guidelines—both for our H.I.M. ON CALL coders and our client hospitals' coding teams.

We're also taking additional steps post-audit to mentor coders on specific ICD-10 changes. Depending on the nature of the error, we assign the coder a pre-existing lesson or design a new lesson including theory test and corresponding practice cases in our software provider's system. If errors found during coding audits are widespread, the entire team participates in an educational lecture conducted by our learning and development manager.

Friedman: What is most challenging about conducting code audits in ICD-10 versus ICD-9?

Nedorost: From what we have seen so far the complexity of ICD-10-PCS coding has been the most challenging for our internal coding reviewers. It is certainly more time consuming and tedious compared to ICD-9.

Crow: The most challenging aspect for TrustHCS is post-audit education with our hospital clients. We don't personally know the coders and their levels of education, knowledge base, or experience. It is challenging for an external auditor to determine whether coding issues are due to coder interpretation of the case, lack of anatomy and physiology understanding, or misunderstanding of guidelines that affected their code assignment. Strong communication and relationships between hospital coding managers and external coding auditors is absolutely essential to ensure post-audit feedback and education that effectively reduces future coding errors.

Boomershine: Auditors knew codes by memory in ICD-9 and rarely needed to verify their findings. In ICD-10, every code needs to be referenced. Each case takes longer to thoroughly audit. One example is coding conventions. Keeping abreast of the coding conventions—"includes," "excludes1 and excludes2," and "use additional"—also requires additional auditor time. This information needs to be researched for each code reviewed to verify the coder has followed ICD-10 coding guidelines. Finally, the special character assignment for procedures requires delving much deeper into the procedure notes to ensure the coder assigned each character of the code appropriately.

Milligan: Everyone in the industry is new to ICD-10—including auditors. As mentioned above, information must be researched, which requires more time for both coder and auditor. Also, research materials aren't as abundant in ICD-10. We are all suffering from the shortage of validated coding resources.

Friedman: Please describe three best practice strategies for hospitals to improve their internal coding audit processes in ICD-10.

Nedorost: Based on our experience at Thomas Jefferson University Hospital, I recommend the following best practice strategies for proactive coding audits in ICD-10:

- **Share** information as you get it. When you see a trend or pattern, share it immediately with everyone to establish clear and concise guidelines along the way.
- **Collaborate** with CDI. We have monthly calls with our coding and CDI staff to discuss cases, collaborate on findings, and walk through the CDI/coding reconciliation process. Collaboration with CDI creates a valuable learning experience for both teams.
- **Involve** your staff. Have a coder bring an interesting case or topic to each staff meeting and share with the group for open discussion.

Crow: Timeliness and rapid action are the keys to better coding outcomes in ICD-10. Here are three practical steps TrustHCS recommends to our hospital clients:

- **Audit** the case as soon as it is coded whenever possible. This allows the auditor to see exactly what the coder saw at the time of coding. Coding a chart with discharge summary 45 days after the date of initial coding may yield a different set of codes and reduces the effectiveness of audit results.
- **Ask, listen, and understand** how the coder arrived at a specific code, and why. Realizing the coder's line of thinking helps the auditor know where additional education is needed.
- **Provide** feedback to coders in a timely manner so they remember the case and can apply the learning moment to future cases.

Boomershine: ICD-10 gives coding teams the opportunity to sharpen their approach to initial code assignment and the auditing process. Audits are important to ensure we are using the code system effectively to assign the most appropriate

specificity (even if it doesn't change the DRG or reimbursement). For internal coding teams, HRS suggests the following best practices:

- **Review** the coding foundations. Go back to basics. It's important to keep abreast of coding guidelines. While some guidelines haven't changed, many have. Make sure coders are reminded of these important building blocks.
- **Focus** on coder education. Guarantee that feedback from audits gets back to the coders. Include coders' responses in your audit cycle.
- **Discuss** *Coding Clinics* as they are released. Have coders review and discuss the new *Coding Clinics* as they are released to be sure they have the most up-to-date information.

Milligan: Our advice for hospital-based coding teams centers on education, communication, and information sharing. Based on H.I.M. ON CALL's experience with ICD-10 coding audits so far, we recommend:

- **Gather** as much research information as possible on new ICD-10 resources and updates. This includes collecting data from your own coding efforts. Look for trends in what types of errors the coders are making. They might not be the same as in ICD-9—only time will tell.
- **Conduct** educational sessions regarding particular coding trends as they are uncovered—by your own internal team or your external coding partners.
- **Communicate** audit findings, no matter how detailed, with your own coders and vendors—early and often. For example, we are in constant communication with our clients to see what both sides are finding in ICD-10.

ICD-10 Coding Audits Evolve

The dynamics of coding audits are shifting. Procedures have evolved. More coding audits lay ahead. As each roundtable participant mentioned, processes and best practices will continually morph as new ICD-10 coding patterns and trends emerge.

Finally, new ICD-10 challenges requiring additional audit activity are expected on October 1, 2016 when the physician grace period concludes and nearly 6,000 new codes are introduced. Strong communication—with internal coding teams and external coding partners—remains essential as the industry continues to refine its collective ICD-10 coding expertise.

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