Coding Compliance: Practical Strategies for Success

Save to myBoK

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"Fraud," "abuse," "upcoding," "unbundling," and "compliance" have all become buzzwords in the news media. Eliminating healthcare fraud and abuse has become a top priority for the federal government. Government investigations are on the rise and providers everywhere tremble at the thought of becoming the next investigative target. An Office of Inspector General (OIG) audit of the Health Care Financing Administration (HCFA) revealed errors in 30 percent of all claims paid by HCFA in fiscal year 1996.[1] These errors account for approximately $23.2 billion annually, or 14 percent of total Medicare fee-for-service (i.e., excluding managed care) payments. About half of the errors identified resulted from insufficient or lack of documentation from providers, and one-third of the documentation errors were associated with providers who failed to respond to repeated requests from auditors to submit documentation. The breakdown of the types of errors resulting in the improper payments is as shown in Figure 1.

Breakdown by type of provider is shown in Figure 2.

Figure 1	
Insufficient/No documentation	46.76%
Lack of medical necessity	36.78%
Incorrect coding	8.53%
Nonconverted/ Unallowable service	5.26%
Other	2.67%
Total	100%

Figure 2	
Inpatient (PPS)	22.59%
Physician	21.68%
Home health agency	15.74%
Outpatient	12.12%
Skilled nursing facility	10.45%
Laboratory	5.76%
Other	11.66%
Total	100%

As a result of these audit findings, providers can expect to see increased efforts by the federal government to prevent, identify, and punish healthcare fraud. HCFA's action plan to address the problems identified by the OIG audit includes the following measures:

- Increased number of prepayment reviews
- Increased postpayment reviews of medical necessity and medical record documentation supporting claims
- Overpayment recovery
- Providers identified by the audit as submitting improper claims will be targeted for more extensive investigation
- Increased review of evaluation and management claims (as of October 1998, HCFA plans to increase the number of random prepayment reviews of evaluation and management claims)
- Demand for more documentation from providers who submit claims
- Increased security measures to prevent submission of claims from improper providers

But what does all this mean for you, the HIM director, coding supervisor, or coder? What can you do to reduce the chance of your employer becoming a target of a fraud investigation related to coding, or if you do become a target, minimize the risk of assessment of maximum penalties? How can you assure and demonstrate that your organization has accurate, ethical coding practices and medical record documentation that supports the diagnoses and services reported on the claim for reimbursement?

Become Familiar with the "Hot" Targets

First, become familiar with the major investigative targets. Key sources of information on "hot" targets include the annual work

plan for the Department of Health and Human Services (HHS) Office of Inspector General (OIG), fraud alerts issued by the OIG, and focus medical reviews described in fiscal intermediaries' provider bulletins.

OIG's 1998 Work Plan

The OIG's 1998 workplan is currently available. It can be downloaded from the OIG's Web site. This is an excellent source of information regarding the OIG's key initiatives in 1998. Some of the projects described in the workplan that affect coding are:

PHYSICIANS AT TEACHING HOSPITALS (PATH)

This initiative is designed to verify compliance with the Medicare rules that govern payment for physician services provided in the teaching setting and to ensure that claims accurately reflect the level of service provided to the patient. This initiative is being undertaken as a result of the OIG's audit work in this area -- which suggested that many providers were not in compliance with the applicable Medicare reimbursement policies.

DIAGNOSIS-RELATED GROUP CODING

According to the workplan, this review will determine the extent to which hospitals are incorrectly coding hospital discharges for Medicare payment. An approach will be developed to identify facilities that are potentially engaged in inappropriate coding for more thorough review and proper remedial action. Approaches may include the use of changes in case mix or commercial software currently used to detect billing irregularities.

ACCURACY OF AND CARRIER MONITORING OF PHYSICIAN VISIT CODING

This project will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding. Previous work by the OIG has found that physicians are not accurately or uniformly using visit codes. The analysis will build upon this previous work and add more definitive data regarding the accuracy of physician visit coding.

USE OF SURGICAL MODIFIER

This review will determine whether physicians are improperly using modifier 25 on their Medicare Part B claims to increase reimbursements. Modifier 25 is intended to be used to claim "significant, separately identifiable evaluation and management service on the day of surgery."

PHYSICIAN AND OTHER SERVICE PROVIDER USE OF DIAGNOSIS CODES

By comparing a sample of Medicare claims to beneficiary medical records, a medical reviewer will determine the extent to which diagnosis codes on claims match the reason for ordering and providing various services.

BILLING SERVICE COMPANIES

This review will determine whether Medicare claims prepared and submitted by billing service companies are properly coded in accordance with the physician services provided to beneficiaries and whether the agreements between providers and billing service companies meet Medicare criteria. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians.

MEDICARE'S CORRECT CODING INITIATIVE

Medicare's Correct Coding Initiative, designed to improve the accuracy of Part B claims processed by Medicare carriers, will be evaluated. The OIG will evaluate the effectiveness of the initiative in detecting improper billings and whether carriers are uniformly adopting practice patterns being promoted by the initiative.

Specific OIG Investigative Focus Areas For 1998

PNEUMONIA DRG UPCODING PROJECT

This project was initiated to identify hospitals that falsify the diagnosis and DRG on claims from viral to bacterial pneumonia. The OIG's Office of Investigations is working with the Department of Justice to initiate a nationwide project in this area.

PROJECT BAD BUNDLE

The OIG's Office of Investigations launched Project Bad Bundle to identify hospitals that unbundle blood chemistry tests when using automated equipment and then bill for each analysis separately, or bill for an automated test in addition to several of the analyses separately. "Unbundling" refers to the practice of submitting individual bills for separate tests that should be bundled

together into a single bill for a group of related tests. The amount allowed under Medicare for this "bundled" amount is considerably lower than the sum of the amount for tests billed separately.

This project, formerly known as the Ohio Outpatient Laboratory Unbundling Project, has recovered $8.8 million in reimbursement and penalties as of mid-1997, in Ohio alone. It has been expanded nationwide to encompass 5000 hospitals.

Note: The projects described above are only a few of the initiatives described in the 1998 workplan. See the actual workplan for a complete list.[2]

Compliance Checklist

Do you have:

- A code of conduct?
- Written policies and procedures?
- Educational and training programs for staff and physicians?
- Effective communication mechanisms?
- Auditing and monitoring systems?
- Appropriate disciplinary and corrective action measures?

Coding Compliance Program

Corporate compliance programs are seen as an effective mechanism to assure compliance with regulations and minimize risk of fraud. A coding compliance program should be a key component of any corporate program -- complementing, not conflicting with, the corporate compliance program. Even if your organization has not yet begun to develop a corporate program, you can still establish a coding compliance program. In developing a coding compliance program, you need to be proactive to prevent someone less qualified from taking the initiative and creating a program for you. Begin with a risk assessment (according to the target areas outlined above and the process described under Auditing and Monitoring. Include provisions within your compliance plan that specifically address weak areas identified in this assessment. This will assure that special attention is given to functions and processes that are particularly prone to placing your organization at risk. Convene a multidisciplinary team to address areas of the compliance plan that require cooperation from entities outside your department, such as policies and procedures that address physician documentation or updating the chargemaster.

The key elements recommended by the government for inclusion in a corporate compliance program can be addressed in a coding program:

Code of Conduct
Develop a code of conduct for your department which establishes your commitment to ethical, accurate coding in accordance with all regulatory requirements. AHIMA's Standards of Ethical Coding should be incorporated in your coding code of conduct.

Your department's commitment and adherence to official coding guidelines should be explicitly stated.

COMPARATIVE DATA SOURCES

Comparative data is necessary to establish internal coding data monitors. Data may be obtained from a variety of sources, usually for a charge. Many private companies offer access to giant databases, often in a user-friendly electronic format. Many states, through state data organizations or hospital associations, release claims data for all payers. Peer review organizations often provide comparative data reports. The most notable comparative data is Medicare MedPar data, which can be obtained from the HCFA at:

Health Care Financing
Administration
Public Use Files
Accounting Division

Written Policies and Procedures
Develop comprehensive internal policies and procedures for coding and billing and make sure these written procedures are kept up to date.

INTERNAL CODING PRACTICES
Describe your internal coding practices, including the course of action coders should take when the coding situation is not addressed in official coding guidelines. Whenever possible, reference the official coding guidelines (promulgated by the cooperating parties comprising AHIMA, the American Hospital Association, the National Center for Health Statistics, and HCFA). AHIMA's practice brief entitled "Data Quality" (*Journal of AHIMA,* February 1996) is also a valuable resource for developing coding policies and procedures.[3]

DOCUMENTATION
Medical record documentation requirements should be addressed. What documentation should be available at the time the record is coded? All physician documentation? All test results? What procedures do you have in place to assure that medical record documentation is adequate and appropriate to support the coded diagnoses and procedures? Your

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HCFA also provides some public use files free of charge. These can be accessed from HCFA's home page at www.hcfa.gov/stats/ stats.htm. [note: URL no longer accessible; see http://www.cms.hhs.gov/data/default.asp.]

Other sources of health data include:

- American Hospital Directory (www.ahd.com) Analysis of facility-specific financial and DRG data
- Data Advantage (www.data-advantage.com) Comparative healthcare information products
- HCIA (www.hcia.com) Telephone: (800) 568-3282 Hospital benchmarking and profiling products
- The Center for Healthcare Industry Performance Studies Telephone: (800) 859-2447 Hospital benchmarking and profiling products
- The MEDSTAT Group Telephone: (800) 650-1550 Hospital benchmarking and profiling products
- Iameter Inc. Telephone: (415) 349-9100 Hospital benchmarking and profiling products
- National Center for Health Statistics (http://www.cdc.gov/nchs/datawh.htm) Data warehouse
- National Health Information Resource Center Links to sixty health data sites [link not active as of 10/01]

In addition, the National Association of Health Data Organizations (www.nahdo.org) has published two books with information on health data sources: *State Health Data Resource Manual: Hospital Discharge Data Systems and A Guide to State-level Ambulatory Care Data Collection Activities.*

This list is not all-inclusive. A number of private vendors offer comparative databases for healthcare providers. At least 37 states have been mandated to collect hospital-level data. Depending upon the state, this data may or may not be available to the public. Contact your state hospital association for information concerning the availability of comparative data.

commitment to assigning codes based on physician documentation and to obtaining physician clarification whenever necessary should be explicitly documented in your policies and procedures.

You may wish to establish that a physician adviser is available to provide guidance to the coding staff regarding clinical issues affecting code assignment and to serve as a liaison with the medical staff.

MEDICAL NECESSITY

Incorporate the pertinent guidelines regarding medical necessity from the OIG's Model Compliance Plan for Clinical Laboratories. Submission of a claim to Medicare for a medical item or service which the healthcare provider knows (or should know) is not medically necessary is considered a fraudulent practice for which civil penalties may be assessed. Services that are not covered by the Medicare program, such as most routine examinations, should not be billed inappropriately so as to appear to be covered services. Screening, for instance, which encompasses examinations and/or diagnostic procedures performed in the absence of signs or symptoms, is generally not covered under the Medicare program (there are a few exceptions, such as mammograms and pap smears). The appropriate V code should be assigned to indicate a screening examination.

Whenever a test is performed that is believed to be reimbursable by Medicare and no waiver of liability has been issued to the beneficiary, the provider furnishing the test must maintain sufficient information in the medical record to support medical necessity of the test. Upon request, a laboratory should be able to provide documentation supporting the medical necessity of a service the laboratory has provided and billed to a federal program. It is not enough for the hospital or independent laboratory to state that information is available from a third party, such as a physician's office. If the third party does not wish to comply with the hospital's request for documentation for the purpose of complying with an audit, or the supplied documentation is inadequate, then it is the provider that bears the risk of nonpayment by Medicare. Fiscal intermediaries have the authority to deny a claim that has insufficient documentation to support it. A pattern of claims submission for medically unnecessary services can be construed as fraud. Simply linking the procedure code to a payable ICD-9-CM diagnosis code is not sufficient. The ICD-9-CM code(s) reported on the claim must be supported by documentation in the medical record. The OIG's Model Compliance Plan for Laboratories directs laboratories to only submit diagnostic information obtained from the physician ordering the test. According to the model plan, laboratories should **not**:

- Use diagnostic information provided by the physician from earlier dates of service (other than standing orders)
- Use "cheat sheets" that provide diagnostic information that has triggered reimbursement in the past
- Use computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician
- Make up diagnostic information for claims submission purposes

Laboratories **should** utilize uniform requisition forms that encourage physicians to order only those tests they believe are appropriate and require physicians to document the need for each test. The ordering physician

Publication of the names of specific vendors does not constitute an endorsement by AHIMA of any particular product or service.

should be contacted to obtain diagnostic information in the event that the physician has failed to provide such information.

Where diagnostic information is obtained from a physician or the physician's staff after receipt of the specimen and the requisition form, documentation of the receipt of such information should be created and maintained. Note that the Model Compliance Plan does not require that the physician's signature accompany the diagnosis. AHIMA recommends that when diagnostic information is obtained verbally from the physician's office, this information, the date received, and the name of the individual you spoke to at the physician's office be documented in the medical record (e.g., on the registration form, requisition, or physician's order sheet). Be aware that a fraud investigator could review the medical record at the physician's office to substantiate the diagnostic information you submitted on the claim. If the laboratory cannot produce documentation to support medical necessity, or the physician's office record does not support the reason for the test reported on the laboratory's claim, it is the laboratory's claim that may be denied, even though the test was ordered by the physician.

CHARGEMASTER

An annual review of the chargemaster by a representative from your department should be specifically included in your policies and procedures.

COMPUTER SOFTWARE

Identify any perceived errors in the logic or edits incorporated in your encoder software. This is an area where well-trained coding personnel are a definite asset because they are able to readily recognize inappropriate direction provided by the encoding software. Refer encoder issues to the software vendor. Document all communication with the vendor, including your inquiries and the vendor's response. Regularly follow up with the vendor until the issue is resolved. If you identify any unequivocal conflicts with official coding rules or guidelines, address them immediately. The coders should be immediately informed of the erroneous instruction and directed to disregard the encoder in this instance. If your encoder allows customized edits, incorporate an edit to remind the coders of the error and the appropriate code assignment. Document the encoder problem-including the date it was detected and how it was handled-in your coding policies and procedures. It is a good idea to have current ICD-9-CM and CPT books available so the validity of encoder instructions can be verified.

PAYMENT POLICIES

Incorporate payment policies affecting code assignment in your coding policies and procedures. Maintain a copy of the provider bulletin that addresses this policy with your coding policies and procedures. This will assure that you will be able to provide documentation supporting this coding practice. If your encoder allows customized edits, add a payer-specific edit for the code or codes affected by the policy. If the payer's policy is not consistent with official coding guidelines or rules, send a letter to your fiscal intermediary and HCFA regional office pointing out the discrepancy and the possible problems it could cause. AHIMA's *Payer's Guide to Healthcare Data Quality and Integrity* can be used as a tool to encourage adherence to official coding guidelines.

CONSULTING FIRMS

Include policies and procedures pertaining to the procurement of a coding consulting firm. Evaluate a consulting firm carefully before signing a contract. There is nothing inherently wrong with utilizing a consultant to review medical record documentation and assure optimal code assignment based on documentation. Many ethical, responsible consulting firms have helped to significantly advance coding quality and coder and physician education. It is, however, important to be aware that if a provider utilizes a consulting firm for revenue optimization reviews, this may draw the scrutiny of fraud investigators, particularly if the consulting firm charges on contingency. In connection with some government investigations, hospitals have received letters informing them they must advise if outside consultants were utilized during the period and matter in question or if the provider was billing in response to any information previously provided by a consultant. An OIG Fraud Alert was issued in 1997 after an investigation into laboratory billing irregularities revealed a possible connection between false claims and consultants. The OIG noted that when a consulting firm is paid on contingency, there is little incentive to correct coding errors that do not result in higher reimbursement. The government determined that this type of arrangement between providers and consultants is ripe for upcoding, unbundling, and other manipulation, which increases costs to the Medicare program. The Fraud Alert recommends that government agents investigating hospital practices should determine whether the hospital has this type of consulting contract. If such a contract exists, the investigating agent is expected to contact the fiscal intermediary to compare the consultant's clients to other hospitals not using this consultant.

Before entering a contractual agreement with a consulting firm, be sure to check references and the qualifications of the personnel responsible for conducting the work described in the contract. Some things to think about ahead of time: Do they possess an HIM credential? Does their experience match the type of work they will be doing for you? For instance, you wouldn't want someone with only outpatient coding experience performing DRG validation. What are the company's continuing education requirements for their staff? Determine their fee structure. Is it a flat, hourly, or per record rate, or is it contingency based? Verify that the firm has quality control mechanisms in place. Find out if they have a corporate compliance plan. If they do, ask to review it. Ask the consulting firm to review and agree to adhere to your compliance program.

Once the firm is on board, review all of the consultant's recommendations before implementing them. The consultant should report all errors that result in decreased reimbursement, as well as those that involve increased reimbursement. Claims adjustments for both types of errors should be submitted to the fiscal intermediary. If you question the accuracy of the consultant's recommended code change, ask for references or supporting documentation (such as *Coding Clinic*) to support the consultant's advice. Make sure that for every code change requiring additional physician documentation, this documentation is obtained prior to submission of a claims adjustment. Verify that a recommendation from a consultant or information presented during a seminar does not conflict with official coding guidelines or government regulations. A number of facilities have gotten into trouble because they were coding correctly to begin with, only to change their procedures because of advice obtained from a consultant or seminar. It is particularly important to verify the appropriateness of revising a coding practice since sudden changes in coding or billing patterns attract attention, which increases the risk of being audited or targeted for a fraud investigation. Make every effort to get the consultant to take responsibility for any action related to his recommendation. Make sure your policies and procedures stipulate that you have the right to refuse to implement a consultant's recommendation when you can demonstrate that the advice conflicts with official coding guidelines or regulatory requirements.

Education and Training

Stipulate the qualifications and experience expected of the individuals in coding positions.

Make sure coding staff have been properly trained and receive ongoing continuing education. Ongoing education is necessary to assure that knowledge of changed rules and regulations is kept up to date. How will employees be educated on issues of relevance to their work processes? How will new employees be educated prior to performing any job responsibilities that could place the organization at risk? How will ongoing education on new issues, coding guidelines, or regulations occur? How will employees' knowledge attainment and retention be determined? These are all questions that should be answered in your compliance program.

Conduct periodic inservices to reinforce understanding of the procedures. Keep records of all staff in-services, including signatures of staff members acknowledging their participation in the training session and their understanding of the policies/procedures.

When documentation deficiencies are identified, educate the physicians on improving their documentation. Clarify conflicting or ambiguous information with the physician. When clarification or additional information is obtained from the physician, make sure this information is subsequently documented in the medical record. The physician may respond to the coder's query verbally or via an exchange of notes, then the coder assigns the code based on this exchange, but the physician never adds the information to the medical record. Thus, the medical record documentation does not support the code assignment.

Provide education outside the HIM department. Educate ancillary departments on the importance of documentation to support medical necessity of ordered tests and on the need for annual updating of the chargemaster. Educate physicians and facility staff on coding, reimbursement, and documentation rules, as well as fraud/abuse penalties and sanctions. Since coding accuracy depends on the quality and completeness of physician documentation, physician education on documentation requirements is especially critical. Educate the business office staff on coding processes and in turn, invite them to educate your department on the billing process, including claims rejections and appeals.

Make sure to document all internal and external training, including who was trained, what they were trained on, and the dates of training.

Incorporate a commitment to the availability of essential coding resources, including *Coding Clinic for ICD-9-CM, CPT Assistant,* and current versions of ICD-9-CM and CPT, in your compliance plan.

Special training programs should be designed to target areas found to be deficient during an internal or external audit.

Communication

Procedures for communication of changes in regulatory requirements should be established. A procedure needs to be in place to assure that changes or additions to rules and regulations are communicated to all affected staff. This includes changes that may be contained in publications, such as provider bulletins, that have not been regularly disseminated to the coding staff in the past. You will need to establish a mechanism to assure that memoranda or regulatory issues and provider bulletins are disseminated to all affected staff. As new or revised regulations are published, add this information to your coding and billing policy/procedure manuals. Maintain an up-to-date index for this manual so information is easily accessible at all times.

Establish mechanisms for all staff to be updated on changes **before** the effective date of the change.

If you disseminate a memo describing a revised policy or procedure change, ask staff to sign the memo acknowledging their receipt of the information. Keep the memo and staff signatures on file.

Make sure there is a process within your organization for employees to report potential fraud, including any pressures being placed on them to code improperly.

Auditing and Monitoring

Evaluate your internal coding practices and assure they are consistent with coding rules and guidelines. Examine your operations with respect to **all** potential risks and institute appropriate safeguards and compliance controls. Don't just focus on the current "hot issue" in the press. If you have developed facility-specific coding guidelines, make sure they are not in conflict with official guidelines.

Monitor coding accuracy through periodic audits. A concurrent review allows you to identify errors and correct them before submitting a claim.

Keep in mind that no one expects a zero percent error rate. Mistakes are okay as long as they truly are mistakes and actions are taken to prevent their recurrence.

These internal audits may indicate problem areas requiring more intensive review and corrective action.

If instances of potentially improper code assignments are identified, review all pertinent policies/procedures, including official coding guidelines and billing manuals. Review a statistically valid, random sample of cases in order to determine whether the problem is an isolated case or one that occurred during an isolated time period; or if it is a widespread, ongoing problem. Interview staff to find out more information about how the particular billing or coding practice in question got started (e.g., Did a consultant or new coding supervisor initiate it? Was it adopted after attending a particular seminar?).

Also, perform a trend analysis. Have there been any significant changes in case mix or coding practices? Have any DRGs that show substantial increases in the numbers of cases been assigned to them?

Evaluate claims denials and code and DRG changes from the fiscal intermediary (FI) and Peer Review Organization (PRO). Appeal all denials you believe to be inappropriate, even if only small amounts of money are involved. Use information gleaned from patterns of errors or denials to educate staff.

Monitor payers' changes of your codes or downcoding of claims for frequency and patterns. Correct any errors in your coding and billing practices identified during this review to prevent future denials. Appeal all code changes by the FI or PRO you believe to be inappropriate. Cite official sources to support your position. Follow up on the issue until you have received a response from the payer. High denial rates or repeated coding or billing errors could increase your risk of being audited.

Make sure overpaid, as well as underpaid, claims are submitted to the fiscal intermediary. If you only submit adjustments for the claims in which you are seeking higher reimbursement, you could be charged with fraud. The investigators can claim that you were aware of instances in which you were overpaid, but you failed to return the overpayment to the payer. This can be viewed as a "willful intent" to defraud the government.

EXTERNAL AUDIT

You may wish to consider having an external audit of your operations, documentation, and claim submission processes (either before or after you have identified a potential problem). A good external audit can help you evaluate your risk objectively and

produce recommendations for implementing a proactive approach to correct any problems. Furthermore, it can help promote physician education and awareness, a focus on documentation issues, and coder training. Just remember to select an audit firm carefully. There are many firms out there, and just like in any other business, their services vary greatly in quality. Select a firm who can perform an unbiased review -- which means they have no incentive to maximize reimbursement. Check the firm's references. The ideal choice would be a firm with expertise in these types of risk evaluation, such as previous experience in developing compliance programs for healthcare organizations. Physicians' offices should also consider hiring an outside consultant to perform a review of internal control procedures and of records associated with coding, billing, record retention, and collection procedures. Audits should be conducted only under the direction of legal counsel so that findings are protected under the attorney-client privilege.

Data Monitors for Compliance

MedPar billing data can be used to identify hospitals with coding or billing practices that fall outside comparative norms. A hospital's billing data can be compared to national, state, and regional norms to determine significant variations. Variations are not in themselves indications of abusive or fraudulent coding practices, since the norms themselves may represent inaccurate coding. They do, however, identify hospitals that appear "different" from their peers. This may be an indication of DRG miscoding leading to inappropriate reimbursement for inpatient care, or there may be a valid explanation for the variation. The challenge for the HIM professional is to identify the variations, determine the validity of the coding practices represented by the data, and document circumstances resulting in unexpected variations.

Figures 3-8 represent an analysis of one state's 1996 MedPar data.[4] There are more than 100 hospitals in this state, although only 15 hospitals are listed on each graph for the purpose of illustrating the usefulness of data monitors at the hospital level. The 15 hospitals have been divided into three groups of five hospitals. These three groups represent a low (light blue), median (medium blue), and high (dark blue) peer group within the state for each monitor. There are two lines on each graph: one representing the state norm, the other representing the national norm. Percentages are listed as whole numbers except on the graph indicating the percentage of change in case mix index. Hospitals with fewer than 10 cases per DRG, DRG pair, code, or code pair as represented by the title of the graph have been excluded (percentages appear magnified when small numbers are used).

Health information management departments should establish specific data monitors to determine how they compare to national, regional, and state norms. Currently, changes in case mix index and the ratio of complex to simple pneumonias appear to be two areas under investigation. Additionally, variations in complications/comorbidities (CC) percentage (patients with CCs coded as a percentage of total patients in DRG pairs) may represent an area of focus. Problem areas identified following an audit of coding practices may also represent areas of concern. These audits may be performed either internally or by a qualified external auditing company. Data monitors, therefore, should be established for all areas under scrutiny by investigators as well as areas identified as problematic at the hospital level.

Significant variations should be investigated to determine if there is a valid explanation. Changes in case mix index can be the result of many factors. For instance, the addition of services such as open heart surgery, orthopedic surgery, or the addition of a new physician to the medical staff can result in a significant increase in case mix index from one year to the next. Shifts in volumes of certain DRGs may also cause increases in case mix index. This can result in a variation in the percentage of change in case mix index when compared to national, regional, and state norms. If your data analysis reveals a reasonable explanation for an aberration in coding or billing patterns, document this explanation, along with the official sources that support it, for evidence if you should become a target of a fraud investigation.

Figure 3 - State "A" Percentage of Change in CMI

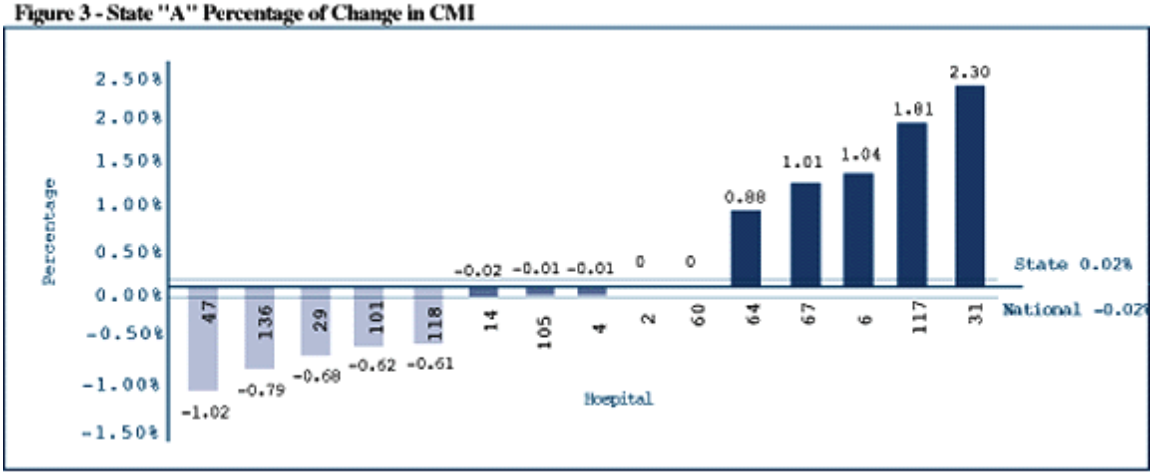


Figure 3 represents the percentage of change in case mix index from fiscal year 1995 to fiscal year 1996. This can be calculated at the hospital using the following formula:

(1996 CMI - 1995 CMI / 1995 CMI) x 100

The hospitals represented show as much as a 2.3 percent change in case mix index during this time period. If the coding is accurately reflected by the case mix, determination of the underlying cause should be identified and documented. Were new services added? Did a new physician with a high volume of patients join the medical staff? Was there a decrease in high-volume, low-weighted DRGs during the past year? Any of these could result in a significant variation in case mix index.

Monitoring case mix index against average charges can also be indicative of potentially inappropriate coding practices. If there is a wide disparity between the two (e.g., high case mix/low charges or low case mix/high charges), coding practices should be reviewed to determine if overcoding or undercoding could be the cause. A hospital's charge structure should also be examined as a possible cause for disparity between case mix and average charges.

Diagnoses that affect certain DRG assignments when listed as additional diagnoses are considered CCs in the Prospective Payment System. And approximately 40 percent of all Medicare patients fall into DRG pairs. A DRG with a CC has a higher relative weight and, by extension, a higher reimbursement than the same DRG without a CC. In other words, the presence of a CC indicates greater resource intensity required to care for a patient based on severity of illness. When a code is assigned to represent a CC that is not supported by the physician's documentation in the medical record, the resource intensity of the case is fraudulently misrepresented and the hospital is overpaid for the care provided.

Figure 4 - State "A" CC Percentage

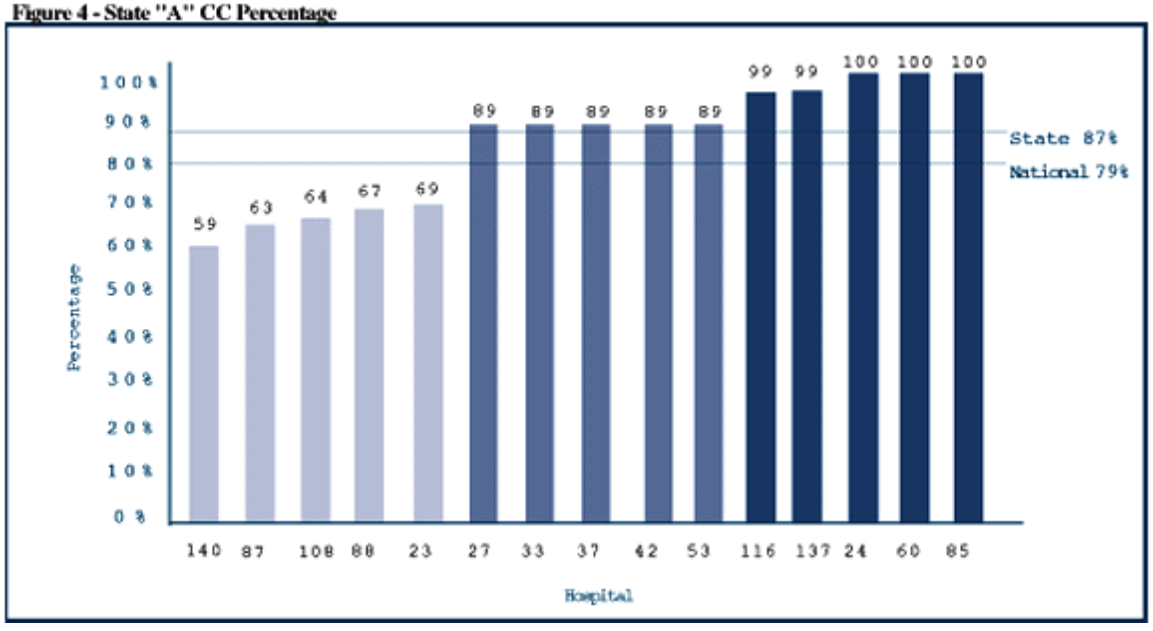
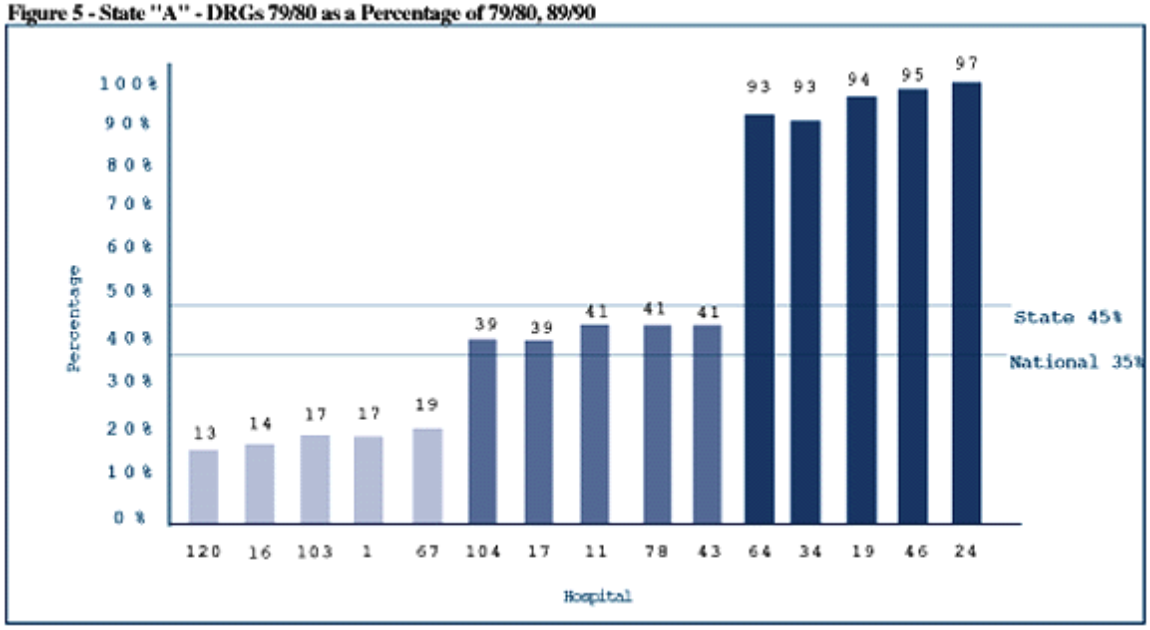


Figure 4 illustrates variations in CC percentage in comparison to state and national norms. This can be calculated at the hospital using the following formula (where n = number of cases):

[n("CC" DRGs) / n("CC" DRGs) + n("no CC" DRGs)] x 100

Significant variations may be an indication that valid CCs are not being coded or that there is potential overcoding. The high peer group represented in Figure 4 reflects a CC percentage of 99 percent to 100 percent for fiscal year 1996. There is no right or wrong number when measuring CC percentage. However, when variations occur either above or below the norms, the HIM department should investigate and address inaccurate coding practices internally.

Figure 5 - State "A" - DRGs 79/80 as a Percentage of 79/80, 89/90



According to the OIG's 1998 workplan, one of the specific areas of investigative focus is the inappropriate assignment of DRGs 79/80 (complex pneumonia) instead of the accurate assignment of DRGs 89/90 (simple pneumonia). Figure 5 illustrates the low, median, and high peer groups with DRGs 79/80 represented as a percentage of DRGs 79/80 plus DRGs 89/90. This can be calculated at the hospital using the following formula (where n = number of cases):

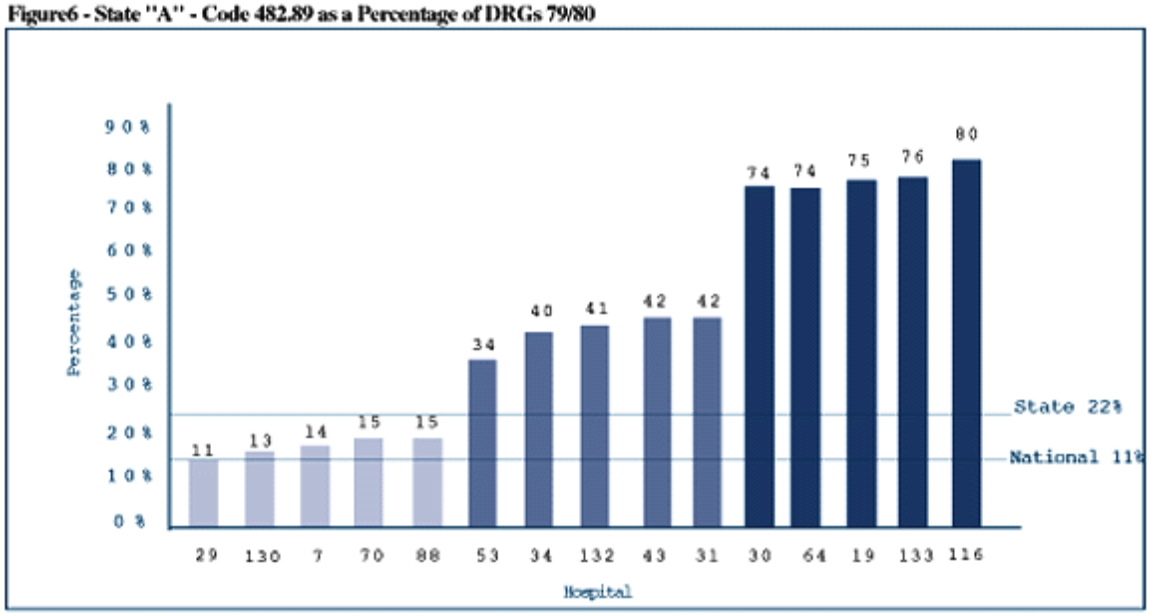
[n(DRG79) + n(DRG 80) / n(DRG 79) + n(DRG 80) + n(DRG 89) + n(DRG 90)] x 100

There are significant variations among all three peer groups, with the median falling between the national norm (35 percent) and the state norm (45 percent). As stated previously, these variations may be appropriate, but the variations illustrated by the high peer group would most certainly set off alarms for both internal and external investigation.

When DRGs 79/80 appear problematic, the HIM department should set up data monitors for specific diagnoses resulting in the assignment of these DRGs. An inordinately high percentage of cases for a particular diagnosis in DRGs 79/80 may alert the HIM director that an audit of those cases should be performed to ensure accurate coding. In Figure 6, code 482.89 (pneumonia due to other specified bacteria) has been calculated as a percentage of DRGs 79/80. This can be calculated at the hospital using the following formula (where n = number of cases):

[n(PDX 482.89) / n(DRG 79) + n(DRG 80)] x 100

Figure6 - State "A" - Code 482.89 as a Percentage of DRGs 79/80



The state and national norms are 22 percent and 11 percent, respectively. The high peer group identifies hospitals with 74 percent to 80 percent of DRGs 79/80 coded to "other bacterial pneumonia."

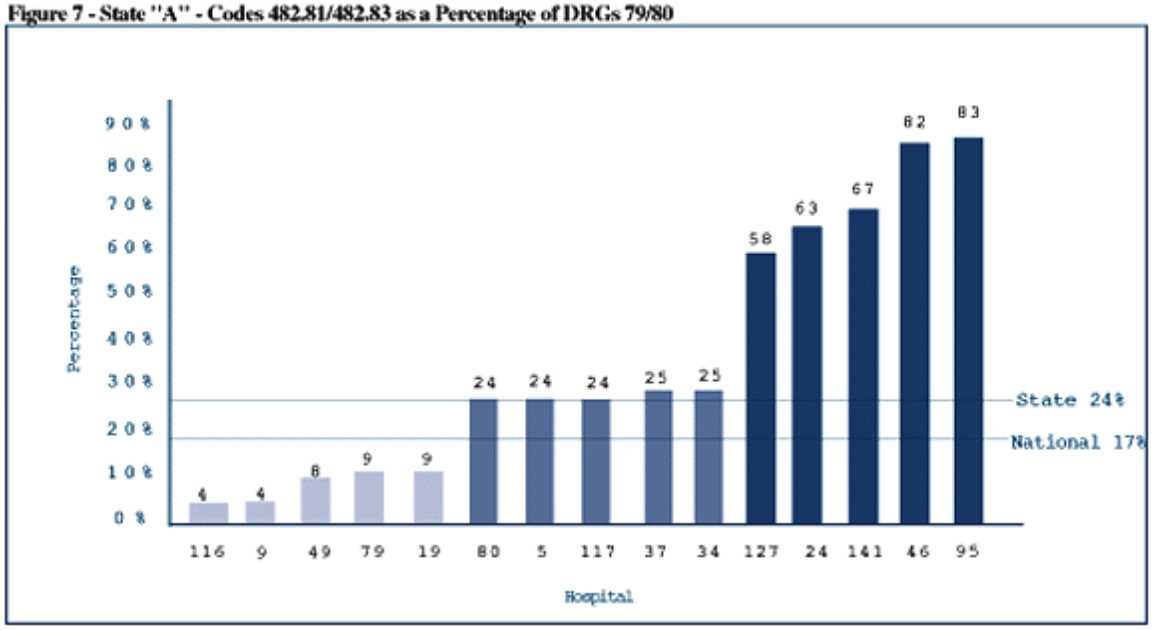
Hospitals 19 and 64 appear in the high peer group for DRG 79/80 as a percentage of all pneumonias, as well as in the high peer group for code 482.89 as a percentage of DRGs 79/80. The HIM departments in these hospitals should carefully evaluate the accuracy of cases classified to "other bacterial pneumonia" in DRGs 79/80 to determine if these are being coded appropriately based on physician documentation.

Another specific diagnosis that should be monitored in DRGs 79/80 is gram-negative pneumonia. This may be assigned to code 482.81, pneumonia due to anaerobes, or code 482.83, pneumonia due to other gram-negative bacteria. This can be calculated at the hospital using the following formula (where n = number of cases):

[n(PDX 482.81) + n(PDX 482.83) / n(DRG 79) + n(DRG 80)] x 100

Variation from national, regional, or state norms could indicate overly aggressive coding without supporting physician documentation. In Figure 7, the high peer group illustrates that as many as 83 percent of the cases assigned to DRGs 79/80 are coded to gram-negative pneumonia; this is significantly "different" than the state (24 percent) and national (17 percent) norms.

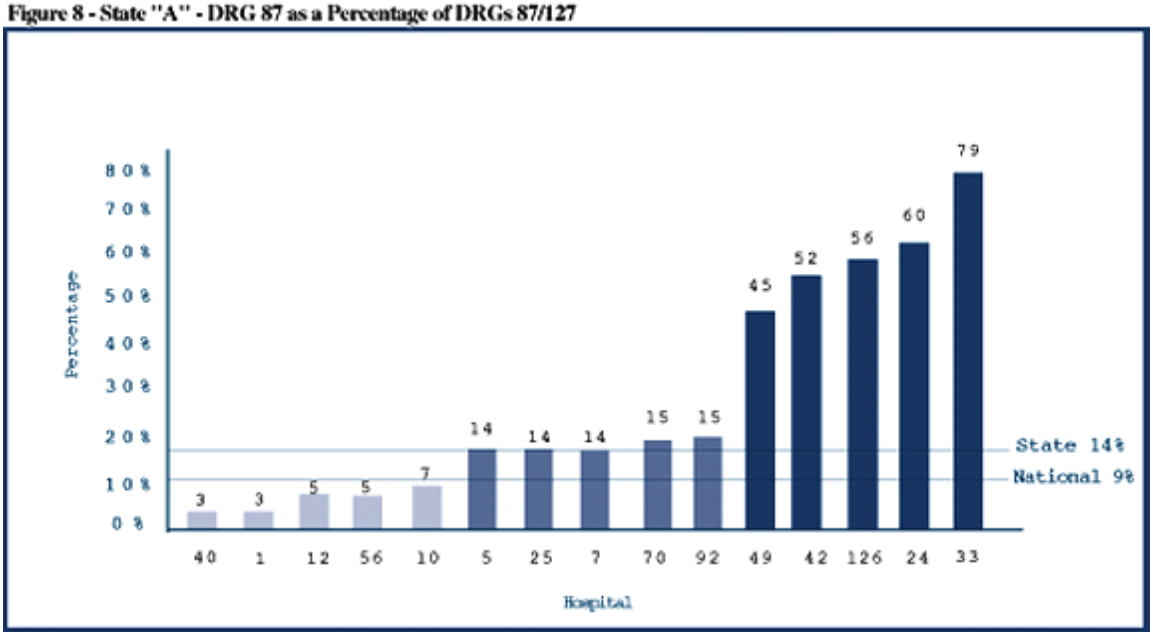
Figure 7 - State "A" - Codes 482.81/482.83 as a Percentage of DRGs 79/80



Hospitals 24 and 46, which are part of the high peer group in the graph of DRGs 79/80 as a percentage of all pneumonias, also appear in the high peer group identified in Figure 7. These two hospitals should carefully review their coding and documentation to determine whether or not these cases have been appropriately classified.

Problematic areas identified at the hospital level should also be monitored on an ongoing basis. For example, an external audit company identifies a significant number of cases classified to DRG 87, pulmonary edema and respiratory failure, that should have been classified to DRG 127, heart failure and shock (DRG 127 is weighted lower than DRG 87). In these cases, acute pulmonary edema was being sequenced as the principal diagnosis, with heart failure sequenced as an additional diagnosis -- even though the alphabetic index of ICD-9-CM instructs the coder to only code heart failure when both conditions exist.

Figure 8 - State "A" - DRG 87 as a Percentage of DRGs 87/127



As demonstrated by Figure 8, there is significant variation from the norms. This can be calculated at the hospital using the following formula (where n = number of cases):

[n(DRG 87) / n(DRG 87) + n(DRG 127)] x 100

The HIM director should identify potentially problematic diagnoses within DRG 87 and set up specific data monitors. For instance, acute pulmonary edema (518.4), as demonstrated in Figure 7, and respiratory failure (518.81) should be monitored. When respiratory failure is present upon admission with decompensated congestive heart failure, congestive heart failure should be sequenced as the principal diagnosis (DRG 127). If respiratory failure is sequenced first, the case will be inappropriately classified to DRG 87.

In addition to establishing data monitors for problematic diagnostic areas, hospitals may also choose to monitor problematic procedure coding in the same manner. For instance, lysis of adhesions coded in addition to hernia repair results in the assignment of DRGs 150/151 -- peritoneal adhesiolysis -- rather than the lower weighted DRGs 159-163-hernia procedures. Although the code for adhesiolysis may be appropriate, when variations from the norms occur, they should be investigated to ensure accurate coding practices.

Disciplinary Action

Corrective and/or disciplinary action should be taken against individuals who have violated the organization's compliance policies and procedures. This means all individuals, not just employees. If a physician, contractor, or coding vendor violates the policies, appropriate disciplinary measures (such as suspension of staff privileges or contract termination) should be taken.

Corrective Action

If you identify an inappropriate coding or billing practice that could be construed as fraud (i.e., it resulted in overpayments), inform your supervisor immediately. If you are not satisfied with the response (e.g., the allegations are not taken seriously and no internal investigation has been initiated), refer the matter to your organization's corporate compliance officer or to

administration if there is no compliance officer. A compliance program to correct the problem and assure it doesn't recur should be implemented at once -- before you become the target of a fraud investigation. Also, if you delay in correcting the problem, it may send the wrong message to any employees who are aware of it. Not only will it send a message that management may not be fully committed to the corporate compliance plan, an employee may decide to take matters into his own hands and file a qui tam lawsuit. If a government investigation does occur and it is discovered that management was aware of the problem and did nothing, the government may find the organization has acted in reckless disregard, which will increase the penalties. However, if management has taken appropriate steps to correct the problem and prevent its recurrence, the government will be less likely to issue sanctions.

Corrective action may include new policies/procedures, employee discipline and education, and computer system modifications. Refunds may need to be paid to affected third-party payers. Sometimes, voluntary disclosure of the misconduct to the appropriate authorities may be warranted. In cases involving small overpayments, it may be sufficient to simply send a refund check with a brief explanation that funds are being returned for claims billed in error. When the refund is large, further explanation-or a face-to-face meeting-may be necessary, especially if is not possible to make full restitution to all third parties that are affected. Not taking any action and/or retaining the financial benefits of a detected violation is not an appropriate response. It could lead to increased criminal or civil liability if later discovered.

Notes

1. A copy of the full report, "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1996," may be obtained by calling the Inspector General's office at (202) 619-1343.

2. Department of Health and Human Services. 1998 Office of Inspector General workplan.

3. Coding Policy and Strategy Committee. "Practice Brief: Data Quality." *Journal of AHIMA* 67, no. 2 (1996): insert.

4. 1996 MedPar data provided courtesy of MetriCor Inc., Louisville, KY.

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