Constructing a Coding Compliance Plan

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The government has turned its attention to coding compliance. Do you have an effective program in place? Use the steps in this article to build a coding compliance program that protects your organization.

Coding compliance has become an integral part of every HIM department's activities in recent years. In an effort to promote effective compliance programs, the Office of Inspector (OIG) of the Department of Health and Human Services (HHS) published the *OIG Compliance Program Guidance for Hospitals* in 1998.[1] This and several other compliance program guidelines encouraged organizations to develop their own voluntary compliance programs to promote adherence to applicable laws, program requirements, and private health plans. Additionally, the False Claims Act established liability against anyone who knowingly presented a false claim for payment to the federal government or conspired with others to do so.

In this article, we'll examine the steps behind constructing an effective coding compliance program. Each step uses tools that HIM professionals are comfortable working with, such as performing audits, developing policies and procedures, and educating peers, and combines them to build a powerful compliance structure that protects the organization from fraud and error. The most successful coding compliance program is comprised of clear, sound guidelines and procedures with good mechanisms to detect, correct, and prevent coding errors. It's an evolving process that needs to be continually reviewed and enhanced, using those same HIM tools.

Construction Begins

The most important part of a coding compliance program are the standards supporting it. The organization's standards of conduct provide the ethical culture expected of all employees. Coding professionals should also understand and abide by AHIMA's Standards of Ethical Coding (See "AHIMA Standards of Ethical Coding.")

Develop Coding Policies and Procedures

Coding policies and procedures serve as guidelines for coding and billing functions and provide documentation of the organization's intent to correctly report services provided. The policies should include requirements for accurate, complete, and timely documentation and coding practices as well as incorporate the laws and regulations governing coding. Complying with these policies is key in preventing coding errors or reimbursement problems.

Many resources are available to develop coding policies and procedures, but some of the more critical resources include *Coding Clinic, CPT Assistant*, the fiscal intermediary local medical review policies (LMRP), and information used by peer review organizations (PRO) for the Payment Error Prevention Program (PEPP). Keep in mind that the laws, regulations, and guidelines are constantly changing and regular review of the coding policies and procedures is necessary to ensure compliance with the current requirements. Update policies and procedures as changes occur and plan for a complete review annually. Finally, establish routine monitors of the policies and procedures to ensure compliance.

Develop a Good Working Relationship with the Billing Department

A positive working relationship with your organization's billing department is essential to an effective coding compliance program. Constant interaction and exchange of information between these departments will help an organization to submit

correct claims. Keep in mind that the OIG is looking at the accuracy of the claim, so working collaboratively with the billing department is imperative.

Keep the Chargemaster Current and Accurate

A current, comprehensive, and compliant chargemaster is the cornerstone of the reimbursement process and a compliance program. The HIM and billing departments need to work together to verify that appropriate charges, codes, and edits are in place and to conduct a review of denials so appeals can be made as needed.

Further, ongoing review, update, and maintenance of the chargemaster is required to verify that all billable services are accounted for and accurately hard coded. A multidisciplinary team should review the chargemaster or participate in the review process, because each discipline represented brings its own unique skills and insights to the process. Coding experts can advise on coding guidelines and assist with determining which codes best represent the services charged. They can also decide if direct HIM coding or chargemaster hard coding is needed.

Establish Edits for Claims

The coding and billing departments should work in tandem to establish both the inpatient and outpatient claims edits needed to identify errors prior to submission of the claim. Many of these edits are the same as those used by the fiscal intermediary (FI) or are contained in the numerous LMRPs. The coding laws, regulations, and guidelines should be used to establish the appropriate edits for your organization. Many software programs can maintain these edits, but these programs should be reviewed routinely to verify they are correct and complete.

Build on a Strong Foundation

Develop a Coding Compliance Work Plan

A pillar of a coding compliance program is developing a work plan to verify the effectiveness of the program. Use the high-risk areas selected by the government as examples of fraud, abuse, or wrongdoing, including the OIG Compliance Guidelines and the OIG Annual Work Plan as a starting point for your organization.[2] While the OIG Annual Work Plan changes each year, many items carry over from year to year. Compliance with these risk areas may prevent the OIG from knocking on your door.

Through a contract with the Centers for Medicare and Medicaid Services (CMS), the PRO in each state has implemented PEPP to reduce the payment error rate and protect the Medicare trust fund.[3] The PROs have been directed to increase monitoring efforts through the implementation of PEPP. Their key responsibilities are to verify that services provided are medically necessary, coding for services is accurate, and payments for services are reasonable. PROs are continually reviewing claims data and healthcare organizations are being asked to evaluate current admission and coding practices. The PRO in each state determines the specific codes, DRGs, or other matters to monitor. Organizations should include these high-risk areas in their coding compliance plans. (See "Compliance Risk Areas.") Do not limit compliance audits and monitors to the OIG and PRO issues only; be sure to include problems areas specific to your organization.

Prioritize the high-risk areas so more critical areas can be reviewed first and included in the work plan. Also, some risks will need to be monitored on a regular basis while others may only need periodic review.

Conduct Audits and Evaluate the Results

Ongoing record review should include regular monitoring of coding activities. Because audits are a significant part of the coding compliance program and work plan, it is important to select and perform them correctly. (See "Piece by Piece: Performing a Coding Audit".)

Once the work plan has been developed, establish a time line and identify who will be responsible for the work plan line items. Track the plan's progress and determine if further actions are necessary. The work plan will keep the compliance program on track and will be evidence of good faith efforts to have an effective coding compliance program.

Determine Action Plans Based on Audit and Monitor Results

Once the audit is completed, determine action plans for areas in which problems have been identified. Typical actions include:

- revision to policies and procedures
- development of additional policies and procedures
- further education of coders of new or revised requirements
- education of coders
- education of physicians
- revision or addition of routine monitoring
- revision to edits
- improvement of documentation

Establish a Coding Compliance Committee

Establish a coding compliance committee and meet periodically to approve policies and procedures, review findings and results from audits, focus on problem areas, and determine actions that need to be taken. In a multi-hospital organization, a system-wide coding compliance committee can be used to develop policies and procedures, evaluate system problems, and benchmark information. For example, the coding compliance committee can direct "system roaming coding audits" in which coders from each facility rotate to each facility to evaluate coding accuracy.

Assess Education Needs

Education and training can heighten the effectiveness of a coding compliance program. Because the laws, regulations, and guidelines constantly change, it can be difficult for coders and clinicians to keep up with all the rules. Design education strategies to communicate appropriate information regarding these changes. When deficiencies or errors are identified through audits and monitors, implement education action plans and evaluate for improvement.

There are many educational opportunities available to coders. One of the best methods of education may be the organization's own physicians explaining a particular diagnosis or procedure. Additional educational avenues include audio seminars and e-learning. Frequently available via the Internet, e-learning programs provide lessons, tests, and a way to track lesson completion. Many e-learning programs cover numerous topics, making them excellent channels for continuing education.

Education can also be provided in the form of medical record reviews. Incomplete or inaccurate documentation of diagnoses, complications, and comorbidities may lead to lost reimbursement or billing that does not comply with laws and regulations. A concentrated review of the medical record both concurrently and retrospectively by a multidisciplinary team of physicians, care coordinators, and coders will improve documentation.[4] The team reviews the medical record for documentation of medical necessity and confirmation of conditions and treatments. If the documentation is not found during the review, the team discusses the record with the physicians on the case and explains why additional information or clarification is needed. The team works to ensure Medicare guidelines and coding rules are being followed.

For this approach to work, intensive training sessions should be conducted with the team using Medicare and coding guidelines to ensure the documentation supports the codes and medical necessity documentation is present. Physician leaders should be identified to assist with education and follow up with other physicians on staff. The goal of the program is to improve documentation, enhance coding, and improve the accuracy of the case mix index (CMI). Both the multidisciplinary team and the physicians benefit from working together to achieve appropriate documentation.

Perform Routine Maintenance

Track the Case Mix Index

Review and validation of the CMI is vital to appropriate reimbursement. Use valid baseline averages for the CMI data to help track any deviations. The average relative weight, percentage of discharges by specialty, average length of stay, and average charges are used to validate an organization's CMI, which affects the calculation for each DRG payment. The HIM

department helps the organization receive the appropriate reimbursement by coding the accurate DRG payment for each record. This, in turn, helps to maintain the most accurate CMI. Other factors affecting the CMI but outside the HIM department's scope and control are:

- changes in admitting patterns by physicians
- new services
- changes in overall admission patterns

Review Denials and Submit Appeals

It is imperative to review denials received from the FI because they can often be appealed, resulting in additional payment for the services rendered. The access, billing, quality, and care coordination departments, nursing, and the HIM department should be involved in the review of denials. These departments can work together to form a very effective appeal process. In addition to coding, other types of denials may include observations, one-day stays, patient types, and medical necessity. One of the most important factors in an appeal is finding the appropriate documentation in the medical record to support and defend the issue.

As the denials are evaluated, look for any trends or problems. Do any edits need to be added or changed? Have all of the coding guidelines been followed? What additional education is needed for coders, physicians, and others? The follow-up needed to correct or improve the process is just as important as making the appeal. With effort, these types of denials can be reduced. The trends or problems identified and the actions taken can make a much stronger coding program.

Monitor Accounts Receivable

The HIM department plays a key role in the cash flow and bottom line of the organization. Part of an effective compliance program includes monitoring the accounts receivable (AR) on a daily basis. The AR reveals how many claims have not been submitted and the dollar amount for each claim. If medical records have not been coded, the claims have not been submitted. Reviewing the AR on a daily basis will reveal which records are most important to code. High dollar accounts may need to be coded first because they will affect cash flow the most. These records may also be the most difficult to code and may take longer for chart completion. Coding is not the only reason an account is in AR, but it is often the primary one.

Evaluate and Implement Process Improvements

Once the results of audits have been evaluated and action plans developed, it is time to implement improvement processes. These processes can help to improve documentation, improve the accuracy of coding, improve and enhance operational efficiencies, and provide the focus for additional education and training.

Your Shelter in the Compliance Storm

An effective coding compliance program will have many benefits, including the establishment of processes to meet regulatory requirements, submission of accurate claims for appropriate reimbursement and correction of reimbursement errors, and improved coding quality. Improved operational efficiencies and more reliable data for reporting and research will also flow from a compliance program. Don't underestimate the benefits of improved relations between the HIM department, billing department, and physicians.

If your organization is part of a multi-hospital system, work together to evaluate trends, problems, and best practices. Many problems or concerns may be the same across organizations. By working together to find the solutions, all facilities involved will benefit.

An effective coding compliance program will assist physicians and coders in avoiding activities that could be targeted as fraud and abuse or claims categorized as fraudulently submitted. If the OIG comes knocking at your door, the coding compliance program will help to demonstrate and defend your voluntary efforts to be compliant.

Notes

1. *Federal Register* 63, no. 35, February 23, 1999; p 8987-8998.

2. Health and Human Services Office of Inspector General Fiscal Year 2002 Work Plan—Centers for Medicare and MedicaidServices. Available at the OIG Web site, http://oig.hhs.gov/publications/workplan.html.

3. Texas Medical Foundation Payment Error Prevention Program (PEPP). Available online at www.tmf.org/pepp/ index.html.

4. Information on Arthur Anderson's DRG Assurance Program is available at www.anderson.com. [note: web site no longer active]

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Piece by Piece: Performing a Coding Audit

Performing a coding audit can seem like a daunting task, so start by breaking it down into pieces. Begin by clearly defining the purpose and goal of the audit—this will drive the audit process. For example, a purpose statement could be "The audit is being performed to identify coding errors." The corresponding goal could be "To improve coding and billing processes for correct reimbursement."

Next, identify data elements for consistent data retrieval. The value of the data element must be weighed against the time it will take to abstract it. In some cases, collection of data elements may depend on the method for obtaining them. Some software programs often can determine ways to retrieve and record data elements. Examples of data elements for an audit include:

- patient demographic information such as medical record number, account number, admit/discharge date, payer, age, discharge status, attending physician, surgeon, and coder
- original principal and secondary diagnoses codes
- audited principal and secondary diagnoses codes
- original principal and secondary procedures codes
- audited principal and secondary procedures codes
- DRG, relative weight, and payment amount
- auditor

The frequency of audits will depend on the number of coders, complexity of cases, results of initial assessments, and number of locations in the organization.

The next step is determining whether concurrent or retrospective audits will best serve your organization. Many annual audits are done retrospectively, while routine monitoring is done concurrently. Routine monitoring of policies and procedures will determine if staff is adhering to them. Concurrent audits provide the opportunity to make corrections before the bill is submitted to the fiscal intermediary (FI). Some audits, however, must be performed retrospectively. If retrospective audits are conducted, rebilling or repayment may be necessary, which may raise a red flag with the FI. Any overpayments discovered during an audit should be returned to the affected payer with documentation and explanation of the reason for the refund included.

The sample size and the method of selecting the sample are very important. The sample selection should include service types; clinician types; patient encounter types; high, medium, and low charges; diagnoses and procedures, DRG/major diagnostic category for inpatient cases, and APCs for outpatient cases. Large samples do not necessarily provide more reliable results. Keep in mind that the samples need to be consistent and measurable.

There are two types of samples: statistically significant and probe (or focused). A statistically significant random sample is representative of the entire population, whereas focused or probe samples are not. Instead, probe samples provide a way to quickly investigate if potential problems exist. Any errors identified by either a probe sample or a statistically significant sample must have claims resubmitted with repayment if necessary.

Much compliance discussion has centered around the use of external auditors versus internal auditors. When determining whether your organization will be using internal or external auditors, keep in mind that periodic reviews by external auditors may give a more objective review and provide another set of eyes reviewing the information. Further, when conducted every two to three years, external audits can provide verification of internal controls. Many audits can be conducted internally using existing coding staff. Coding professionals should play an active role in the compliance program; here is an opportunity that demands their expertise. Whether using internal or external auditors, take steps to establish attorney-client privilege to protect the audit from discoverability.

Begin the audit by establishing baseline data if possible, so subsequent audit results can be compared to the baseline data. Evaluate the results and identify problems, trends, or variations. Share the results of audits with coders as a form of education. The coders should be involved from the very beginning when an audit is selected, because they are the most knowledgeable about the coding guidelines.

Compliance Risk Areas

The OIG and PROs are targeting the following areas for compliance.

OIG Compliance Program Guidelines	**OIG Work Plan**	**PEPP**
• Billing for items or services not rendered • Providing medically unnecessary services • Upcoding • DRG creep • Outpatient services rendered in connection with inpatient stays • Billing for discharge in lieu of transfer	• OPPS • DRG pairs • Specific, high-risk DRGs such as pneumonia and cerebral vascular accident (CVA) • Results of PEPP reviews • Outlier payments	• Pneumonia • Septicemia • Chronic obstructive pulmonary disease • DRG pairs • CVA • Congestive heart failure • Arteriosclerotic heart disease

AHIMA's Standards of Ethical Coding

In this era of payment based on diagnostic and procedural coding the professional ethics of health information coding professionals continue to be challenged. A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. The following standards of

ethical coding, developed by AHIMA's Coding Policy and Strategy Committee and approved by AHIMA's Board of Directors, are offered to guide coding professionals in this process.

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data.

2. Coding professionals in all healthcare settings should adhere to the ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modification) coding conventions, official coding guidelines approved by the Cooperating Parties,* the CPT (Current Procedural Terminology) rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable healthcare settings.

3. Coding professionals should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.

4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.

5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.

6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.

7. Coding professionals, as members of the healthcare team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.

8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.

9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.

10. Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

* The Cooperating Parties are the American Health Information Management Association, American Hospital Association, Health Care Financing Administration, and National Center for Health Statistics.

These guidelines are also available at http://www.ahima.org/infocenter/guidelines/.

13 Steps to Coding Compliance

Below are the steps to developing an effective coding compliance plan.

1. Develop coding policies and procedures.
2. Develop a good working relationship with the billing department
3. Verify the chargemaster is current and accurate.
4. Establish edits for claims.
5. Develop a coding compliance work plan:
    a. Identify high-risk areas to audit and monitor
    b. Prioritize the high-risk areas to audit and monitor based on the OIG Compliance Guidelines, the OIG Work Plan, PEPP activities, and organization-specific concerns
    c. Select audits and monitors
6. Conduct audits and monitors and evaluate the results.
7. Determine action plans based on audits and monitors.
8. Conduct coding compliance committee meetings.
9. Track the case mix index.
10. Review denials and submit appeals.
11. Monitor accounts receivable.
12. Assess education needs of coders, physicians, and others.
13. Evaluate and implement process improvements.

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