Covering the Bases of Coding Compliance

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by Peggy Hapner, RHIA, CCS

As HIM professionals already know, data quality-one of the basic tenets of compliance-depends on comprehensive documentation and accurate code assignments. Because coding plays a major role in payment, reporting data accurately, managing data flow and data collection, and training staff about data quality issues are essential. Communication must also be a priority because many problems can be avoided if cooperation and information-sharing is an established standard among HIM, coding and billing staff, physicians and other care providers, and other departments.

Although specific coding problems vary in each facility, reviewing and evaluating coding, payment, and compliance practices tend to reveal the same three weaknesses. These are:

- lack of information
- inadequate or faulty documentation
- poor communication between physicians and coders

Following is a look at each of these problems and how to approach them.

Lack of Information

Far too often, coding department staff members do not have the resources they need to do their job properly. It is not uncommon to see outdated CPT and ICD-9-CM coding manuals in a facility, though coding compliance and appropriate payment cannot be achieved without the most current editions of these manuals. Further, many coders are unnecessarily left on their own to sort out coding problems. Providing copies of *CPT Assistant and ICD-9-CM Coding Clinic* is a simple but often overlooked way to improve coding. Finally, access to local medical review policies (LMRPs) is another necessity for coders because assigning codes for procedures that are not covered will result in denials and payment delays.[1]

Inadequate or Faulty Documentation

Clinical documentation provided by physicians and other healthcare providers directly contributes to code assignments and payment. Medical records must justify diagnoses, admissions, treatments performed, and continued care. The information in the operative report must be comprehensive and readable.

However, sometimes documentation is missing from the patient's record or the available information lacks specificity about the procedures or services that were provided. When documentation is provided, it may be illegible. In these situations, coders cannot abstract enough information to assign codes properly.

Physicians and providers are not the only weak link in the coding-payment chain, however. Coders can also be at fault by assigning codes based on incomplete or illegible information instead of contacting the physician for more information or clarification. The Department of Health and Human Services Office of Inspector General (OIG) targets this practice, known as "assumption coding." As always, "If it's not documented, it didn't happen," holds true.

To ensure the most accurate coding, coders should be trained to read the documentation thoroughly and glean as much detail on the procedures performed as possible from the record. Only then can they consistently and accurately choose all of the appropriate CPT and ICD-9-CM codes.

Third-party payers, along with Medicare, scrutinize claims data to determine if the documentation supports the codes assigned for the services provided. These payers use a variety of software programs to edit the claims data for completeness and the appropriateness of codes billed.

Poor Communication

Poor communication among the coding, billing, and patient accounts departments can be another hindrance to compliance. Business offices often receive claims denials or rejections but may not share these with those staff members responsible for code assignments. As a result, coders may not know that their inappropriate code assignments have caused claims denial or delay and payment loss. Additionally, code assignment improvements cannot be made without a concentrated effort to share this kind of information. Staff from the appropriate departments should work together in identifying rejections and denials, tracking denial trends, and taking corrective action. Similarly, lack of communication between coders and providers can cost facilities and providers more money than they can probably imagine. Assigning codes from poor documentation instead of talking with the physician can lead to inaccurate, incomplete code assignments, which in turn lead to claims denials or inadequate payments.

Establishing a coding and documentation policy can solve this problem. HIM department and medical staff should work together to establish an official policy that instructs coders to ask the physician for additional information when documentation is lacking. When the additional information is obtained, the physician should add it to the record so it can be considered for code assignment.

Training and educational sessions for physicians about the importance of proper documentation can play a vital role in closing the communication gap. Providing them with the official coding and documentation guidelines available also strengthens the case for accuracy and complete clinical information.

OPPS Spotlights Outpatient Coding

Accurate, comprehensive code assignment has become even more important with the implementation of the outpatient prospective payment system. It is important that all outpatient care areas (ambulatory surgery, endoscopy suites, emergency department, urgent care center, hospital-based clinics, and ancillary services) supply quality information for coding, which has been a challenge for hospitals.

After determining the appropriateness of ICD-9-CM diagnosis and CPT procedure code assignments, hospital coders may forget to assign or incorrectly assign unlisted procedure codes. Many questions also arise for coders when they are faced with the need to code bilateral procedures or "separate procedures" and when they must assign modifiers.

The facility should apply the HCFA-endorsed coding guidelines when billing outpatient services, and these should be applied for all payers, unless other specific directives have been received.

In general, assign diagnosis codes for all conditions treated and list first the diagnosis code that is chiefly responsible for the outpatient encounter or the diagnosis code that coincides with the procedure performed.

Medical necessity must be established through the use of ICD-9-CM diagnosis codes when reporting services to third-party payers. It is the facility’s responsibility to justify care, so the following information should be provided:

• knowledge of the emergent nature or severity of the patient’s condition

• all the facts regarding signs, symptoms, complaints, and patient or family history describing the reason for the service

• knowledge of Medicare’s LMRP

Ongoing Changes

The key to any quality monitoring program for coding is complete and timely documentation. Keeping apprised of all the changes that have occurred and continue to occur with the outpatient prospective payment system have also proven to be a challenge to outpatient coding staff. Make time to read the transmittals and HCFA’s Question and Answer information for Ambulatory Payment Classification (APCs) groups, because this is the method in which HCFA releases information to providers on how to report codes for services provided in the outpatient arena.

DRGs in the Crosshairs

The OIG's targeted DRG list and its list of problem-prone DRGs below provides an excellent framework for determining specific areas of inpatient coding problems. HIM and coding department managers may want to initiate quarterly audits to review accuracy and errors, then track changes from the last audit forward. This record may also highlight where educational efforts are needed.

DRG 014 – Specific cerebrovascular disorders except transient ischemic attack (TIA)

DRG 015 – Transient ischemic attack and precerebral occlusions

DRG 079 – Respiratory infections and inflammations, age > 17, with CC

DRG 080 – Respiratory infections and inflammations, age > 17, without CC

DRG 087 – Pulmonary edema and respiratory failure

DRG 088 – Chronic obstructive pulmonary disease

DRG 089 – Simple pneumonia and pleurisy, age > 17, with CC

DRG 096 – Bronchitis and asthma, age > 17, with CC

DRG 097 – Bronchitis and asthma, age > 17, without CC

DRG 121 – Circulatory disorders with acute MI and major complications, discharged alive

DRG 122 – Circulatory disorders with acute MI w/o major complications, discharged alive

DRG 124 – Circulatory disorders except AMI, w/cardiac cath. and complex diagnosis

DRG 125 – Circulatory disorders except AMI, w/cardiac cath. w/o complex diagnosis

DRG 127 – Heart failure and shock

DRG 130 – Peripheral vascular disorders with CC

DRG 132 – Atherosclerosis with CC

DRG 138 – Cardiac arrhythmia and conduction disorders with CC

DRG 140 – Angina pectoris

DRG 143 – Chest pain

DRG 144 – Other circulatory system diagnoses with CC

DRG 148 – Major small and large bowel procedures with CC

DRG 149 – Major small and large bowel procedures w/o CC

DRG 174 – Gastrointestinal hemorrhage with CC

DRG 175 – Gastrointestinal hemorrhage without CC

DRG 188 – Other digestive system diagnoses, age > 17, with CC

DRG 239 – Pathological fractures and musculoskeletal and connective tissue malignancy

DRG 296 – Nutritional and miscellaneous metabolic disorders, age > 17, with CC

DRG 297 – Nutritional and miscellaneous metabolic disorders, age > 17, without CC

DRG 316 – Renal failure

DRG 320 – Kidney and urinary tract infections, age > 17, with CC

DRG 416 – Septicemia, age > 17

DRG 429 – Organic disturbances and mental retardation

DRG 430 – Psychoses

DRG 475 – Respiratory system diagnosis with ventilator support

When inpatient claims with the above DRGs are reviewed, be sure to verify that the diagnosis and procedure codes assigned are accurate. Pay particular attention to codes that would group the cases to a higher-weighted and, therefore, higher-paid DRG. Also, review whether the complications and comorbidities identified and the code sequencing are accurate.

Note

1. Local medical review policies can be accessed at www.lmrp.net.

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