ICD-10 Coding Audits Reveal Error Trends to Avoid

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With thousands of new and revised ICD-10 codes implemented with the new coding update on October 1, 2016, reviews and audits are essential to identifying patterns, trends, and best practices that affect documentation, coding, training, education, compliance, query practices, data analysis, and more.

Some of the trends identified through audits are:

- Incorrect ICD-10 codes based on the clinical documentation
- Missed codes (though supporting documentation is present in the medical record)
- Insufficient or inconsistent documentation to support the code assignment
- Lack of supporting documentation

Overall, recent audit findings suggest some of the official guidelines have not been fully understood and the *AHA Coding Clinic for ICD-10-CM/PCS* has not been thoroughly reviewed for additional coding guidance. Best practice is to conduct routine internal and external audit reviews to provide valuable insight and mitigate risk due to incorrect code assignments.

Top Audit Findings—Trends to Watch

Since the release of ICD-10-CM/PCS Official Guidelines for Coding and Reporting updates, various trends and issues have been identified. Based on audit findings, clarification is provided below to help resolve some of these common recurring errors.

Linking Related Conditions

Certain conditions must be coded as related, even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

Coding professionals are often not applying this guideline to diabetes and all the manifestations listed in the Alphabetic Index under the main term Diabetes and the subterm "with." Examples include arthropathy, chronic kidney disease, dermatitis, foot ulcer, gangrene, nephropathy, polyneuropathy, retinopathy, and more. It is important to note that if a physician documents a related condition separately—doesn't specify "with"—the coding professional may assume a cause-and-effect relationship and automatically link the two conditions, as it may impact the DRG, severity of illness, or risk of mortality.

Peripheral Neuropathy versus Polyneuropathy

If peripheral neuropathy is documented when coding diabetes, the correct code assignment is E11.42 DM2 with diabetic polyneuropathy—not E11.40 DM2 with diabetic neuropathy unspecified. Peripheral neuropathy (alone) codes to G62.9 polyneuropathy, which is listed under the main term Diabetes and the subterm "with" in the Alphabetic Index.

Congestive Heart Failure

Congestive heart failure can now be automatically linked with hypertension in ICD-10-CM. In ICD-9-CM, a cause-and-effect relationship was presumed with hypertension and chronic kidney disease only.

Heart Failure—HFpEF and HFrEF

Heart failure with preserved ejection fraction (HFpEF) may be interpreted as diastolic heart failure. Heart failure with reduced ejection fraction (HFrEF) may be interpreted as systolic heart failure. Coding professionals are often not applying the guidance per the 2016 first quarter *Coding Clinic*, pages 10-11. Doing so can significantly reduce the number of queries.

Post-term Infant Gestational Age

As a reminder, the ICD-10-CM code for P08.21, Post-term infant is often missed. This is not a new issue, but still occurs. Post-term infant and prolonged gestation of infant may be assigned based only on the gestational age of the newborn. A specific condition or disorder does not have to be associated with the longer gestational period to assign these codes per the 2006 second quarter *Coding Clinic*, pages 12-13.

Weeks of Gestation

Category Z3A codes, weeks of gestation, should not be assigned for pregnancies with abortive outcomes or for postpartum conditions. This category is not applicable to these conditions, but is often coded.

External Cause Codes

External cause codes are often missed for each encounter for which the injury or condition is being treated—initial, subsequent, sequela—which is required in the state of California.

Clinical Criteria

The published coding guideline regarding clinical criteria and code assignment is still often misunderstood or misinterpreted by coding professionals. It is not the coder's responsibility to decide whether or not to assign a code based on their interpretation of clinical criteria. The physician should clearly provide supporting documentation for the diagnosis, justify the treatment and services, and document the course and results as defined by the Centers for Medicare and Medicaid Services (CMS) requirements. Ensuring required documentation and code assignment requires a strong collaboration with the health information management (HIM) department, clinical documentation improvement (CDI) team, and physician liaisons. This is critical—not an option.

Percutaneous and Open Procedures

Incorrect code assignment of open versus percutaneous procedures continues to occur. There's a misconception that once "incision" is documented it is automatically coded to "open"—cutting through the skin or mucous membrane and/or other body layers to expose the site of the procedure. "Percutaneous" is the entry by puncture or minor incision or instrumentation through the skin or mucous membrane and/or other body layers to reach the site of the procedure. Since both approaches may involve incision, careful review of the documentation in the operative report is crucial. If documentation is not clear, query the provider for clarification. Keep in mind that improved, compliant, and non-leading query templates are needed to accurately support incisional or non-incisional.

Peripherally Inserted Central Catheter (PICC) Lines

Coding professionals incorrectly report the procedure code assignment for PICC line insertions and fail to validate the correct position of the tip of the catheter. For example, a coder may code the site of entry rather than where the tip was placed, often at superior vena cava.

Unspecified Codes

The use of unspecified codes is an ongoing issue, but to a lesser degree than before ICD-10. Symptom codes are often used, but there should be a definitive diagnosis supported by the clinical documentation and knowledge of the patient's condition. However, sometimes symptoms or unspecified codes are appropriate to accurately capture the healthcare encounter, which commonly occurs during emergency department encounters. According to CMS, every encounter should be coded to the level

of certainty known. Coders cannot assume the role of physician. Best practice is to query the physician to ensure coding accuracy and compliance.

Optimal Coding and Productivity a Perpetual Challenge

Coding professionals are under increased pressure to achieve optimal quality and productivity. Leadership is focused on maintaining productivity, often to the demise of quality coding. We're all programmed to meet productivity standards, while striving to meet quality measures as well. For example, consider the number of progress notes required for an average four-day length of stay. While copy and paste documentation can be an efficient option with the electronic health record (EHR), responsibility to present a complete and accurate story of each patient cannot be undermined. Balancing productivity and quality is vital, and may be difficult to achieve.

One effective practice is to remind coding professionals to use a "payer agnostic" approach to code assignment—always code each case as completely and accurately as possible. Whether it's risk-adjusted HCC-based or MS-DRG-based, all codes supported by documentation should be captured.

Measuring coding performance is still in its infancy. As an industry, HIM is not there yet. However, the web-based coding assessment application Central Learning recently conducted a nationwide ICD-10 coder contest providing baseline ICD-10 accuracy and productivity results. After analyzing the contest data the following steps were identified to help HIM directors and coding managers improve ICD-10 coding:

- Target the bottom five diagnosis-specific coding areas for ongoing coder knowledge assessment, training, and monitoring initiatives.
- Continue assessing coder knowledge in ICD-10.
- Provide targeted ICD-10 education and training to address knowledge gaps.
- Supplement internal coding reviews with monthly external coding audits.
- Balance coding productivity and accuracy performance metrics.
- Monitor coding denials from payers as they are predicted to increase in 2017.

Overall, the results emphasize the value of continuing education, audits, and feedback to ensure understanding and proper implementation of ICD-10.

Audits and Compliance Forge a Steady Path Ahead

As the ICD-10 journey unfolds, all professionals involved are still learning. Communication, collaboration, and education are essential to success. Physician champions, HIM professionals, CDI teams, coding professionals, auditors, and compliance professionals must work together to promote high standards of coding practice.

Failure to identify and address coding accuracy issues can increase the likelihood of recovery audits and place value-based care initiatives at risk. Conducting coding audits on a regular basis to ensure accuracy and compliance must be part of every organizational strategic plan. And it's important for auditors to adopt a non-punitive approach—creating partnerships to build a solid foundation for the years ahead.

References

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