Keys to Auditing Hospital and Professional Fee Coding

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A good audit program can save a provider from sanctions or fines. Whether you work on the hospital or physician side, here are some tips for better auditing practices.

Coded data is increasingly used for reimbursement, financial planning, clinical research, and evaluating quality of care. So it is more important than ever for this data to be reliable. The key to ensuring the accuracy of coded data is routine auditing—which should form the foundation of any coding quality management program.

In this article, we'll take a brief look at some auditing basics and offer some important how-tos for auditing hospital and professional fee billing.

An Ounce of Prevention: Auditing Basics

In the past, an audit program was supposed to make more money for an institution. Today, a good audit program can actually save an institution from sanctions or fines.

An audit program helps staff identify problem areas and implement solutions. The best practice is to audit concurrently, by looking at records coded each day and making any indicated changes before the bill is mailed or "dropped." If this is not possible, a retrospective audit of potential risk areas can be conducted, and a change in billing can be submitted to correct the error prior to an OIG audit. This way, an organization can avoid punitive damage charges from the OIG.

Some have said that coding is an art, not a science. In either case, a high-quality assessment program developed around the audit function can certainly help make the coding process more exact. Such a program provides objective evidence of the quality of work being performed. It also aids in identifying types of errors committed so that larger issues can be addressed and solutions that will improve overall data quality can be implemented. When an audit process is documented, an organization can prove, whether to the OIG or to hospital administration, that procedures are in place for improving and controlling the quality of coding.

Auditing can help to identify sources of coding error. Generally, there are three types of coding errors: clerical, judgmental, and systemic.

Clerical errors generally represent careless mistakes and are usually random and infrequent.

Judgment errors represent subjective, decision-making mistakes. To minimize judgment errors, a coding staff should have proper procedures and adequate training to guide decisions.

Systemic errors are the most important errors. The OIG identifies them through data trending. Systemic errors can potentially affect every record.

How to Audit Hospital Coding

Many hospitals have not only automated the coding and abstracting process but have invested in coding audit software as well. In a best-case scenario, automated data is downloaded from the abstracting system into the coding audit software. Several kinds of software are available; most offer a combination of optimizing and quality edits. From a compliance standpoint, it is important that the software provides both of these functions. Some programs will allow edits specific to each individual entity

to be added.

Once the software reviews the daily coded data, cases that have failed the edits are identified. These cases will have the reason for failure noted. From there, it is simply a matter of retrieving the record and reviewing it for any corrections. If this is done at the end of each day, corrections can be entered into the abstracting system before the bill is dropped. This eliminates the need to rebill the account and protects the institution from scrutiny resulting from too many rebills.

If the hospital has automated only the coding and abstracting process, not the auditing process, the process of auditing software can be mimicked. A department can create a report that includes details of the records coded that day. Cases that warrant auditing can be identified when reviewing the report.

While this approach may be more cumbersome, it still meets the goal of optimizing and ascertaining quality. The review can be performed and changes made to the abstracting system before the bill is dropped.

Some hospitals provide coding and abstracting systems that do not interface with the billing system. These stand-alone systems do not provide data reporting systems, because they are limited to providing a grouper for coding but do not store the coded data. In this scenario, concurrent auditing cannot be performed. Instead, staff should request reports from the billing system that allow data review for optimizing opportunities and quality assessment.

When suspect records are reviewed, the problem may be incomplete documentation. If the department has online access to the billing system, the detail bill can be reviewed to determine what resources are being used, which may provide a clue as to what conditions are being treated. Any indications in the information contained in the billing or clinical systems that might indicate missing documentation should be referred to the physician for clarification. Or, if the online system is found to be inaccurate, the appropriate corrections can be made in the billing or other system.

How to Audit Professional Fee Coding

As in hospital coding, it is preferable to audit evaluation and management (E/M) codes prior to billing. This will minimize the amount of additional work needed to correct errors and exposure to audits based on suspicious billing patterns.

Concentrating on high-exposure areas is one of the best ways to audit professional fee coding. For example, there is currently a great deal of scrutiny of critical care billing and its overuse. The best way to address this issue is to audit a sample of encounter forms with critical care codes on them, comparing the encounter form to the actual documented physician's note and determining accuracy. This audit helps determine both coding accuracy and the appropriateness of documentation.

Most institutions audit E/M codes with an audit tool, such as a form that records the number of findings in each area of history and physical examination. The level of complexity of medical decision making is also recorded. The appropriate level of E/M service is determined based on the number of findings in each of these three areas. These tools can provide coders with feedback regarding accuracy.

Again, audits can also provide physicians feedback regarding the quality of documentation. Suppose the severity of a patient's illness was very high, but the physician did not document all the necessary key components of history, exam, or decision making necessary to bill a high-level visit. In this instance, the auditor could educate the physician about demonstrating complexity of the patient and the care rendered and improving documentation in the future.

Many institutions have invested in software programs that review codes submitted for professional fee billing before the bill drops. The programs have pre-programmed edits for modifier usage, correct ICD-9-CM code assignment, codes needing additional documentation, bundling issues, and other criteria. Generally these programs relate more to submitting a "clean claim" rather than coding at the appropriate level. But they may help pinpoint more systemic coding issues.

It is important to note that some hospital coding and professional fee coding audits can be performed at the same time. However, auditing the same medical record for two different types of coding is a bit of a challenge. Hospital coding is more of a "macro" view, looking at the record as a whole, determining the principal diagnosis, the secondary diagnoses, and any procedures, which in turn determine the DRG. Professional fee coding is more of a "micro" view, looking at each physician

note individually and "scoring" it based on Health Care Financing Administration (HCFA) billing guidelines. The record is looked at as a series of notes, rather than a record as a whole.

Despite the difficulties, it is possible to audit for both areas if an auditor has experience in both types of coding. Such a dual audit can be helpful in improving physician documentation by identifying areas where further education is needed.

It's also possible to audit for the correct ICD-9-CM code assignment for the hospital and professional fee sides at the same time. The correct categorization of the disease process is the same, whether for determining a DRG or determining the correct diagnosis to be paired with the E/M code.

Once the auditor determines the correct assignment of the ICD-9-CM code, he or she should verify that the code is matched to the appropriate provider and to the appropriate note when auditing the E/M code. Each provider in the record must be treating a separate ICD-9-CM diagnosis-if not, the providers will not be paid. It is important, from both the reimbursement and compliance standpoints, to ensure that each physician is billing for the treatment of a separate condition.

The Big Picture: Trending

Concurrent review does not eliminate the need for retrospective auditing. Without reviewing the aggregate data, one may not see the big picture. The daily process needs to be augmented with a look at trends.

A good way to do this is to look at large groups of patients, comparing year-to-year activity or one six-month group to another. Reviewing this data can help you identify changes in patterns. A month-to-month comparison may not demonstrate a trend, because the patients are spread out over many codes and many DRGs.

Building New Understanding Through Trending Hospital Data

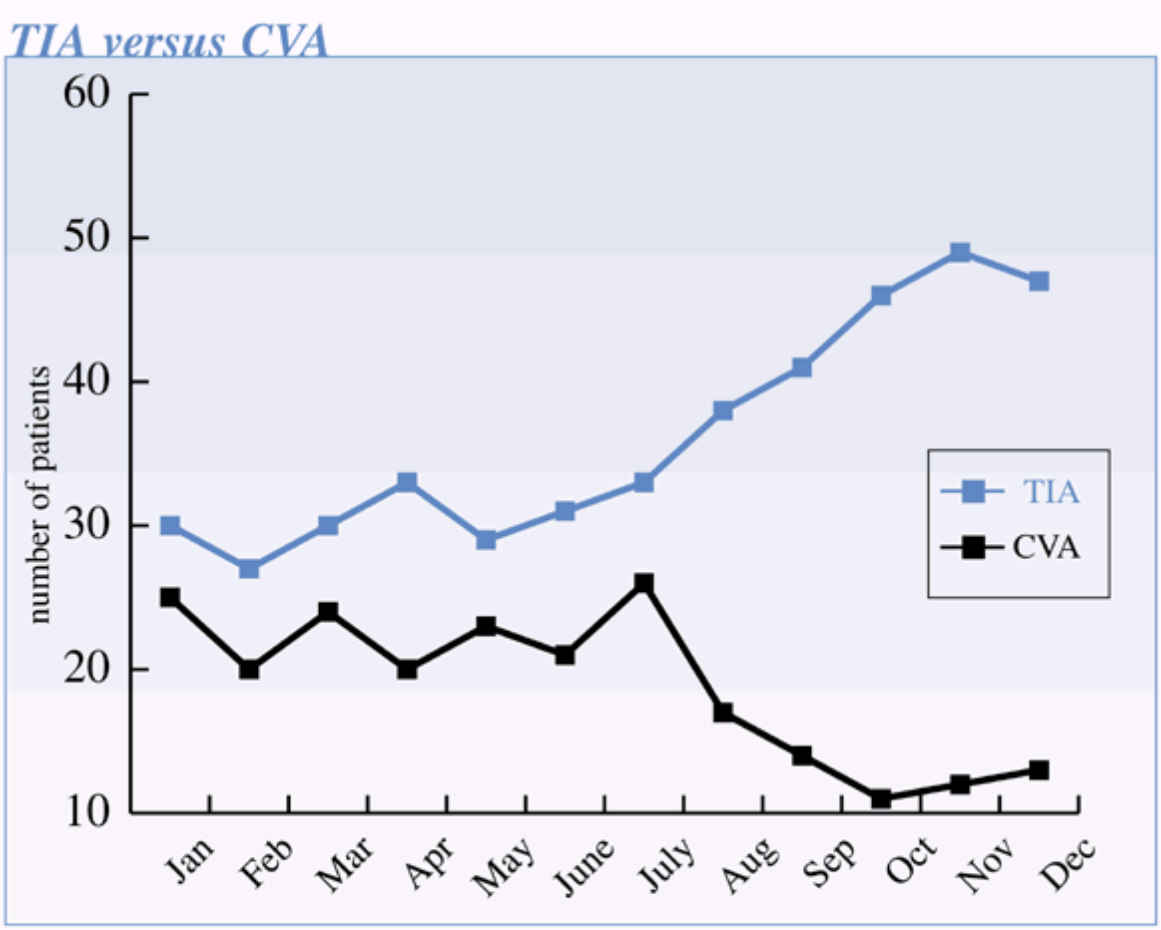
A good way to look at an institution's coded data is to use case mix. Case mix is an interrelated but distinct set of patient attributes that include severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.

The case mix index is obtained by averaging the DRG relative weight for all hospital patients. This review is the broadest that can be performed. Changes can by seen in a year-by-year comparison. When a change in pattern is identified, a focused audit can determine the accuracy of coding and grouping.

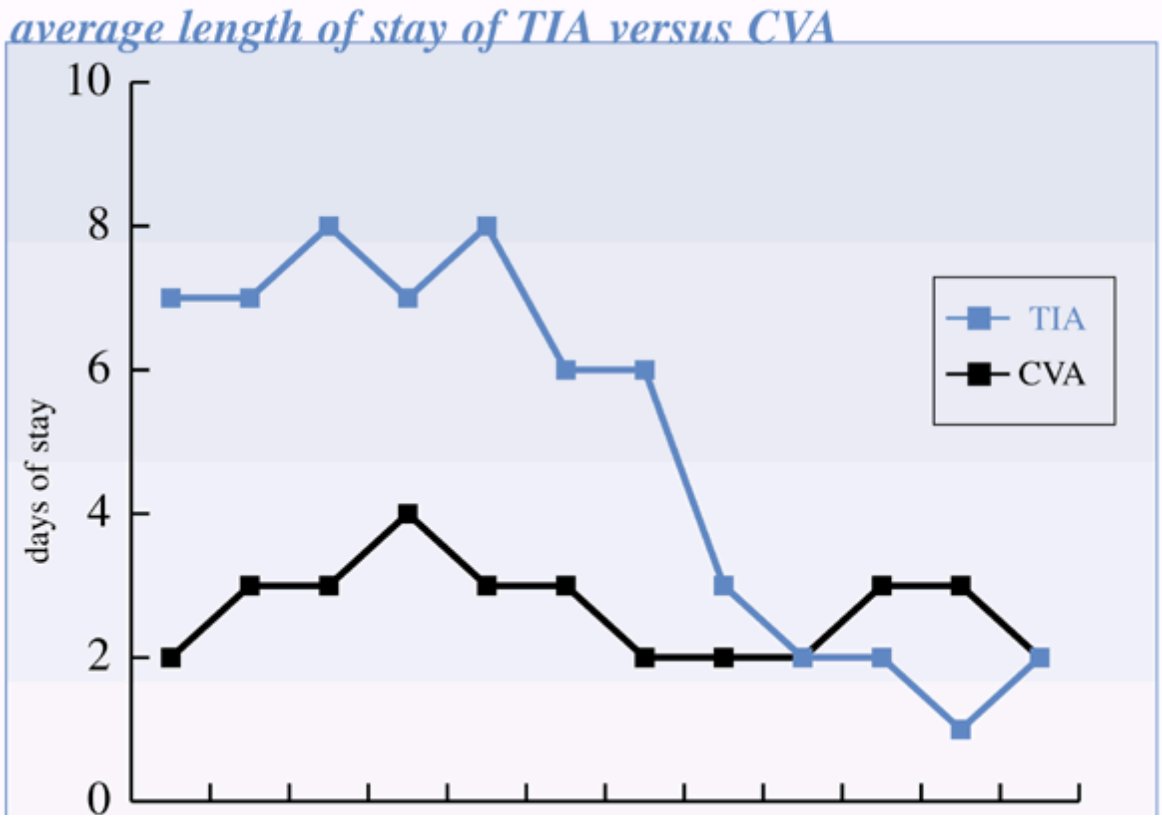
Individual DRGs can also be a basis for comparison on a year-by-year basis. Because the OIG Work Plan includes review of cases assigned to DRG 014 and 015, Transient Ischemic Attack (TIA) and Cerebrovascular Accident (CVA), these DRGs could be audited daily-as well as looking at the historical data to identify any changes in DRG assignment patterns.

Let's consider an organization that compared the total number of patients and length of stay in each DRG. Auditors noticed that while the numbers of patients assigned to each DRG was relatively stable, the CVA population's length of stay plummeted.

To explain the changes in patterns, auditors investigated further and found that the change was probably attributable to a change in treatment-a drug called tissue plasminogen activator. The use of this clot-busting drug had a major impact on the length of stay of stroke patients, allowing then to be discharged earlier with fewer sequela.



After July, something dramatic occurred, perhaps a change in coding practice or documentation issues. Whatever the source, the change is so dramatic as to warrant further investigation.



After July, the average length of stay for the CVA population decreased dramatically and leveled out. This could be related to a change in physician practice patterns or coding practice. Upon investigation, it was found that in July, tissue plasminogen activator came into use at this institution, which affected length of stay.

A retrospective review can be focused by looking at the use of "other specified" codes. These codes classify conditions whose frequency does not warrant more specific classification. They are not to be used as a reservoir for incomplete diagnoses. In fact, the OIG has recently looked at patients coded to "Other Specified Bacterial Pneumonia." Audit a selection of cases with "other specified" codes to ensure that these have been assigned correctly.

Clues to Practice Patterns Through Trending Professional Fee Data

Looking at frequency of an E/M code assignment over a certain period of time and comparing it with another period of time can also be a way to identify coding errors, changes in practice patterns, or documentation issues. Once the source of a change has been identified, corrective measures can be instituted if necessary.

For example, a change such as a substantial increase in the frequency of critical care billing since the same period of time last year needs to be investigated immediately. Perhaps the physicians have been educated on proper documentation practices and now document time spent rendering critical care more consistently; perhaps the institution has expanded the number of critical care beds; or perhaps a new coder did not understand the definition of "critical care" and billed it automatically every time he or she saw a time documented. Whatever the explanation, it's important to know the reason behind the change.

Practice patterns of certain physicians can be identified through trending E/M coding. It might be educational to compare the number of consultations among physicians or the number of consultations rendered this year versus last year. This kind of comparison could identify over- or underutilization of certain physicians or specialties. Even if the practice patterns are not problematic, any significant change in the frequency of E/M codes could indicate a change in practice patterns or documentation problems.

A Worthwhile Investment

An audit process helps to verify that an institution is assigning correct codes to data based on coding guidelines. In the bigger picture, audits can help identify trends that are important to the institution as a whole for current operations and future planning. The resulting increase in quality and assurance of accurate billing data is well worth the investment in a good data quality management program.

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Tips for Your Audit Program

Thinking about implementing an audit program? Here are some tips:

- If possible, **look at records coded daily** using coding audit software or another system.

- **Review records** for correct application of coding conventions, optimization potentials, and accuracy in code assignment, specifically in the OIG areas of concern.
- **Document the results** of the record review. Make the changes before the bill is "dropped," if possible.
- **Give feedback** to the coding staff, physicians, or other involved parties about specific errors or changes.
- **Identify in-service** topics to be presented to the coding group or physicians.
- **Use trend data** to identify changes in treatment patterns, documentation patterns, or coding patterns.
- **Document** all components of the program.

Audits Have Come A Long Way

Hospital medical record departments have long been required to keep indices of diagnoses and procedures, but not until the advent of the Medicare prospective payment system (PPS) has there been much concern about the quality of this data.

In the early days of the PPS, coded data was generally audited to ensure that records were being grouped to the highest-paying Diagnosis-related Group (DRG) legally allowable. Many for-profit companies emerged with the mission of performing optimizing audits to identify cases where the potential existed for reassignment to a higher-paying DRG. These companies were paid on a contingency basis-often a percentage of the difference between the DRG the hospital originally billed and the DRG assigned by the company.

It was relatively easy to identify the focus of the audit. Usually, it involved simply targeting the DRG pairs that relied on complicating or comorbid conditions and selecting the lower-paying DRG to audit, or looking at similar DRGs and reviewing for information to change a simple diagnosis to a more complex diagnosis, resulting in assignment to a higher-paying DRG.

Those days are gone. Today, any good audit program will continue to look for ways to optimize, but correct coding is defined by following the guidelines of the classification system, as well as correct application of Uniform Hospital Discharge Data Set definitions. A good audit program will identify problems with record documentation, ICD-9-CM coding conventions, and even the quality of official advice received from payers or the cooperating parties.

Professional fee coding has likewise evolved. In the past, many physicians assigned E/M codes based on severity or how much time, effort, and complexity was involved in the service rendered. They rarely were informed of or paid attention to the appropriate method of assigning an E/M code.

Many times, code assignment depended on the location of the patient. For example, patients in critical care units would receive critical care codes, no matter what their current condition.

In addition, the Physicians at Teaching Hospitals guidelines were not always strictly followed when documenting and billing visits. Attending physicians often did not completely document all of the services they rendered. If the house staff member documented the findings, many attending physicians billed based on the house staff note alone without documenting a complete note themselves.

Here, too, times have changed. Insurance companies and other outside agencies, particularly the OIG, are looking closely at professional fee coding and billing. HCFA's billing guidelines must be followed to avoid a time-consuming and costly audit. As in hospital coding, auditing E/M codes will help to identify documentation problems, coding quality issues, and other clinical and administrative issues.

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