Leading Change in a Laboratory Compliance Program

by Cheryl Rupp, ART, CCS

In any situation, there is a positive side and a negative side. At any moment, I decide.

—author unknown

Compliance has become the trendy buzzword in almost every industry these days, but perhaps nowhere is it quite as prevalent as in the healthcare industry. Media and government attention focus on healthcare systems—from individuals to multi-hospital systems—to close the door on fraudulent activities and abuse of government funds. But the changes are coming rapidly. And no sooner do we devise a new policy or procedure to counteract such activities, than a new one comes along to replace it. This takes us back to square one—and back to the quotation above: we can face these changes with a grim attitude, or we can embrace them as a force for positive change in our healthcare delivery system.

Compliance is about responsibility, and the HIM department plays a leading role in any compliance program.

In the world of multi-hospital entities, HIM professionals can unite to face these types of changes and challenges. Our greatest challenge was coordinating consistent policies and procedures throughout 130 hospitals. The positive aspects of this approach are many: consistent policies and procedures across the hospital system, consistent application of compliance practices, effective monitoring techniques, and improved communication. When you work as a team, each piece of the puzzle is fastened into place by networking, decision making, and finally implementation.

Where Did We Start?

In 1997, when the federal government released its Model Compliance Plan for Laboratories, we faced a daunting task—one that had a significant impact on operations, yet would help promote and maintain high levels of ethical and legal conduct throughout our hospitals. We ventured down the road of lab compliance by creating a team that offered the input of many people and perspectives. The team comprised personnel from corporate information services, legal, compliance, business services, laboratory, and charge master departments. The teamwork laid a foundation that made the transition to compliance an achievable goal.

Once the team got started, three target issues surfaced. First, we had to involve all managers—both senior/administrative team members and department heads. They would serve as part of our information dissemination team. Each hospital formed its own internal laboratory compliance team to carry out the instructions of the corporate team, led by legal counsel. Next, we knew that the cooperation of our medical staff members was crucial to the program's implementation and survival. Their training and that of their office staff had to be timely and well organized, due to the change in ordering practices. Finally, we realized the enormous responsibility that was about to be placed upon our HIM/medical records departments—accurately assigning ICD-9-CM codes to each laboratory encounter.

The Buck Stops Here

Of course, the key to any successful compliance program is adequate and appropriate documentation. After we identified the three goals, we decided to begin by stopping inappropriate laboratory requisition forms from getting through the system. This would give coding staff the necessary information to accurately code.

To create such a change, management strongly encouraged staff members not to register any patient presenting to admitting or the laboratory without a completed requisition form until the request was clarified with the physician. Since documentation of the diagnosis helps justify medical necessity, admitting and/or laboratory staff would contact the ordering physician. If a

definitive diagnosis was not provided, symptoms would be documented. When a diagnosis or symptom was provided, it would be noted on the requisition form, dated, timed, and signed by the person receiving the diagnosis.

If the test ordered did not appear to meet medical necessity based on software edits or reference materials, an Advanced Beneficiary Notice (ABN) would be signed by the patient. Either the laboratory or admitting could handle this process, depending on where registration took place. Standardized forms, both for requisitions and for the ABNs, are used throughout each hospital to ensure consistency.

Assigning the Right Code

Under the new policy, a packet of patient materials goes from the admitting office to the lab and finally to the HIM department. This packet includes the laboratory requisition form, the ABN (if applicable), and the test results. No encounter may be coded without these documents, and they must remain in the HIM department and be readily accessible. This brought us back to the issue of who would be responsible for getting codes onto the bill. Fortunately, we already had a solution.

Already in existence was our company-wide policy stating that any diagnosis coding occurring in the facility is to be performed only by qualified coding personnel under the direction of the HIM director or manager. No other personnel, including physician office staff, business office staff, admitting staff, or laboratory staff may issue an ICD-9-CM code. There is no deviation from this policy under any circumstances. The diagnoses to be coded for bill drop must be obtained only from the laboratory requisition forms.

But what to do about referral labs? Or those forms that already had numeric diagnoses assigned on them? Initially, these issues created some confusion, but eventually our internal task force agreed on a compromise protocol. With respect to specimens received as reference lab (the hospital did not physically register the patient, but rather their specimens), the hospital could accept an ICD-9-CM numeric code from the ordering physician or other licensed practitioner. However, any other outpatient encounter required that the laboratory receive a narrative diagnosis at the front end. Again, only qualified coders could assign an ICD-9-CM code to those encounters. Included in these encounters were outpatient surgeries, observation patients, and outpatient emergency room procedures.

Our program has rolled out—not without its obstacles. But while there have been some bumps in the road, it has instilled an important key word in the quest for compliance: responsibility. This became even more apparent when the decision on where the code for billing would come from was finalized. It was our policy that only qualified HIM professionals should be responsible for assigning codes across the entire spectrum of the coding process, inpatient or outpatient. The extension of our policy to the laboratory compliance project was a natural one, and one you might want to discuss at your facility.

Remember that every bill for services that leaves your facility is a reflection of you and your ethical practices. Don't you want the certainty that your bills are as accurate and ethical as possible? As a responsibility to your organization—and to your profession—it is important to make sure that your bills are as accurate and ethical as possible.

Cheryl Rupp *is regional manager for compliance at Tenet HealthSystems,Texas region, in Dallas, TX. Her e-mail address is Cheryl.rupp@tenethealth.com.*

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