Managing and Improving Data Quality (2003 update)

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Editor's note: The following information replaces information contained in the February 1996 "Data Quality" Practice Brief.

Complete and accurate diagnostic and procedural coded data is necessary for research, epidemiology, outcomes and statistical analyses, financial and strategic planning, reimbursement, evaluation of quality of care, and communication to support the patient's treatment.

Consistency of coding has been a major AHIMA initiative in the quest to improve data quality management in healthcare service reporting. The Association has also taken a stand on the quality of healthcare data and information.[1]

Data Quality Mandates

Adherence to industry standards and approved coding principles that generate coded data of the highest quality and consistency remains critical to the healthcare industry and the maintenance of information integrity throughout healthcare systems. HIM professionals must continue to meet the challenges of maintaining an accurate and meaningful database reflective of patient mix and resource use. As long as diagnostic and procedural codes serve as the basis for payment methodologies, the ethics of clinical coders and healthcare organization billing processes will be challenged.

Ensuring accuracy of coded data is a shared responsibility between HIM professionals, clinicians, business services staff, and information systems integrity professionals. The HIM professional has the unique responsibility of administration, oversight, analysis, and/or coding clinical data in all healthcare organizations. Care must be taken in organizational structures to ensure that oversight of the coding and data management process falls within the HIM department's responsibility area so data quality mandates are upheld and appropriate HIM principles are applied to business practices.

Clinical Collaboration

The Joint Commission and the Medicare Conditions of Participation as well as other accreditation agencies require final diagnoses and procedures to be recorded in the medical record and authenticated by the responsible practitioner. State laws also provide guidelines concerning the content of the health record as a legal document.

Clinical documentation primarily created by physicians is the cornerstone of accurate coding, supplemented by appropriate policies and procedures developed by facilities to meet patient care requirements. Coded data originates from the collaboration between clinicians and HIM professionals with clinical terminology, classification system, nomenclature, data analysis, and compliance policy expertise.

Thus, the need for collaboration, cooperation, and communication between clinicians and support personnel continues to grow as information gathering and storage embrace new technology. Movement of the coding process into the business processing side of a healthcare organization must not preclude access to and regular communication with clinicians.

Clinical Database Evaluation

Regulatory agencies are beginning to apply data analysis tools to monitor data quality and reliability for reimbursement appropriateness and to identify unusual claims data patterns that may indicate payment errors or health insurance fraud. Examples include the Hospital Payment Monitoring Program tool First Look Analysis Tool for Hospital Outlier Monitoring (FATHOM), used by Quality Improvement Organizations, and the comprehensive error rate testing (CERT) process to be used

by Centers for Medicare & Medicaid Services carriers to produce national, contractor, provider type, and benefit category-specific paid claims error rates.

Ongoing evaluation of the clinical database by health information managers facilitates ethical reporting of clinical information and early identification of data accuracy problems for timely and appropriate resolution. Pattern analysis of codes is a useful tool for prevention of compliance problems by identifying and correcting clinical coding errors.

Coding errors have multiple causes, some within the control of HIM processes and others that occur outside the scope of HIM due to inadequacy of the source document or the lack of information integrity resulting from inappropriate computer programming routines or software logic.

Data Quality Management and Improvement Initiatives

The following actions are required in any successful program:

- Evaluation and trending of diagnosis and procedure code selections, the appropriateness of reimbursement group assignment, and other coded data elements such as discharge status are required. This action ensures that clinical concept validity, appropriate code sequencing, specific code use requirements, and clinical pertinence are reflected in the codes reported
- Reporting data quality review results to organizational leadership, compliance staff, and the medical staff. This stresses accountability for data quality to everyone involved and allows the root causes of inconsistency or lack of reliability of data validity to be addressed. If the source for code assignment is inadequate or invalid, the results may reflect correct coding by the coding professional, but still represent a data quality problem because the code assigned does not reflect the actual concept or event as it occurred
- Following up on and monitoring identified problems. HIM professionals must resist the temptation to overlook inadequate documentation and report codes without appropriate clinical foundation within the record just to speed up claims processing, meet a business requirement, or obtain additional reimbursement. There is an ethical duty as members of the healthcare team to educate physicians on appropriate documentation practices and maintain high standards for health information practice. Organizational structures must support these efforts by the enforcement of medical staff rules and regulations and continuous monitoring of clinical pertinence of documentation to meet both business and patient care requirements

HIM clinical data specialists who understand data quality management concepts and the relationship of clinical code assignments to reimbursement and decision support for healthcare will have important roles to play in the healthcare organizations of the future. Continuing education and career boosting specialty advancement programs are expected to be the key to job security and professional growth as automation continues to change healthcare delivery, claims processing, and compliance activities.[2]

Data Quality Recommendations

HIM coding professionals and the organizations that employ them are accountable for data quality that requires the following behaviors.

HIM professionals should:

- Adopt best practices made known in professional resources and follow the code of ethics for the profession or their specific compliance programs.[3] This guidance applies to all settings and all health plans
- Use the entire health record as part of the coding process in order to assign and report the appropriate clinical codes for the standard transactions and codes sets required for external reporting and meeting internal abstracting requirements
- Adhere to all official coding guidelines published in the HIPAA standard transactions and code sets regulation. ICD-9-CM guidelines are available for downloading at www.cdc.gov/nchs/data/icd9/icdguide.pdf. Additional official coding advice is published in the quarterly publication AHA Coding Clinic for ICD-9-CM. CPT guidelines are located within the CPT code books and additional information and coding advice is provided in the AMA monthly publication CPT Assistant. Modifications to the initial HIPAA standards for electronic transactions or adoption of additional standards

are submitted first to the designated standard maintenance organization. For more information, go to http://aspe.os.dhhs.gov/admnsimp/final/dsmo. htm and www.hipaa-dsmo.org/faq/ [link no longer valid]

- Develop appropriate facility or practice-specific guidelines when available coding guidelines do not address interpretation of the source document or guide code selection in specific circumstances. Facility practice guidelines should not conflict with official coding guidelines
- Maintain a working relationship with clinicians through ongoing communication and documentation improvement programs
- Report root causes of data quality concerns when identified. Problematic issues that arise from individual physicians or groups of clinicians should be referred to medical staff leadership or the compliance office for investigation and resolution
- Query when necessary. Best practices and coding guidelines suggest that when coding professionals encounter conflicting or ambiguous documentation in a source document, the physician must be queried to confirm the appropriate code selection[4]
- Consistently seek out innovative methods to capture pertinent information required for clinical code assignment to minimize unnecessary clinician inquiries. Alternative methods of accessing information necessary for code assignment may prevent the need to wait for completion of the health record, such as electronic access to clinical reports
- Ensure that clinical code sets reported to outside agencies are fully supported by documentation within the health record and clearly reflected in diagnostic statements and procedure reports provided by a physician
- Provide the physician the opportunity to review reported diagnoses and procedures on pre- or post-claim or post-bill submission, via mechanisms such as:
    - providing a copy (via mail, fax, or electronic transmission) of the sequenced codes and their narrative descriptions, taking appropriate care to protect patient privacy and security of the information
    - placing the diagnostic and procedural listing within the record and bringing it to the physician's attention within the appropriate time frame for correction when warranted
- Create a documentation improvement program or offer educational programs concerning the relationship of health record entries and health record management to data quality, information integrity, patient outcomes, and business success of the organization
- Conduct a periodic or ongoing review of any automated billing software (chargemasters, service description masters, practice management systems, claims scrubbers, medical necessity software) used to ensure code appropriateness and validity of clinical codes
- Require a periodic or ongoing review of encounter forms or other resource tools that involve clinical code assignment to ensure validity and appropriateness
- Complete appropriate continuing education and training to keep abreast of clinical advancements in diagnosis and treatment, billing and compliance issues, regulatory requirements, and coding guideline changes, and to maintain professional credentials

HIM coding professionals and the organizations that employ them have the responsibility to not engage in, promote, or tolerate the following behaviors that adversely affect data quality.

HIM professionals should not:

- Make assumptions requiring clinical judgment concerning the etiology or context of the condition under consideration for code reporting
- Misrepresent the patient's clinical picture through code assignment for diagnoses/procedures unsupported by the documentation in order to maximize reimbursement, affect insurance policy coverage, or because of other third-party payer requirements. This includes falsification of conditions to meet medical necessity requirements when the patient's condition does not support health plan coverage for the service in question or using a specific code requested by a payer when, according to official coding guidelines, a different code is mandatory
- Omit the reporting of clinical codes that represent actual clinical conditions or services but negatively affect a facility's data profile, negate health plan coverage, or lower the reimbursement potential
- Allow changing of clinical code assignments under any circumstances without consultation with the coding professional involved and the clinician whose services are being reported. Changes are allowed only with subsequent validation of the documentation supporting the need for code revision

- Fail to use the physician query process outlined by professional practice standards or required by quality improvement organizations under contract for federal and state agencies that reimburse for healthcare services
- Assign codes to an incomplete record without organizational policies in place to ensure the codes are reviewed after the records are complete. Failure to confirm the accuracy and completeness of the codes submitted for a reimbursement claim upon completion of the medical record can increase both data quality and compliance risks[5]
- Promote or tolerate the falsification of clinical documentation or misrepresentation of clinical conditions or service provided

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Notes

1. For details, see AHIMA's Position Statements on Consistency of Healthcare Diagnostic and Procedural Coding and on the Quality of Healthcare Data and Information at www.ahima.org/dc/positions.

2. For more information on AHIMA's specialty advancement programs, go to http://campus.ahima.org. Institutes for Healthcare Data Analytics and Clinical Data Management are planned for the 2003 AHIMA National Convention. Visit www.ahima.org/convention for more information.

3. AHIMA's Standards of Ethical Coding are available at www.ahima.org/.

4. Prophet, Sue. "Practice Brief: Developing a Physician Query Process." *Journal of AHIMA* 72, no. 9 (2001): 88I-M.

5. More guidelines for HIM policy and procedure development are available in Health Information Management Compliance: A Model Program for Healthcare Organizations by Sue Prophet, AHIMA, 2002. Coding from incomplete records is also discussed in the AHIMA Practice Brief "Developing a Coding Compliance Document" in the July/August 2001 *Journal of AHIMA* (vol. 72, no. 7, prepared by AHIMA's Coding Practice Team).

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