Ongoing Coding Reviews: Ways to Ensure Quality

by Nell S. Thompson, RRA, and Doreen Koch, ART

As compliance becomes an increasingly hot topic, how can a facility ensure its coding quality? Here are some ways that HIM departments can improve the quality of coding on a daily basis.

Coding practices are continually evolving, and this evolution has brought a greater emphasis on quality. Only 15 years ago, it was daily practice for coders to aim to code as many charts per day as they could, as long as all diagnoses were documented in the chart and procedures performed had a corresponding code. Coding was not a process of "putting a puzzle together" to determine if the clinical picture documented in the chart was reflected by the diagnoses coded. The main purpose for assigning codes was for diagnoses and procedure indexing.

The implementation of DRGs changed coding assumptions, requiring a coder to know which DRG paid the most in order to sequence the diagnoses and procedures so the hospital could be reimbursed at the highest amount possible. The advent of Coding Clinic in 1984 brought coders an official resource "dedicated to improving the accuracy and uniformity of medical record coding."[1] Indeed, the first publication of Coding Clinic discussed false claims and warned that "the Office of Inspector General (OIG) will be analyzing and monitoring the software programs that advertise an increase in reimbursement. Coding practices of hospitals using these programs will then be investigated to determine if there has been a deliberate practice of miscoding—falsifying claims."[2]

The predictions of 1984 are now reality. The OIG is actively evaluating for fraud and abuse. How can an HIM department assure administrators that coding practices are not putting a facility at risk? In this climate, ensuring coding quality should be every HIM professional's responsibility, and assessing the accuracy of the codes and DRG assignment should be a routine function of the HIM department.

Codes and Standards: Good Starting Points

The current industry focus is on coding compliance, but to attain quality coding results, all functions of the entire department must perform at an excellent standard. The HIM department at Wesley Medical Center, Wichita, KS, looks to a code of ethics/standards of performance that not only include coding and data abstracting expectations but also specify requirements for adequate and appropriate documentation, maintenance of master patient index, transcription ethics, and confidentiality standards (Exhibit 1, below). Sharpening a combination of all of the record completion activities provides the best foundation for excellence in coding and data collection. AHIMA's Code of Ethics is a good resource for preparing professional standards of performance, as is the OIG's Compliance Program Guidance for Hospitals.

A Quality Coding Assessment Program

Ongoing coding quality reviews are essential to validate the accuracy of coding and DRG assignments and to demonstrate the qualifications of the staff. A lack of coding integrity and inaccurate data has implications outside the areas of reimbursement and compliance. The integrity of the data is important for research, statistics, marketing, planning, and comparative analysis of facility performance.

Wesley Medical Center is a 760-bed tertiary teaching facility with more than 700 physicians on staff. The facility participates in a number of internal and external databases (trauma registries, outcomes systems, etc.), which necessitates vigilant concern for data integrity. In addition, Wesley is associated with a medical research institute that supports both investigational and clinical research projects. Because coding integrity and data accuracy is important, a coding compliance program has long

been in place. In 1991, Wesley's HIM department created a full-time position for a coding quality analyst within the coding section. This person is responsible for:

- conducting coding quality reviews for inpatient and outpatient cases
- educating coding staff and ancillary personnel on coding issues, especially as related to claims/billing/reimbursement issues
- maintaining knowledge of federal, state, and private regulations for coding, reimbursement, and data collection requirements by third parties
- collaborating with external entities in order to influence data integrity on a local and statewide basis

The coding quality analyst position's minimal requirements are three years coding experience in an acute care environment, AHIMA certification, effective communication skills, knowledge of federal, state, and third-party coding and reimbursement regulations, and the ability to analyze and interpret statistical data.

Reviews: The Foundation of Quality Assessment

Reviews are the cornerstone of the quality analyst's work. Each year, the coding section staff and manager determine the reviews the coding quality analyst will perform during the year. The review plan outlines the cases that will be reviewed for each month, how the cases will be selected, the type of review to be performed and what outcome data will be reported. This working list is subject to adjustment throughout the year.

The process of selecting cases for review is determined by evaluating the following indicators:

1. *High risk*

    - DRGs that have the most impact on case mix
    - CPT codes that have a high impact on reimbursement
    - potential for DRG change as identified by historical data, peer review organization, or literature

2. *High volume*

    - DRG
    - diagnosis
    - procedure

3. *Special interest*

    - new procedures or codes, e.g., implementation of CPT modifiers
    - finance department request based on reimbursement issues
    - consistency between related procedures performed by two different ancillary departments, e.g., radiological invasive procedures performed by cardiovascular lab versus radiology department
    - business office request by percent of write-off
    - code assignments impacted by discharge summary documentation
    - claim denials referred to HIM from patient accounts

The types of reviews performed include focus reviews, pre-billing reviews, retrospective reviews, or a combination of the three types.

Focus Reviews

Focus reviews are performed when a special interest is identified or for new procedures or treatments. These reviews are conducted to evaluate the impact of annual updates of DRGs and ICD-9 or CPT new/revised codes. Outcomes of focus reviews have resulted in coordination with ancillary departments for medical record form revisions to capture appropriate documentation, improve data collection, and support documentation for medical necessity.

Pre-billing Reviews

Pre-billing reviews are performed on preselected, high-risk DRGs to avoid submission of corrected claims. The review is conducted after the coder has processed the chart but before the information is released for final billing. Coders refer cases that fall within the list of selected DRGs for pre-billing review to the coding quality analyst for review. This list is reviewed, revised, and updated annually. The cases selected under pre-billing review are cases that usually have a high potential for DRG changes and/or a high impact on case mix. The financial impact of the outcomes of review (DRG changes), both increases and decreases, are reported to the chief financial officer and facility compliance officer.

Retrospective Reviews

Retrospective reviews are performed after the account is billed or coding process is finalized. These reviews are excellent ways to assess consistency between coding staff. Retrospective reviews that focus on a specific type of patient or diagnosis (e.g., obstetric cases with pregnancy-induced hypertension), help evaluate coding staff consistency, and evaluate appropriate documentation.

Outcome results from retrospective review can indicate where coding education may be needed. During retrospective review, a comparative review between charge codes and ICD-9 or CPT codes may be performed to determine if services provided are appropriately indexed. This review type may require ancillary departments to provide the coding quality analyst with a list of cases from their specific databases. Comparative review can be performed for such departments as pharmacy, lab, transfusion, or respiratory therapy.

Outcomes Reporting

The coding quality analyst collects and maintains detail information of each case reviewed. This information is used to profile individual coders' accuracy rates for pattern analysis and competency reviews. This data may lead to coder continuing education opportunities and other process improvements. Summary information is reported by the coding quality analyst to the HIM staff, director, and the department's line officer. The information outlines the number of cases reviewed, number of DRG changes, and the dollar impact of the change. Other data that are continuously collected and reported are routine monitors, e.g., case mix index, Medicare CC percent, productivity, and turnaround time. Trending reports such as individual coding reports/feedback, DRG analysis, and surgical versus medical DRGs (case mix index) are also plotted on a graph and available for review and reporting. With any request for statistics, summary data is reviewed for accuracy.

Validating the Coding Quality Process

Once a coding quality program is in place, it is necessary to make sure it is effective. To validate Wesley's review process, outside auditors re-review the charts reviewed by the coding quality analyst during the pre-billing review process. Coding audits scheduled through the corporate office also occur periodically. Although the idea of external auditors can be an intimidating prospect, the audits are viewed as educational opportunities. After the final results of the audit, the coders meet with the consultant to review the findings and discuss reasons and justifications for the original codes assigned. Assigning codes and justifying codes are two different but related skills. Learning how to communicate justification of codes assigned is a valuable tool when discussing coding issues with physicians, external auditors, peer review organizations, and other agencies.

Continuing Education and Coding Staff Support

Coders must have opportunities for continuing education related to coding guidelines and clinical education. Both Wesley and its parent company, Columbia/HCA, support continuous coding education. Wesley encourages attendance at regional coding workshops, purchasing resources (such as *Coding Clinic*, numerous textbooks and reference books, the *ICD-9-CM Coding Handbook*, and *CPT Assistant*), and distributing current published material and articles. Columbia/HCA supports the coder's continuing education through the development of a DRG coding course on the corporate intranet. This course provides actual medical records with questions and answers on code and DRG assignment based on coding guidelines.

In addition, each hospital in the Wichita area hosts a local coding roundtable meeting. The group invites physicians to speak on topics of special interest to the coding staff, such as a disease or new technology. These coding roundtables take place during the lunch hour. The host hospital selects the speaker and prepares the agenda and CE certificates. Questions and relevant scenarios can be sent in advance to the speaker prior to the meeting.

Wesley coding staff members meet monthly to discuss common coding issues, coding quality review results, coding consistency between coders, DRG/coding changes, payer issues, and procedural changes. All of the above continuing educational activity is documented and entered into the facility's educational database to maintain the continuing education hours for each coder.

Other Coding Responsibilities

The HIM and patient accounts departments work together closely on claim denials. Reviewing payer denials or paid DRG discrepancies helps coders learn the rules as they are applied by different payers. Patient accounts staff refer all denials related to coding issues to HIM staff, where they are reviewed by coders. Coders review the codes assigned to determine if it is appropriate to change, add, or delete codes, and notify patient accounts of appropriate outcomes—either by correcting the code or providing the reasons why the codes are correct according to coding guidelines and will not be changed.

Occasionally, payers request codes that may not follow coding guidelines. These requests impact data integrity of diagnoses or procedure indices. The Kansas Health Information Management Association and Wesley have initiated a working relationship with several of the payers to discuss appropriate application of standard coding guidelines. Although this process is relatively new, the results will provide statewide benefits when all payers apply coding guidelines consistently.

Orientation and Training

Coders new to the HIM coding section must meet both Columbia and Wesley orientation competencies during training. Columbia's orientation checklist includes a review and familiarization of required coding references. During the first two weeks of employment, the new coder reviews coding videotapes that include overviews of laboratory findings, diagnostic testing, anatomy and physiology of cardiovascular, respiratory, and gastrointestinal systems, and specific surgical procedures. Columbia provides an inpatient and outpatient coding manual that outlines corporate coding policies and procedures.

A new coder also participates in hospital-wide orientation, departmental orientation, and position-specific orientation. Hospital-wide orientation includes facility policies, benefits, ethics, hospital policies, and basic phone and computer application. Departmental orientation includes performance improvement and departmental routine monitors, as well as policies and procedures. Position-specific orientation is outlined in the orientation competency assessment checklist (Exhibit 2, below). This competency assessment generalizes the areas of each skill a new coder will achieve before the training period is complete. The coding quality analyst, in conjunction with the HIM staff, trains, assesses, and validates the new coder's competencies.

Quality Review Options

In some facilities, it may not be possible to hire one full-time employee to perform coding quality reviews—but it is still important that the reviews occur. Options for consideration in initiating coding quality review include contracting with an outside audit firm or asking the coding staff to review each others' charts (e.g., one coder per week performs reviews of other coders, or coders trade charts on a rotational basis). Small facilities that employ only one coder could create a partnership with another small facility and review each other's charts for accuracy. It's helpful to keep things simple: it's not necessary to review every chart by every coder every time. Improvements or shortcomings can be discovered in every review. Small improvements eventually generate large results.

With increased emphasis on compliance, there is also increased pressure from internal and external sources for accuracy in coding. An administration that values coding quality and data integrity creates an environment for ethical practices. Building a time commitment to new quality initiatives and providing opportunities for continuous education and the necessary resources to support the coding staff also support the coding functions in your facility and contribute to a quality program.

exhibit 1—Wesley Medical Center HIM standards of performance

I. **Purpose**

To define the standard of performance for health information management practices concerning confidentiality of health information, coding compliance,

complete and accurate documentation, abstracting data elements for comparative and aggregate data.

II. **Policy**

A. Confidentiality of Health Information

1. HIM employees will protect the confidentiality of primary and secondary health records as mandated by law, professional standards, and hospital policies

B. Diagnosis and Procedure Coding and Abstracting

1. HIM employees will promote accurate and ethical coding and complete documentation that reflects the level of services provided to the patient
2. The diagnosis and procedure coding will be governed by official coding guidelines and all codes mandated by the guidelines should be assigned and reported
3. Assignment of ICD-9-CM, CPT-4, ICDO codes, and DRG will be performed by qualified staff
4. HIM coders will strive for the optimal payment to which the facility is legally entitled, but it is unethical and illegal to maximize payment by means that contradict regulatory guidelines
5. HIM abstractors will collect data accurately to reflect the documentation in the record for use in education, research, reimbursement, and contracts with authorized users

C. Medical Record Documentation

1. Physicians should be consulted for clarification when they enter conflicting or ambiguous documentation in the chart
2. Assessment must be made of the documentation in the chart to ensure that it is complete, adequate, and appropriate to support the diagnoses and procedures selected to be abstracted and to describe the patient's condition and treatment
3. As the legal document for patient care, all HIM employees are responsible for the condition and repairs of the medical record

D. Master Patient Index

1. The integrity and accuracy of the master patient index will be maintained in order to serve as the foundation for consolidated medical records and for the electronic library

E. Transcription See AAMT Code of Ethics.
F. Professional See AHIMA Code of Ethics.
G. Business Ethics See Columbia/HCA Corporate Code of Conduct.

exhibit 2—HIM orientation competency assessment

Employee_____ Employee #_____
Date_____

The following competency assessment checklist will reflect competent demonstration of orientation skills. The employee must be able to perform the skill independently, according to Wesley Medical Center policies and procedures, before competency is validated. All skills must be observed by the department director, preceptor, or designee to validate competency. Validator(s) must sign and initial the final page of the checklist.

Position: **CODING** Self-Assessment Y=Yes; N=No Competency Validation

Skills:	Have you ever utilized this equipment and/or skill?	Do you feel competent in using this equipment and/or skill?	Related policy and procedure reference	Preceptor discussed or demonstrated Date and Initials	Competency validated Date and Initials
Application of encoder product	Y/N	Y/N			
Assign & sequence ICD-9 codes for all patient types	Y/N	Y/N			
Assign & sequence CPT codes for ER and ASC	Y/N	Y/N			
Optimize DRG and/or ASG	Y/N	Y/N			
Reimbursement methods for all payers	Y/N	Y/N			
Application of coding resources	Y/N	Y/N			
Unbillable process within HIM (billable & unbillable records)	Y/N	Y/N			
Data fields required for abstracting	Y/N	Y/N			
Blue Cross S+I abstracting	Y/N	Y/N			
Sending/receiving e-mail via MOX (MediTech)	Y/N	Y/N			
Chart locations (IFA; Perm; DIS, etc.)	Y/N	Y/N			
Checking charts to locations	Y/N	Y/N			
Requesting charts	Y/N	Y/N			
Patient care inquiry—online data	Y/N	Y/N			
HIM processes impacting coding: charting assembly, analysis, checking	Y/N	Y/N			
Coding section performance improvement monitors	Y/N	Y/N			
Section performance improvement activities	Y/N	Y/N			
Rebill process	Y/N	Y/N			
Patient accounts requests	Y/N	Y/N			

Other:

Preceptors:
Signatures _____ Initials _____
_____ _____
_____ _____

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Notes

1. "Introducing Coding Clinic for ICD-9-CM." *Coding Clinic for ICD-9-CM* 1, no. 1 (1984): 1.
2. Brooks, Patricia. "DRG Software Packages—Uses and Misuses." *Coding Clinic for ICD-9-CM* 1, no. 1 (1984): 15.

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