Increasing Coding Compliance *and* Reimbursement

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HCCS HIM SERVICES

Agenda

- Coding
  - Right people, Right tools
  - Team Approach
  - Audits and Monitoring
- Industry Guidance
  - Compliance Plans
  - Identifying and Measuring Areas of Risk
- Defining Best Practices
- The rest of the story- HCCS's experience

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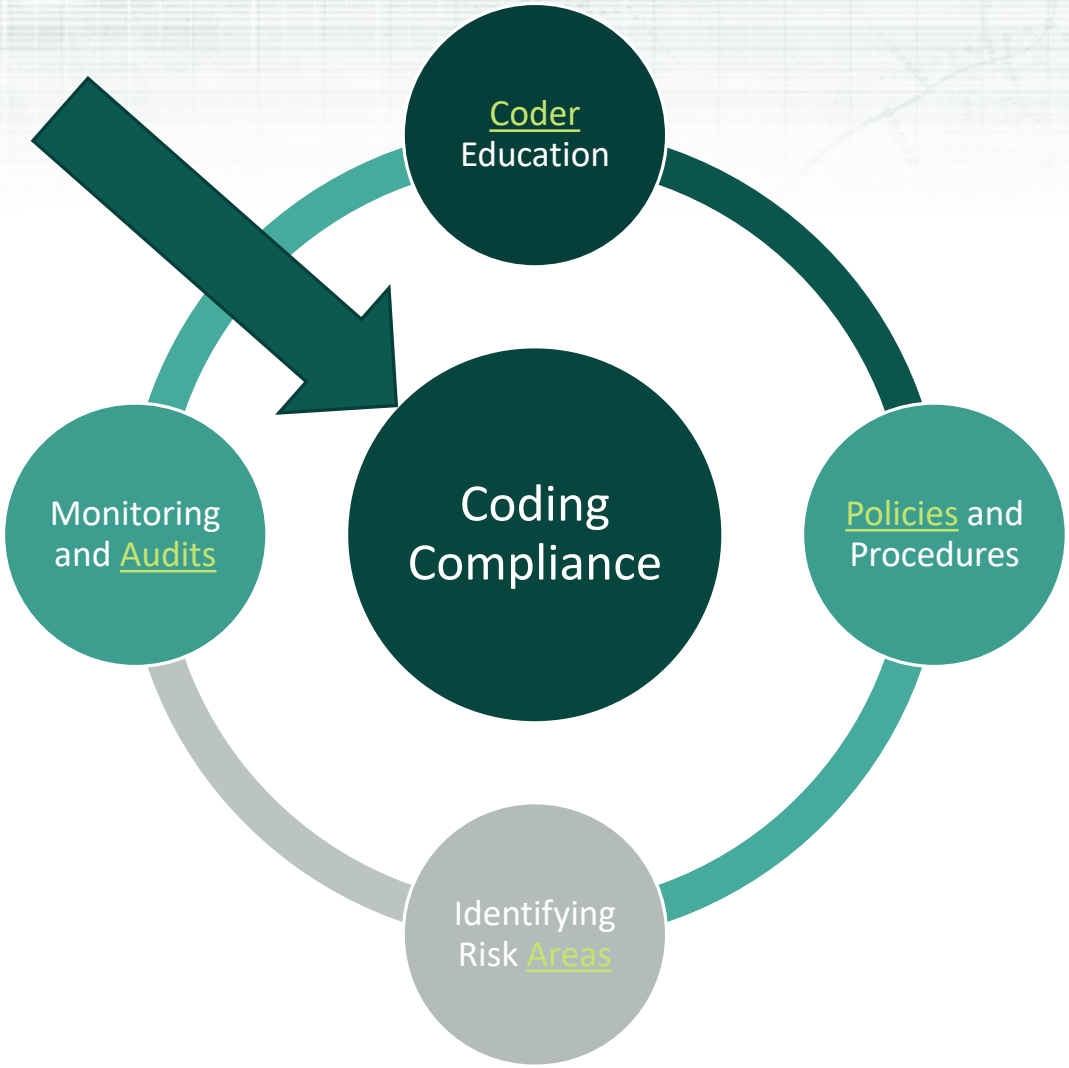

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Take the Test to determine your risk

- ❑ Do you offer mandatory education to your coders currently?
- ❑ Are your coders credentialed?
- ❑ Do you validate your coders recertification and mandated CEU's?
- ❑ Do you have coders who code multiple specialties (i.e. inpatient/outpatient)?
- ❑ Do you have access to and review the most current education, such as Coding Clinics quarterly, CPT assistants?

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Coder Education

- Know your sources!
- Know your Code maintenance schedules
- Provide education, don't assume your coder is handling
- Leveraging technology to provide cost-effective education, especially those with limited time or resources

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Best Practices

- Monthly/ongoing training is **imperative**

Areas to include:

- Current CPT Assistant reviews
- Current AHA Coding Clinic reviews
- Changes to the PPSs
- Annual CPT Changes (January)
- Annual ICD-10 Changes (October)
- Annual OIG Workplan
- Clinical Information related to coding (procedures, disease process etc.)
- Identifying your teams weaknesses, and providing group remedial

Policies and Procedures

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Take the Test to determine your risk

- ❑ Do you have **Coding** Policies and Procedures in HIM and available to your Coding staff?
- ❑ Have your Policies and Procedures been reviewed for accuracy within the last 12 months?
- ❑ Do you have an expected coding accuracy rate documented within your policy and procedures?

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Example Policies and Procedures:

- Audit and Monitoring System
  - Audit/Monitoring Schedule
  - Concurrent and Targeted Audits
- Rebills Process (APC/DRG Changes)
- Ambiguous or deficient documentation
- Explanation of Source Guidance (Official)
- Process when no Source guidance is available

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Code of Conduct

Every HIM should develop a code of conduct

- AHIMA's Standards of Ethical Coding
- AAPC's Standards of Ethical Coding

http://bok.ahima.org/CodingStandards#.WmElzqrrumQ

https://www.aapc.com/aboutus/code-of-ethics.aspx

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Excerpts from the AHIMA Standards of Ethical Coding

- Apply accurate, complete, and **consistent coding practices that yield quality data**
- **Facilitate, advocate, and collaborate with healthcare professionals** in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.
- **Advance coding knowledge and practice through continuing education**, including but not limited to meeting continuing education requirements.

Identifying and Measuring Areas of Risk

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Take the Test to determine your risk

- ❑ Do you concurrent audit certain DRG's, pre-bill review?
- ❑ Do you target certain DRG's retrospectively?
- ❑ Are you familiar with target areas from OIG, CMS, RAC and incorporate them into your internal monitoring?

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- **CERT** (Comprehensive Error Rate Testing)- The improper payment rate estimates the payments that did not meet Medicare coverage, coding, and billing rules
- CMS and MACs analyze data and MACs develop strategies to reduce improper payments
- Corrective actions include:
  - Refining improper payment rate measurement processes
  - Improving system edits
  - **Updating coverage policies and manuals**
  - **Conducting provider education efforts**
  - Prior authorization projects
  - Risk based provider screening
  - Comparative Billing Reports (CBRs)to specific providers
  - **Program for Evaluating Payment Patterns Electronic Report (PEPPERs) to inpatient hospitals**

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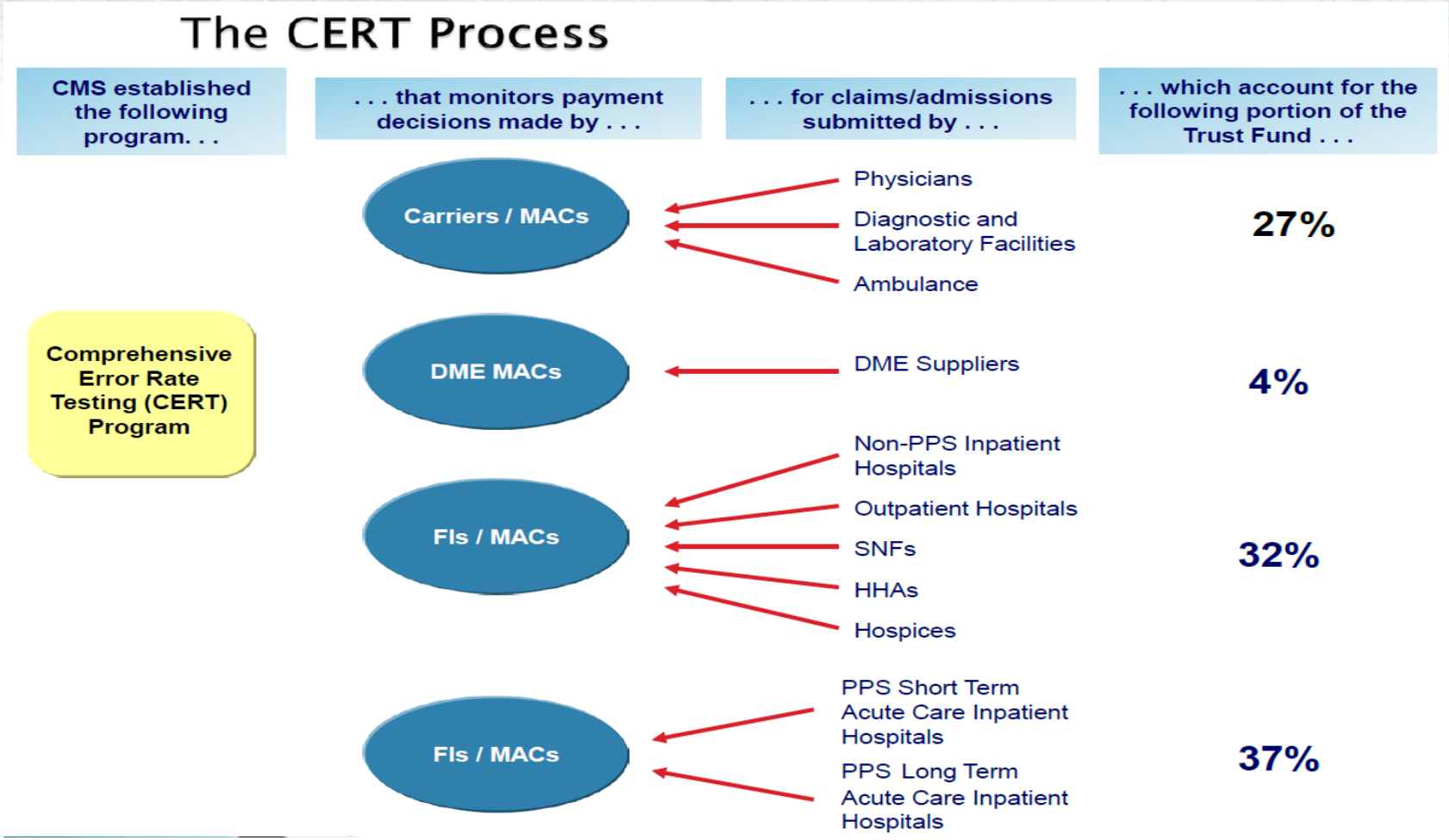

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/downloads/CERT_101.pdf

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CERT Major Error Categories

- **No Documentation**
  - provider does not have or fails to respond in timely manner
- **Insufficient Documentation**
  - the medical documentation submitted is inadequate to support payment for the services billed; or
  - the CERT contractor reviewers could not conclude that the billed services were actually provided, provided at the level billed, and/or were medically necessary
- **Medical Necessity**
  - the CERT contractor reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage and payment policies
- **Incorrect Coding**
  - a different code than that billed,
  - that the service was performed by someone other than the billing provider or supplier,
  - that the billed service was unbundled, or
  - that a beneficiary was discharged to a site other than the one coded on a claim.
- **Other** (do not fit other categories e.g. non covered service, duplicate bill)

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- American Hospital Association's **RAC*Trac*** 2,575 hospitals have participated in RAC*Trac* since data collection began in January of 2010. 745 hospitals participated this quarter.
- 60% of reviewed claims in Q4 2015 were found to not have an overpayment.
- 40% of hospitals indicated, for automated denials, that outpatient coding error had the largest financial impact.
- 81% of hospitals received a complex denial based on inpatient coding in Q4 2015.
- Hospitals report appealing 49% of all RAC denials.
- 39% of hospitals report having a denial reversed in the discussion period
- 48% of all hospitals reported spending more than $10,000 managing the RAC process during the 4th quarter of 2015, 29% spent more than $25,000, and 7% spent over $100,000.

http://www.aha.org/content/16/15q4ractracresults.pdf

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Know where previous improper payments have been Found

Look to see what improper payments were found by the RACs:

- Demonstration findings: www.cms.hhs.gov/rac
- Permanent RAC findings: Will be listed on the RACs' websites
- Look to see what improper payments have been found in OIG and CERT reports
- OIG reports: *www.oig.hhs.gov/reports-and-publications/index.asp*
- CERT reports: *www.cms.hhs.gov/cert*

www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Addlinks.pdf

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New and Ongoing OIG Items

- Jan 2018-
  - Hospitals Billing for **Severe Malnutrition** on Medicare Claims
- December 2017-
  - Payment Credits for **Replaced Medical Devices That Were Implanted**
- October 2017-
  - **Specialty Drug Coverage** and Reimbursement in Medicaid
  - Review of Medicare Payments for **Bariatric Surgeries**
  - Review of Medicare Payments for **Telehealth Services**
  - **Intensity-Modulated Radiation** Therapy
  - Payments for Patients Diagnosed with **Malnutrition**
  - Risk Adjustment Data - **Sufficiency of Documentation Supporting Diagnoses**

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OIG Compliance Program Elements:

- Standards, Policies, and Procedures
- Communication, Education, and Training on Compliance Issues
- Monitoring, Auditing, and Internal Reporting Systems
- Discipline for Non-Compliance
- Investigations and Remedial Measures

Audits and Monitoring

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Take the Test to determine your risk

- ❑ Do you have regular scheduled internal audits performed on your coders and billers?
- ❑ Do you have regular scheduled external audits performed on your coders?
- ❑ Have you had DRG or diagnosis specific audits to measure coder proficiencies?
- ❑ Does administration see these coder audit reports?
- ❑ Do you complete CAPS (Coding Action Plans) as part of the corrective action?

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Audits should be front and center to identify risk

Internal audits

- Identify your own risk

External audits

- Understand and manage external audits
- Government and commercial rules
- How do your coders stack up?

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Types of Audits

- Baseline Audits
- Ongoing Audits
- Internal Audits
- External Audits
- Remedial Audits

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Areas to Consider looking at

Inpatient	Outpatient
MS DRG assignment	CPT Coding
APR DRGs vs. MS DRGs	E/M Coding
Diagnosis	Modifier Use
PCS Coding	ProFee Coding

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Internal Audits

- **Targeted audits or not?**

- **Concurrent Audits**
  - Targeted DRG's: Who is reviewing, HIM/Nursing?
    Why is this important

  - Are DRG's applied within admission or 24 hours?
    Why is this important

  - Targeting certain populations

  - An error is found, now what?

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Internal Audits

- **Retrospective Audits**
  - Is HIM the last word or is there CDI for discussion?
  - Are discrepancies reviewed
  - What is the TAT on reviews
  - Rebills
- **Education based on audits**
  - Identifying trends
  - providing targeted education
- **Balancing accuracy expectations**

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Internal Concurrent Audit Complexity

- Daily pre-bill second level review of all Medicare cases, hospital-acquired conditions (HACs), and mortalities
- Third-level risk adjusted clinical review for mortality cases (performed by clinical documentation improvement (CDI) specialists)
- Review of all PSIs [patient safety indicators] for validation, coding, and clinical opportunities daily by coding and CDI teams

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Hot Topics: The Revolving door

Become Familiar with the "Hot Topics"

- Annual work plan for the Department of Health and Human Services (HHS)
- Office of Inspector General (OIG) work plan or focus areas
- Fiscal Intermediaries provider bulletins
- Targeted audits for risk assessment such as certain DRG's

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Taking a look at the data

- PEPPER Reports
- Monitor Denials
- Monitor Internal items such as Bell Curves
- Evaluate current performance, comparing to peers

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Taking Inventory and doing more with less

- Invest in software to track and identify risk
- Inventory where audits are taking place currently and consolidate

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Coding/Corrective Action Plans (CAP)

- What is a Coding Action Plan
- Items CAP typically covers
- Focus on Remediation
- Follow up is key
- Goals and Outcomes Measurement

Defining Best Practices

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- Interdisciplinary TEAM Approach

  - Coding- Coding Manager, Auditors, Lead Coders
  - Physician- Physicians or a physician liaison
  - Nursing- CDI Specialists
  - Quality- Quality or Utilization Review staff
  - Admissions- Admissions Manager

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Action Items

- Writing Policies and Procedures
- Ensure education needs are met
- Importance of credentialed coders
- Ensure the right tools are available
- Review where your facility's area of risk is, take action!

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Action Items

- Validate if your productivity standards are correctly set, and look for areas of opportunity
- Identify a productivity tracking measuring mechanism.

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Action Items

- Auditing and monitoring Systems in place
- Effective communication mechanisms in place
- Take a good look at denials

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Learning Outcomes

- Coding Compliance
- Coder Education
- Policies and Procedures
- Identifying and Measuring Areas of Risk
- Audits and Monitoring
- Defining Best Practices

HCCS's Stories

Stories of Success

A client facility has been under the impression that Queries are a bother to the physicians. Coders have been instructed not to Query physicians and just code what they can. HCCS had to do a lot of education on coding guidelines and rules. When that was not enough we had to show them the missing reimbursement. It took the CFO and Physician liaison to work with the physicians to implement a query process.

A client facility wanted us to remove codes for CVA's when the radiologist report did not agree with the physicians diagnosis. Many hours were taken educating staff and nurses about coding guidelines.

HCCS's Stories

Stories of Success

In a client hospital South of San Francisco, we took over coding for the hospital's Emergency Department charts. We have been able to increase their charges by more than $30,000,000, which netted them over $5 million.

This was done by changing the way they assign their E/M codes and making sure that all documented procedures are captured.

They annualize about 55,000 ED visits a year – we are making them over $100 net per chart, just by making sure that codes are correctly assigned.

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References

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THANK YOU FOR YOUR TIME

We welcome all questions!

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