Coding, Corroboration, and Compliance
How to assure the "3 C's" are met

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OIG 1996 - $23.2 Billion errors

- Figure 1
- Insufficient/No documentation 46.76%
- Lack of medical necessity 36.78%
- Incorrect coding 8.53%
- Nonconverted/Unallowable service 5.26%
- Other 2.67%

- Total 100%

30% of all claims contained errors

- Figure 2
- Inpatient (PPS) 22.59%
- Physician 21.68%
- Home health agency 15.74%
- Outpatient 12.12%
- Skilled nursing facility 10.45%
- Laboratory 5.76%
- Other 11.66%

- Total 100%
- *from Coding Compliance: Practical Strategies for Success - AHIMA*

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OIG 2010 - $6.7 Billion – E/M

- OIG review – incorrect E/M code assignments- $6.7 billion.
- 42 percent of claims for E/M services in 2010 were incorrectly coded, which included both upcoding and downcoding (i.e., billing at levels higher and lower than warranted, respectively), and 19 percent were lacking documentation. Additionally, we found that claims from high-coding physicians were more likely to be incorrectly coded or insufficiently documented than claims from other physicians.

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CMS – 2013- $36 Billion

- Medicare lost over $36 billion to over-billings by providers in fiscal year 2013, with hospitals accounting for 88% of the waste. According to the Government Accountability Office – these astounding losses are largely due to documentation errors, also referred to as “up-coding,” in which a provider erroneously bills Medicare to recoup higher reimbursements. Even among well-meaning providers, clerical errors on Medicare claims drain billions from the program every year. At a result, billing error rates have steadily increased from 8.5% in 2012 to 10.1% in 2013.

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Conditions of Participation

- Verify that the patient records contain appropriate documentation of practitioners' orders, interventions, findings, assessments, records, notes, reports, and other information necessary to monitor the patient's condition.

Compliance

- Regulations
  - ICD-10 and CPT coding guidelines
  - Federal Conditions of Participation
  - Medicare and third party payer regulations

Compliance and the EHR

- Medical necessity concerns are not new with the EHR
  - They are compounded by a record in which templates and check boxes are the only documentation present on the record
  - Health professional documentation that was substandard in the paper record is not improved in the EHR
    - There may be more, but more is not the key to compliance
  - <u>Timing of entries is of considerable concern</u>
    - Override of time entry for time of actual service or task

External Coding Review

- **Preparing for the Audit**
- The first step in preparing for an external coding audit is identifying clear, concise goals. These goals should be specific to the organization and designed to address current needs. Once audit goals are clearly defined and documented, HIM directors can secure executive support, prepare coders, and identify cases

Documentation

- The old "if it isn't documented, it wasn't done" still holds true today
- Services cannot be reported on a claim to a payer until the documentation is complete
- All test results must be present on the record prior to billing
- Health Information Management has the final review before coding and release of the claim

External Coding Review

- Tips to reduce staff anxiety
  - Communicate goals early in the process
  - Position the audit as an educational benefit
  - Let results drive education for each coder
  - Use findings as a tool for improvement
  - Remind staff "no one is perfect"
  - Set individual performance goals, include in employee evaluation

Coding and Billing go hand in hand

- Coding staff today are responsible for billing functions in addition to code assignment
- Education is key
  - ICD-10
  - CPT
  - UB-04
  - Billing methodology
    - CAH
    - RHC
    - Provider based
      - RHC versus Free-standing

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Top 10 - Frequent Coding Findings

- #1 – Infusions, injections and hydration
- #2 – Code assignments from Past History and/or Problem List
    - Matching diagnoses to medications
    - Incomplete current diagnoses documentation
- #3 – E/M
    - Upcoded
    - Downcoded
- #4 – Coding Guidelines
- #5 – Screening versus diagnostic

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Top 10 - Frequent Coding Findings

- #6 – Insufficient queries
- #7 – Lack of medical necessity
- #8 – Where did that diagnosis come from ?
  - Each record must stand alone
- #9 - Possible, probable, likely
  - Inpatient – only at the time of discharge
  - Outpatient – cannot code
- #10 – E/M and Minor procedures

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Top 10 – Frequent Billing Findings

- #1 – Missing charges
  - EKGs
- #2 – Self administered drugs
  - Revenue Code 637
- #3 – Unbundling
  - Misuse of modifiers
- #4 – Screening versus Diagnostic
- #5 – DME codes on hospital/clinic claims

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Top 10 – Frequent Billing Findings

- #6 – Units
  - Drugs
  - Observation
  - Infusions/injections
- #7 – Provider
- #8 – Place of Service
- #9 – Discharge status codes
- #10 – Dates
  - Charge date
  - From and through dates

Conditions of Participation

- Verify that the patient records contain appropriate documentation of practitioners' orders, interventions, findings, assessments, records, notes, reports, and other information necessary to monitor the patient's condition.

Compliance and documentation

- Documentation is critical
  - To support admission
  - To support hourly Observation charges
  - To support an admission from Observation to inpatient status
  - To support a one or two day Inpatient stay
  - To support the medical necessity of a surgical procedure
  - To support Lab and X-ray procedures
  - To support E/M levels

Corroboration through Education

- Providers - Coding
- Nursing Staff – Coding/Billing/Providers
- Ancillary staff – Coding/Billing/Chargemaster

- Billing Staff – Coding/Chargemaster
- Chargemaster –Billing/Coding

Corroboration - Coding

- Education – ongoing
  - Individual and internal
    - Coding Guidelines
    - Coding Clinic
    - CPT Guidelines
    - CPT Assistant
    - CMS Evaluation and Management Guidelines
    - Medicare Benefit Manual

Corroboration - Coding

- External Education
  - CMS and Noridian
    - Webinars
    - Audioconferences
    - Newsletters
  - AHIMA
    - NDHIMA
  - AAPC

Corroboration - Coding

- Reviews - Develop a compliance plan
  - Internal
    - If staffing allows
  - External
      - Ongoing
      - Quarterly
      - Yearly
      - Focus reviews on previously identified issues

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Corroboration - Coding

- Outsourced Coding services
- Review is imperative
  - Internal review (ongoing)
  - External review
    - End of year one
      - Periodic, dependent on findings

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Corroboration – Provider Education

- Cloning of Medical Notes
- Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.
    - CMS Medicare A Bulletin 3Q 2006

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Corroboration – Provider Education

- Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter.

- Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
- *First Coast Options (Medicare Contractor)*

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Corroboration – Provider Education

- Education
  - Provider assigned codes
    - Review by coding staff (always) and educate
    - Policies – who has the final say?
- Queries
  - When to query
    - Insufficient/unclear documentation
    - "Lost" diagnoses
    - Final test results
      - Cannot introduce new information

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Corroboration - Nursing

- Education
- Consistency
  - Documentation in the same place
    - Start times; stop times
- Time of service or time of documentation?
  - Creates conflicts throughout the medical record
  - EHR defaults to document entry
- Template/autopopulation/cloning
  - Why is the patient here?

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Corroboration – Ancillary Staff

- Therapies
  - Documentation requirements
  - Time based codes
- Nutrition
  - Documentation requirements
  - Qualified staff
- Radiology
  - Code descriptions
    - Number of views
    - Combination codes
    - Screening versus diagnostic

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Corroboration – Ancillary Staff

- Laboratory
  - Unbundling
  - Modifiers
  - Medical Necessity

- Emergency Department
  - EMTALA
  - Infusions/injections/hydration
  - Procedures
  - Facility level criteria

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Corroboration – Billing Staff

- Admission status discrepancies
  - Inpatient versus Observation
- Date discrepancies
- Education
  - Preventative services
  - Screening versus diagnostic
  - Modifiers
  - Communication with coding staff
    - Alteration of codes/revenue codes/dates
    - Changes in electronic data submission
- RTP's and denials
  - Review with coding staff

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Corroboration – Billing Staff

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  - Review is imperative
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Corroboration - Chargemaster

- Keep it clean
- Departments
  - Understanding of their chargemaster
  - Review of their chargemaster
    - Quarterly updates
    - Yearly – code changes
    - New procedures added
    - Incorrect charging identification

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Corroboration - Chargemaster

- Policies
  - Pricing
  - Technical versus professional
  - Pharmacy
  - Radiopharmaceuticals
  - Supplies
    - Specific to chargeable versus non-chargeable supplies
  - Room and Board
    - What's included/excluded
    - Carving out Observation hours
  - General Ledger Assignments

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The 3 C's Goal

- Coding – √
- Corroboration - √
- Compliance - √

- **Communicate &**
- **Commit to the**
- **Challenge**

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