Best Practice: A Partnership Approach to a More Powerful Coding Compliance Program

Carla D. Cashio, Chief Compliance Officer, Dekalb Medical
Julia Hammerman, RHIA, CPHQ, Director, Compliance & Education, himagine solutions

Carla Cashio

Carla has over 30 years in risk and control consulting and strategic planning across a broad spectrum of industries, with 15 years concentrated in healthcare. Her experience includes:

- Setting up internal audit departments and implementing enterprise risk management frameworks.
- Leading assessment and remediation efforts to successfully breakdown barriers that impede cash acceleration efforts of revenue cycles.
- Successfully implementing the organization’s inaugural enterprise coding compliance program across the health care system. The program allows for risk remediation soon after audits are completed.
Julia Hammerman, RHIA, CPHQ

Julia has over thirty years of leadership experience in the healthcare industry, including health information, performance improvement, and revenue cycle. Most recently, Julia served as the Enterprise HIM Operations Manager for BJC Healthcare, one of the largest nonprofit healthcare integrated delivery organizations in the country. Julia’s experience includes:

- Completion of HIM ICD-10 work plan tasks, including coder training program, developing dual coding strategy, coordinating coding claims for testing, coordinating forms remediation process and submission of RFP to obtain external coding resources
- Served as Enterprise Coding Project Manager centralizing coding services into Revenue Cycle Management; completing gap analysis and developing coder orientation and training sessions
- Building an Organizational Performance Improvement department to meet changing Joint Commission requirements, which included performance improvement/quality management, HIM, infection control, risk management, and medical staff services
- Serving as HIPAA Compliance Officer and HIM consultant for organizations transitioning to an electronic medical record

Session Objectives

- Program design best practices
- Guidelines and tips for engaging physicians in the process
- Detailed approach on physician education and training
- How to engage an outside partner to complement your resources and improve your ROI
- Expected results
The Ongoing Quality Challenge

The Case for Coding Audits

- Not knowing your coders weaknesses puts your data quality and reimbursement at risk.
- Encoders and CACs are not fully refined to support ICD-10. Audit frequently to ensure correct code assignment.
- Coding audits are essential to any coding compliance plan and is considered by some federal agencies as reasonable efforts against fraud and abuse.
- Substandard quality puts your revenue at risk and exposes you to increased denials and government audits. Audit more frequently to assess skill gaps.
- With increasingly complex government legislation, healthcare organizations continue to struggle to ensure complete and accurate documentation and coding.
What are the main metrics you utilize to measure performance of your department?

Coding accuracy/quality is growing in importance

Source: Benchmark survey conducted by himagine solutions inc. and ADVANCE for Health Information Professionals

Did you increase the amount of auditing in 2016 due to ICD-10 implementation?

Over 70% of providers stepped up their audit efforts in 2016 due to the implementation of ICD-10.

The commitment to auditing coders looks to continue as we move into 2017 as 96% of respondents anticipated increasing or maintaining their level of auditing.

Source: Benchmark survey conducted by himagine solutions inc. and ADVANCE for Health Information Professionals
What are the biggest issues you face with outsource coding vendors?

Quality from outsource coding providers appears to be eroding.

Source: Benchmark survey conducted by himagine solutions inc. and ADVANCE for Health Information Professionals

The Quality Impact Quantified

- 2nd Annual Nationwide coding contest encompassing over 550 coders
- Over 1,636 cases coded – 61% IP, 41% OP, 45% ASU, 36% ED, 72% DRG, 35% Focus RAC DRG
- Quantified $753K of under coding across 998 IP cases, or $754 lost per case
- Extrapolating this over a facility with average annual discharge volume of 50,000 equates to a revenue loss of over $37 million!

* Source: “Central Learning Releases Nationwide ICD-10 Coder Performance Data”, www.centrallearning.com
Key Takeaways

► Quality is a primary concern for HIM/Coding Compliance Leaders
► Impact of ICD-10 exacerbated quality concerns
► Cannot assume you don’t have a quality issue – only an ongoing comprehensive audit program will tell you

Key Considerations for Your Audit Program
Key Considerations for Your Audit Program

*Begin by identifying a clear, concise goal for auditing*

- A Comprehensive Auditing Plan:
  - Specific to your organization
  - Designed to address current needs
  - Balanced with random and focused audit samples
  - Improves coding compliance over time

- Random vs Focused Auditing:
  - Random samples validate current performance across the board and can expose unknown areas of compliance opportunities
  - Focused selections are necessary for a deeper understanding of patterns of errors in high-risk areas, such as OIG targets or other specific compliance concerns

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### Comprehensive Audit Approach

<table>
<thead>
<tr>
<th>Inpatient Audits</th>
<th>Outpatient Audits</th>
<th>Profee Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate MS-DRG/APR-DRG assignment</td>
<td>Validate APC assignment</td>
<td>Validate Place of Service codes</td>
</tr>
<tr>
<td>All Principal and secondary diagnosis and procedures</td>
<td>Validate ICD-10 CM, ICD-10 PCS and CPT-4/HCPCS</td>
<td>Validate ICD-10 CM &amp; E/M assignment</td>
</tr>
<tr>
<td>(ICD-10-PCS and/or CPT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validate MCCs and CCs, SOI and ROM</td>
<td>Validate UB-04 forms for accuracy of units of service and accuracy of CPT/HCPCS codes</td>
<td>Validate 1500 forms for accuracy of units of service and accuracy of CPT/HCPCS codes</td>
</tr>
<tr>
<td>Validate Present-On-Admission (POA) code assignments</td>
<td>Validate correct modifier assignment</td>
<td>Validate correct modifier assignment</td>
</tr>
<tr>
<td>Identify physician query opportunities documentation opportunities</td>
<td>Validate facility E/M assignment</td>
<td>Validate compliance with Teaching Facility/Provider Documentation Guidelines</td>
</tr>
</tbody>
</table>

Identify physician documentation requirements and opportunities for improvement
Focus: Improving & Sustaining Performance

### Traditional Audit
- Performed predominately for compliance purposes
- Episodic in nature
- Coding accuracy generically defined
- Lacking coder level detail
- Results are not actionable

### Performance Audit
- Performed to identify and correct accuracy deficiencies
- Consistent frequency
- Coding accuracy applied to all procedure and diagnostic areas
- Ability to hyper-target at coder level
- Education plan to rectify issues

Process for a Performance Based Audit

- **Review** select coder/physician charts monthly
Process for a Performance Based Audit

- Review select coder charts monthly
- **Assess** compliance and revenue-based improvement opportunities

- Report assessment results and recommend development plan
Process for a Performance Based Audit

- Review select coder charts monthly
- Assess compliance and revenue based improvement opportunities
- Report assessment results and recommend development plan
- Educate coders/physicians on identified issues and opportunities
How DeKalb Medical Center Implemented a More Powerful Coding Compliance Program

Background on DeKalb Medical Center

- $400 million net patient revenue non-profit health system based in Decatur, Georgia
- Three hospital campuses
- 50 physician groups
  - > 800 physicians
  - 55 medical specialties
Challenges

- Buy-in was a significant issue – Three auditee areas needed to agree to be champions for the program (HIM, Provider Administration and Provider Champions, and Legal/Compliance)
- The program had to be seamless to the providers
- Coder deficiencies had to be validated with a quick turnaround
- Education had to be provided
- Quick implementation with limited need for DeKalb resources

External Partner Evaluations

- Directors were involved in vetting the vendors
- Members of each area were included in second level interviews
- Each proposal was reviewed by the directors
- Internal Audit Director rejected use of any vendor engaged in coding contracting activity to ensure independence
Key Considerations for Selecting a Partner

► Must have real-time reporting and validation technology
► A culture of customer service and partnership vs. a “vendor”
► Risk-based program – allowing for drilling down to specific providers and providing discerning audits and education
► Value – What intangibles does a partner bring beyond price?

Technology

► Critical Driver for Internal Audit
  ● Ease of use
  ● Real-time feedback
  ● Ease of communication
  ● Flexible reporting
Excel vs. Technology Platform

Excel
- Manual process
  - Labor intensive
  - Lends itself to errors
- No data analysis
  - Inability to drill down on errors
  - Inability to streamline educational opportunities
- No financial impact reported
- Coders struggle to correct errors timely

Technology Platform
- Automated upload process increases auditor productivity
- Quality reporting
  - Trending data analysis
  - Analysis by coder, by change reason, by ICD-10 chapter error rate, PCS error rate by root operation/body part, etc.
- Financial impact of all DRG and APC revisions
- Immediate coder feedback with revision involvement

Robust Reporting and Analytics

Example Key Findings
Data Represents 33 outpatient coders and 1,079 charts.
- Coders have a 94% overall accuracy during this time period.
- Overall accuracy is primarily impacted by diagnosis code and CPT code accuracy resulting in decreased APC payments and HCC gaps.
- Diagnosis code accuracy impacted by coding from orders versus utilization all available documentation across the 6 systems.
Drill Down Detail by Coder/Provider

<table>
<thead>
<tr>
<th>Code</th>
<th>MS-DRG Accuracy Rate</th>
<th>Discharge Disposition Accuracy Rate</th>
<th>Procedure Accuracy Rate</th>
<th>Diagnosis Accuracy Rate</th>
<th>PQA Accuracy Rate</th>
<th>Overall Coder Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>33.33%</td>
<td>33.33%</td>
<td>83.33%</td>
<td>80.99%</td>
<td>88.89%</td>
<td>81.11%</td>
</tr>
<tr>
<td>2</td>
<td>100.00%</td>
<td>65.67%</td>
<td>50.00%</td>
<td>82.31%</td>
<td>87.50%</td>
<td>85.11%</td>
</tr>
<tr>
<td>3</td>
<td>65.67%</td>
<td>0.00%</td>
<td>81.50%</td>
<td>77.39%</td>
<td>90.19%</td>
<td>82.90%</td>
</tr>
<tr>
<td>4</td>
<td>100.00%</td>
<td>100.00%</td>
<td>0.00%</td>
<td>62.50%</td>
<td>100.00%</td>
<td>86.30%</td>
</tr>
<tr>
<td></td>
<td>Overall Accuracy Rate</td>
<td></td>
<td>43.45%</td>
<td>87.88%</td>
<td>78.16%</td>
<td>91.86%</td>
</tr>
</tbody>
</table>

Financial Impact

Keeping your hospital safe from financial risk and government scrutiny.

Detail analysis of areas of both over-coding (compliance risk) and under-coding (reimbursement risk).

CMI impact is calculated and root causes identified. Opportunities for process improvements and coder education identified and action plans developed.
Provider Accuracy Trending

*Quickly identify Providers with compliance/risk opportunities*

![Provider Accuracy Trending Graph](image)

Variance Analysis Dashboards

*Compliance Officers can quickly hone in on key errors and trends*

![Variance Analysis Dashboards](image)
Reviewer Provides Real-time Audit Feedback

*Enhances and facilitates the learning process*

<table>
<thead>
<tr>
<th>Findings/Notes:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Validate</th>
<th>Revised Code</th>
<th>Description</th>
<th>Reason Code</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>F17000</td>
<td>Acute myocardial infarction, uncomplicated</td>
<td>F1700</td>
<td>Delete</td>
<td>IN</td>
<td>NOT affecting MS-DRG / APR-DRG</td>
<td>Coding Guidelines</td>
</tr>
</tbody>
</table>

The coder response to your message is shown below:

agree, not sure why the edit didn’t catch it... thanks!

The outcome of this conversation is

AGREED

Individual Provider Dashboards

207 - DevLab March 2017 PROFEE: Hospitalists

**CPT/HCPCS**

- Number of Records Reviewed: 10
- CPT/HCPCS Revisions: 0
- CPT/HCPCS Accuracy Rate: 100.00%

**Modifiers**

- Total Modifiers: 0
- Revised Modifiers: 0
- Modifiers Accuracy Rate:

**Service Units**

- Number of Service Units: 10
- Service Units Revisions: 0
- Service Units Accuracy Rate: 100.00%

**Diagnosis**

- Total Diagnosis Codes: 40
- Revised Diagnosis Codes: 6
- Diagnosis Code Accuracy Rate: 85.00%

**Overall Coder Accuracy Rate**

- Total Records: 60
- Total Revised Records: 6
- Overall Accuracy Rate: 90.00%
Communication Tools

Creating Physician Buy-in with Tailored Education
Example 1 – Diagnosis Change

- Physician documented hypertension and chronic kidney disease, therefore, additional code assignment is required.

<table>
<thead>
<tr>
<th>Orig. Code</th>
<th>Description</th>
<th>Validate</th>
<th>Revised Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J189</td>
<td>Pneumonia, unspecified organism</td>
<td>Pass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N179</td>
<td>Acute kidney failure, unspecified</td>
<td>Pass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E119</td>
<td>Type 2 diabetes mellitus without complications</td>
<td>Pass</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H10</td>
<td>Essential (primary) hypertension</td>
<td>Revise</td>
<td>H1120</td>
<td>Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chronic kidney disease, unspecified</td>
</tr>
</tbody>
</table>

Example 1 – Diagnosis Change

**Problem 1**: Community acquired pneumonia (J18.9)
*Assess/Plan*: Presently on IV ceftriaxone and Zithromax, + white count, will f/u

**Problem 2**: Acute kidney injury superimposed on chronic kidney (N17.9)
*Assess/Plan*: Baseline unknown, gentle hydration, will f/u

**Problem 3**: Type 2 diabetes mellitus (E11.9)
*Assess/Plan*: On sliding scare and levement

**Problem 4**: Benign essential hypertension (I10)
*Assess/Plan*: BP holding steady

**Problem 5**: Dyslipidemia (E78.5)

**Problem 6**: History of stroke (Z86.73)
Example 1 - Guidance

1. Hypertension
   The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertensions and conditions not specifically linked by relational terms such as “with”, “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

2. Hypertensive chronic kidney disease
   Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. **CKD should not be coded as hypertensive if the physician has specifically documented a different cause.**
   The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease. *See Section I.C.14. Chronic kidney disease.* If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

Example 2 - Specificity

**Problem 1:** Symptomatic anemia (D64.9)
**Assess/Plan:** Ongoing PRBC transfusion, will f/u cbc

**Problem 2:** UTI (urinary tract infection) (N39.0)
**Assess/Plan:** On IV ceftriaxone, will f/u

**Problem 3:** Dysfunctional uterine bleeding (N93.8)
Provider Buy-in

- Provider Champions
  - Hospitalists
  - Primary Care
  - Specialists

- Other Champions
  - HIM
  - Chief Legal Officer
  - IT

Critical Success Factors

- Vendor Customer Service
- Partnership with Vendor
  - Project Management DeKalb/himagine
  - Collaboration
  - Two-Way Accountability
- Tailored Training
- Champions
- Government, Risk & Compliance Committee
- Early Engagement of IT Team
Key Benefits and Outcomes

- Consistently applied repeatable process – enterprise wide
- Physicians championing the program
- Consistent measurement of accuracy across the enterprise
- Newly implemented physician scorecards
- Easily customized reports
- Easy to work with business partner

Does your facility have a quality issue and not know it?

- Does your facility/system/practice have an audit or compliance program in place?
  - Are audits conducted by internal auditors or do you use a third-party vendor?
  - Have you compared the results of a third-party audit to your internal findings?
- How often are audits conducted?
  - When was the last time an audit was performed?
- How are audit samples selected?
  - Random or focused?
  - Re-audit of the same coder and/or chart type?
- Do you use auditing technology?
  - Does the technology allow you to identify trends using results from multiple audits?
- Have you been subjected to external audits such as RAC?

- Are you able to identify missed reimbursement opportunities?
  - How are the missed opportunities measured?
  - How are the missed opportunities addressed and resolved?
- Do your audits provide insight into individual coder performance?
  - Do you provide feedback and/or education to coders based upon audit results?
  - How is feedback/education provided (e.g., Q&A sessions, webinars, emails with auditors directly)?
- Have you recently experienced any significant turnover that could impact your department?
- Do you have a performance audit program?
  - Are you seeing downward monthly trends in its impact?
  - How does your CMI compare to peer hospitals, is it lower?
THANK YOU!

**Contact Information:**

▶ Carla Cashio  
  ● carla.cashio@dekalbmedical.org  
  ● 404-501-7649

▶ Julia Hammerman, RHIA, CPHQ  
  ● jhammerman@himagnesolutions.com  
  ● 314-627-5151