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RESOURCE CENTER

Improving Documentation

Billing and coding audits will ensure a facility is on track and equipped to handle new requirements.

The 2010 updates to the ICD-9-CM coding system for Oct. 1, 2009 addresses more detailed specificity of code assignment. This detailed specificity is no doubt an early step toward preparation for the highly detailed coding that ICD-10 will require when it is mandatory in October 2013. HIM departments must be ready for these new changes to decrease the likelihood of delayed or denied claims due to non-specific documentation.

In addition to expanding coding requirements, other factors resulting in focal audits are the now widely distributed efforts of the recovery audit contractors (RACs) implemented by collaborative efforts of the Office of the Inspector General and the Centers for Medicare and Medicaid Services (CMS). The assignments of inappropriate codes and submission of improper billing claims can trigger a regulatory review that may result in lost revenue, and even civil or criminal penalties; it is increasingly important for health care facilities to ensure billing and coding documentation is continually accurate and complete.

Frequent, internal and well-documented audits are an important part of a facility's billing compliance plan as well as a proactive process for reimbursement compliance. Health care facilities should, at a minimum, conduct quarterly audits to uncover strengths and weaknesses of billing, coding and documentation practices. In addition, more targeted audits should be performed if there is a specific area of concern or if claim denials have been received that reflect trends of errors.

CONDUCTING AN AUDIT

Before performing an audit, it is important to have a plan. HIM managers should set auditing guidelines to establish the types of audits the facility needs, who will conduct them and how often they will occur. When it comes time for an audit, the following steps may serve as a guide to save time and resources:

- *Define the audit scope.* Know the specific area or process the audit will target and how large an audit needs to be performed. An audit will likely become overwhelming if too many charts are analyzed, but will not be representative if too few charts are reviewed. At a minimum, there should be a review of 20 patient visits for each provider and 5 percent of visits for a given period of time.
- *Audit for medical necessity.* Verify whether the services rendered and length of the hospital stay are considered medically necessary according to CMS guidelines.
- *Track the number of claims denied or in need of correction.* Resubmitting claims can be expensive. If too many claims are being incorrectly prepared, it may trigger an external audit. It is a good idea to provide additional training for staff who may be submitting incomplete or incorrect information for payment.
- *Develop a correction plan.* Once problems have been identified, involve staff in implementing solutions. Review the audit findings, make note of any obvious patterns and trends, and formulate a plan on how to resolve the issues.
- *Monitor problem areas.* After issues found in an audit have been addressed, initiate a process to revisit and review those areas prone to be trouble spots. To ascertain that the proposed action plan does not dwindle and stop in the months following, it is important to make sure that corrections become standard operating procedures.

If an audit uncovers significant problems with code selection, HIM managers should consider bringing in an outside coding reviewer to determine the cause of incorrect coding and provide training for staff so errors can be eliminated in the future. Many staffing firms employ consultants with the expertise to help increase compliance and therefore reduce revenue loss due to denied claims.

In some cases, an audit may find incorrect coding due to incomplete documentation. Without appropriate documentation, coders have difficulty categorizing patients and accurately assessing severity of illness, intensity of service and comorbidity. Coders should work with physicians to ensure they are aware of the documentation needed to justify the medical necessity of the services rendered.

For the complete reimbursement cycle to run smoothly, it is important for HIM professionals, physicians and other staff members to work together to provide accurate and complete documentation, which will prevent delays in reimbursement and claim denials. Conducting routine coding and billing audits will ensure a health care facility is on track, equipped to handle new coding specificity requirements and ready for future regulatory reviews. ■

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