Meeting Objectives

Review

- External Coding Audit Results
- Actions in Response to Results
External Coding Audit Project - Results

Overall Findings

2019 External Coding Audit revealed opportunities within the following areas:

- Coding quality – for both diagnosis and procedure assignment
- Physician documentation
  - Missing inpatient admission orders
  - Lacking specificity and details to justify coding/billing service(s)
- Laboratory Issues
  - Inaccuracy with billing units relate to technical issues
    - e.g. Same lab test done multiple times billed as a quantity of one
  - Customized CCH lab order sets consist of multiple lab tests that lack specificity for medical necessity
    - e.g. Orders for laboratory tests must be patient-specific and include the rationale/need for the test
Probes Audit Results

Examined 25 Records/Claims for facility and professional-fee coding in two (2) Diagnosis Related Groups (DRG) Categories:

- DRG 313 - Chest Pain – 88% Accuracy Rate
- DRG 690 – Kidney and UTI’s W/O Major Complication Comorbidity (MCC) - 92% Accuracy Rate

Reviewed both DRGs due to high frequency of this DRG (Diagnosis-Related Group), this may indicate lost opportunity by not capturing more specific diagnoses

- Identified code assignment errors and missing orders for an inpatient level of service
Outpatient Coding – Performed by Internal Workforce

Probe Audit Results

Probe sample of 25 Records/Claims for facility and professional-fee coding in 2-Outpatient Areas:

- Cardiac Catheterizations
  - Results – 68% CPT Accuracy Rate
  - Reviewed this area due to complex coding where add-on procedures can be under or over coded
  - Identified treating physician orders were missing rationale for procedures

- Dermatology
  - Results – 76% Accuracy Rate
  - Reviewed this area due to high volume of visits and may indicate lost opportunity for capturing all services/procedures based on documentation and coding
  - Identified potential finding of absent procedure documentation; industry standard suggests Dermatology clinics should be performing more procedures than clinic visits
Inpatient Coder Assessment Process

Approach by External Coding Contractor to Assess their Coder Accuracy

- External Coding Contractor,
  - Audits 10-records per month/per coder
  - If a contracted coder does not meet 95% accuracy, a remediation process is initiated
  - During remediation, if the contracted coder does not meet 95% accuracy for 3-consecutive months, then the coder is removed from coding CCH records
  - External coding contractor holds weekly/monthly meetings to discuss any audit or denial findings

- To address inpatient order inaccuracies,
  - If an inpatient order is missing or questionable, the external vendor transitions the records to CCH Coding Leadership
  - CCH Coding Leadership performs a secondary review of the medical records
  - If the secondary review fails to find an inpatient order, the account is transitioned to Finance/Revenue Cycle to modify the admission type based on the existing order.
Internal Processes to Improve Documentation and Coding

The following activities have been implemented at CCH

- Engaged an external Clinical Documentation Improvement (CDI) Specialist team to:
  - Provide physician documentation education through rounding and monthly educational meetings
  - Target diagnosis specificity, complications, co-morbidities, severity of illness and risk of mortality
  - Initiate CDI software to improve CDI activity (3M CDI Artificial Intelligence)
  - Identify specific DRGs for secondary CDI review in the following categories,
    - Hospital Acquired Conditions (HACs)
    - Mortality
    - Signs and Symptoms DRGs

- Implemented software (3M Artificial Intelligence) to guide coders in the following areas,
  - Facility Coding Software (3M 360)
  - Clinic Coding (3M Code Assist)
  - Physician Coding (3M Professional Fee)
Strategy to Optimize Internal Coding Accuracy

Initiatives to Improve Current Processes

- Outpatient and Outpatient Same Day Surgery Coding – Internal Workforce
  - Initiate review and feedback for each internal coder in 2Q2020
  - Continue monthly coding roundtables - discussing difficult coding cases with errors
  - Participate in monthly online webinars from several companies on various industry coding topics where coders can earn their required continuing education units
  - Develop an auditing monitoring program once leadership is staffed
  - Engage external experts to perform independent Quarterly Audits of both Internal and External Coders – contingent upon executive leadership approval and fund allocation (this initiative is not currently budgeted)
Secondary Findings in Laboratory – Probe Review

Findings are an adjunct to the external coding audit

- Follow up on laboratory findings
  - Identifying component of the billing system causing multiple tests to roll-up to one (1).
    - Correction completed, validated the change resolved the inaccurate billing
  - Planning to engage with Physician Leadership to improve Attending/Resident documentation justifying test/re-tests
  - Eliminating/reducing customized CCH lab order sets that are not within nationally defined standards
    - Once complete, will educate all Attending/Residents on tests within any customized CCH lab order set to ensure accurate lab orders are based upon medical necessity
Questions?