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STRATEGIC BRIEF

Components of an Effective Inpatient Coding Compliance Program

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THERE ARE MULTIPLE BENEFITS of an effective coding compliance program. An article published in the January 2019 issue of the *Journal of AHIMA* titled "Components of an Effective Outpatient Coding Compliance Policy Program" identified these benefits and outlined 15 important considerations when developing a voluntary compliance program in the outpatient setting.[1] This article presents additional considerations specific to coding compliance in the inpatient setting. Essential components include inpatient coding policies and procedures, inpatient coder continuing education, diagnosis related group (DRG) reconciliation, case-mix index (CMI) tracking, auditing and monitoring, corrective action, and annual updates.

INPATIENT CODING POLICIES AND PROCEDURES

Inpatient coding policies and procedures should address coding functions, standards, and practices specific to inpatient coding to ensure complete and accurate coding results. Inpatient coding policies should incorporate:

- AHIMA Code of Ethics
- AHIMA Standards of Ethical Coding
- ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting
- Applicable federal and state regulations
- Internal facility-specific policies, including a policy requiring physician documentation to support all reported diagnosis and procedure codes

Procedures related to specific coding functions should include step-by-step descriptions of the process to ensure maximum coding quality and productivity.

In instances where no official coding guidelines exist, facilities should develop internal policies to ensure inpatient coding consistency and accuracy. Internal policies should not conflict with guidance and instructions in the ICD-10-CM and ICD-10-PCS code sets, the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting, published advice in the American Hospital Association's (AHA's) *Coding Clinic*, or any federal or state regulations. The compliance program policy should specify that ICD-10-CM/PCS coding and sequencing guidance takes

precedence over official coding guidelines and official coding guidelines take precedence over facility-specific guidelines.

CONTINUING EDUCATION IS KEY

Regular and consistent education and training for inpatient coders is key to ensuring inpatient coding compliance. Coding compliance issues are often due to inconsistencies or misinterpretation of coding guidance that are a result of a lack of regular education.

Annual education should include information related to complete and accurate documentation and coding and how these components support the overall compliance plan. Ongoing regular education should address both the technical and clinical aspects of a coding topic. This education should include data monitoring, results of ongoing coding audits, and discussion of trends identified in the audit process. Education should also include information related to the Office of Inspector General's (OIG) current work plan and the impact to inpatient coders at least annually.

Regular inpatient coder education provides an opportunity for staff to discuss difficult coding cases and determine a resolution. These education sessions are often more effective when both inpatient clinical documentation improvement (CDI) specialists and coding specialists are included.

Inpatient coder education should address the following areas at a minimum:

- Annual updates to the Inpatient Prospective Payment System (IPPS)
- Annual changes and updates to the ICD-10-CM/PCS classification systems
- Quarterly review of the AHA's *Coding Clinic for ICD-10-CM/PCS* to ensure consistent application of published advice
- Ongoing review and application of the ICD-10-CM/PCS Official Guidelines for Coding and Reporting
- Ongoing review of clinical information related to error-prone diagnosis and procedure codes, such as ICD-10PCS body systems

With increased payer scrutiny surrounding clinical validation, the inpatient CDI process is a critical part of inpatient coding compliance programs. Documentation education and training should be ongoing with a collaborative effort between coding and CDI staff. Inpatient coders and CDI staff should have an opportunity to share and review areas of concern regarding clinical documentation and identified documentation gaps.

> *"Regular and consistent education and training is key to ensuring inpatient coding compliance."*

DRG RECONCILIATION AND CMI TRACKING

DRG reconciliation provides a mechanism to validate final coded DRG cases through a second-level review process. Both CDI and coding staff should provide input in reconciling inpatient cases. Second-level review involves an additional review of the clinical documentation on high-risk inpatient cases to confirm there is appropriate representation of the coded information. These types of reviews identify opportunities for clarification of provider documentation to accurately reflect the patient's severity of illness and validate the clinical appropriateness of the admission. Complete these reviews before claim submission to avoid improper billing resulting in improper reimbursement.

CMI tracking should also be included in the inpatient coding compliance program. The CMI is calculated by dividing the MSDRG relative weights of inpatient discharges in a specific time frame by the total number of discharges in that same time frame.

There are legitimate reasons for CMI variances, such as:

- The addition or deletion of services representative of high-weighted MS-DRGs
- Shifts in volumes from low- to high-weighted MS-DRG cases, or vice versa
- Addition or loss of a new local or regional competitor
- Addition or loss of a specialty physician(s) to the medical staff
- Changes in coding practices or guidelines

However, significant and unexplained variations in the CMI may be an indicator of coding variances and therefore should be investigated.

DRG reconciliation and CMI tracking should be concomitant compliance processes. Effective DRG reconciliation processes may result in appropriate changes to the CMI while a CMI variance may indicate a need for more robust DRG review.

AUDITING AND MONITORING NECESSARY TO MAINTAIN ACCURACY

An inpatient coding compliance plan must include auditing and monitoring of the inpatient coding staff. Ongoing coding quality reviews are necessary to maintain a high level of accuracy, ultimately resulting in billing accuracy. Considerations in developing coding auditing and monitoring processes include:

- Utilize Medical Provider Analysis and Review (MEDPAR) data or other national data to determine differences between an organization's billed data and the national average.[2] Identified variations may or may not indicate potential fraudulent or abusive coding and billing practices. However, variations require further analysis to determine if there is a compliance issue.
- Organizations should monitor those areas under investigation by government payers and other external entities. Examples include:
  - CC/MCC capture rates
  - Single CC/MCC cases
  - High-risk DRGs, such as Sepsis, Acute Respiratory Failure, and Encephalopathy
  - Clinical or DRG denials
  - Changes in CMI

Inpatient coding audits can be performed on cases selected at random or more intentionally. Sampling approaches include, for example, random samples of specific record types or identified coders, focused samples of specific codes, or statistically valid random samples with and without stratification. The inpatient coding compliance program should provide guidance to determine the appropriate sampling methodology to accomplish the goals of a specific audit effort.

HAVE A CORRECTIVE ACTION PLAN

A corrective action plan is a necessary part of any inpatient coding compliance program. Design corrective actions to prevent reoccurrence of the same problem in the future. Corrective actions often include updated policies and procedures as well as staff education to ensure a thorough understanding of the appropriate coding practice.

The compliance officer should investigate any potential coding fraud or abuse issue. The investigation should include interviews with coding staff, coding management staff, and any others directly involved. The investigation should also include review of policies, coded data, and any related previous education provided. The purpose of the investigation is to identify the underlying cause of the coding issue, the extent of the impact, and ultimately determine if there is truly a compliance issue versus an error, for example.

> *"An inpatient coding compliance plan must include auditing and monitoring of the inpatient coding staff."*

KEEP UP WITH ANNUAL UPDATES

Review and update the inpatient coding compliance program at least annually. As previously noted, inpatient compliance should address areas under investigation, which are constantly changing. For example, in 2017 the OIG transitioned to a web-based work plan that is regularly updated. The annual work plan covers projects performed under the supervision of the OIG by the Office of Audit Services, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Counsel to the Inspector General. Each of these agencies assists in the development of the OIG's work plan. Their actions, related to the work plan, include audit, inspection, investigation, and litigation.

Update inpatient coding compliance efforts at least annually to align with industry trends in coding compliance, including OIG priorities. For example, since December 2018,

the OIG Work Plan has included an explanation of the OIG's intent to assess inpatient hospital billing for Medicare beneficiaries. The plan describes a two-part study. The first part gathers "landscape information about hospital billing, and how it has changed overtime." The second part will use the information to "target certain hospitals or codes to look for patterns of incorrect coding or billing."[3]

A robust inpatient coding compliance program should include the essential components described in this article at a minimum and should be regularly updated to ensure all aspects are current and adequate to maintain inpatient coding compliance. ◎

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NOTES

1. Land, Daniel et al. "Components of an Effective Outpatient Coding Compliance Policy Program." *Journal of AHIMA* 90, no.1 (January 2019): 38-39.
2. Centers for Medicare and Medicaid Services. "MEDPAR Limited Data Set (LDS) – Hospital (National)." January 7, 2019. www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/medparldshospitalnational.html.
3. Office of Inspector General. Work Plan. https://oig.hhs. gov/reports-and-publications/workplan/index.asp.

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