United Audit Systems Inc.

Top Documentation and Coding Issues to Include in 2021 Compliance Plans

What's in your 2021 compliance plan?
Make sure you are addressing these top documentation and coding compliance concerns

For Hospitals

1. Risk-based review of inpatient DRG cases, examples include:
   - RAC DRG targets; PEPPER targeted DRGs
   - COVID related inpatient discharges
   - Clinical indicators, cases at risk for clinical denials (e.g. Sepsis, CHF, ARF, severe malnutrition, encephalopathy)
   - IP cases with only 1 MCC/CC code or HAC/PSI cases
   - IP short stay cases (24 - 48 hours) with complex principal diagnosis (e.g. Sepsis, AKI, ARF)
   - Expired patients with risk of mortality (ROM) level 1, 2 or 3
   - DRGs 981 - 983 surgical procedure unrelated to principal diagnosis
   - Complex surgical procedures such as spinal infusions open heart surgeries and/or intestinal excision and resection procedures
   - Discharge Disposition accuracy for DRGs subject to being paid under the Medicare Post-Acute Care Transfer Rule
2. Short stays, inpatient readmissions and three day Skilled Nursing Facility Qualifying Admissions (ensure compliance with admission criteria and 2-Midnight rule)
3. Clinical Indicators, specific to the patient and episode of care, must support queries. Review physician queries to assure query language is compliant and not leading.
4. Infusion and injection coding (including J codes with correct units charged, drug wasting and JW modifier)
5. Interventional radiology and interventional cardiology procedure coding and billing
6. Outpatient Dialysis claims to ensure compliance with Medicare requirements
7. Facet joint injections (CPT 64490 - 64495) inclusive of fluoroscopy CT guidance and contrast injection
8. Outpatient Cardiac and Pulmonary Rehabilitation meet medical necessity and comply with certain documentation requirements
9. NICU (ensure clinical documentation meets medical necessity for NICU level of service)
10. Data mining to identify trends/outliers (e.g. high utilization of certain DRGs, unspecified diagnosis codes or procedure codes, identify and follow up on trends in claim denials)

For Physician Practices

1. Risk-based review of evaluation and management codes (E/M):
   - Appropriate application of FY21 E/M code guideline changes
   - Telehealth visits (audio and visual vs. telephone only); Medicaid behavioral health telehealth
   - Review providers with higher than 10% of visits in level 4 and 5, or outliers on E/M bell curve
   - Level 4 and 5 visits with only one diagnosis code
   - Conduct highly productive provider analysis (review visits per day outlier)
   - Appropriate use of prolonged and critical care services codes as well as time-based codes
2. Appropriate use of Modifiers
   - High risk modifiers: 25, 57, 59 (including XE, XP, XS, XU)
   - Other modifiers to focus on: 24, 58, 62, 63, 76, 78, 80, AS
3. Incident to services (appropriate reporting of NPP services and split-shared services)
4. Teaching physician and supervising physician services
5. Coding and reporting co-morbidities for coverage of routine foot care (meeting specificity in the LCD, use of modifiers Q7, Q8, Q9)
6. Wound care (especially debridement services 1104x, 97597)
7. Copy/Paste documentation (ensure documentation is unique for the visit and presenting complaints)
8. Chart review for documentation of active treatment and specificity of chronic conditions to support HCCs
9. Advanced Care Planning Services - ensure appropriate clinical documentation to support face to face services and/or time spent discussing ACP services.
10. Data mining to identify trends/outliers (e.g. conduct top billed procedure analysis, identify and follow up on trends in claim denials)

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