By Kelly Nueske, RN, CPA, CMA, CIA

How Listening and Collaboration Helped Improve Allina Coding Audits

Obtaining management buy-in to billing compliance audit findings and conclusions is critical to ongoing process improvements and developing collaborative relationships. This could be difficult to accomplish when there are "gray" areas in a billing compliance review that require a degree of subjectivity that depends on the auditor's experience. One of the "gray" areas is coding. This is also one of the most important due to potential reimbursement impacts of an error. This article will discuss the strategies Allina Hospitals and Clinics Audit Services developed to obtain management buy-in and a strong working relationship with coding leadership.

Importance of Correct Coding and Coding Definitions

Coding is key to obtaining proper reimbursement from payers. Proper payment on some claims is not dependent on correct coding; however, correct coding is important for a number of other reasons.

1. Many payers require coding or the claim will be denied.
2. Payers use coding to evaluate medical necessity of the claim.
3. Payers review coding to evaluate reasonableness of the treatment.
4. Codes are used for statistical reporting and documenting critical recovery paths.

Coding was developed years ago for the purpose of data collection to support clinical improvement studies. The data was deemed so valuable by payers that they decided to base inpatient reimbursement on this data with cost considerations factored in. This has posed a challenge to the coding industry because sometimes payer requirements conflict with the original purpose of the coding system.

There are four types of codes submitted on hospital inpatient and outpatient claims, and claims for professional and clinic services.

ICD-9CM Diagnosis Codes are assigned by professional coders on hospital and clinic claims to identify the primary and secondary diagnoses for patient services. Payers use these codes to determine medical necessity, reasonableness of treatment, and determination of the Diagnostic Related Group (DRG) for an inpatient claim. Diagnosis codes range from 000.1 – 999.9 and are reported separately on the UB92 or HCFA 1500 claim form.

ICD-9 Procedure Codes are assigned by professional coders on hospital claims to identify the diagnostic and therapeutic procedures used to treat the patient. These codes can impact the DRG selected for inpatient claims. Procedure codes range from 01.0 to 99.99, and are reported separately on the UB92 claim form.

Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) codes are manually assigned by professional coders to hospital and clinic claims, or are "hard coded" (programmed by billing system) to hospital claims. There are approximately 10,000 codes available to identify the procedures, professional services, and supplies used to treat the patient. These codes are reported separately on the UB92 claim form for outpatient services and HCFA 1500 claim form for professional services. CPT and HCPCS codes are not separately reported for inpatient services, rather they are summarized using Revenue Codes.

Revenue Codes summarize charges into specific revenue categories for billing hospital inpatient and outpatient services on the UB92 form. These codes are programmed in the billing system and

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based on the charge description master number selected for the provided service.

Initial Billing Compliance Reviews

Allina Hospitals and Clinics billing compliance reviews were conducted by business office staff and management recognized as technical leaders in their areas of expertise during 1994 - 1998. Audit Services involvement during these years consisted of selecting random samples for management.

Inpatient and outpatient billing compliance reviews consisted of three main components. Staff responsible for maintaining the common activity master conducted a documentation and CPT code review. This team consisted of registered nurses with knowledge of payer charging requirements and documentation standards. Staff responsible for reviewing new regulations as they were issued from the intermediary and carrier conducted the second component, which was a technical review of the claim. The focus was on ensuring the information reported in form locators was accurate. The final component was a review of the ICD-9 diagnosis and procedure codes conducted by coding leaders in Allina hospitals. Coding staff from one hospital would review the accuracy of coding for another facility.

There was also another team of highly skilled certified coders that reviewed claims for professional and clinic services. Their primary responsibility was to provide coding education to professional coders and physicians within Allina. Coding educators reviewed the evaluation and management coding, ICD-9 diagnosis coding, and technical accuracy of the HCFA 1500 claim form and provided education based on the audit findings.

Transition of Billing Compliance Reviews

As a part of the Medicare and Medicaid Billing Compliance Program, Allina Audit Services assumed responsibility for all billing compliance reviews in January 1999. This was an opportunity to evaluate how reviews were conducted and improve the process where necessary. The goal was to provide management with useful information to manage Allina's Medicare and Medicaid Billing Compliance Program. To accomplish this, Audit Services management met with the various teams that were conducting the reviews to obtain input and advice on how to proceed forward. As a result, two regulatory audit teams were hired and a formal communication process for delivering audit findings and recommendations was developed.

Inpatient and Outpatient Reviews

A hospital audit team was hired, consisting of two registered nurses with common activity master and DRG assurance training, and one certified health information management professional with extensive outpatient and inpatient coding experience. The goal was to train each auditor to conduct all three components (documentation, technical and coding) of the review. A lesson learned in previous years was there was no "big picture" assessment of each claim reviewed due to the involvement of multiple teams. It was important to hire individuals with specific expertise and the ability to learn quickly another technical skill because it would be difficult to recruit individuals with all the necessary technical knowledge. Recruiting success came from networking within the organization, focusing on experienced coders and common activity master staff.

Training the two registered nurses to code inpatient and outpatient claims was accomplished in three ways. First, a coding expert was hired to conduct an accelerated training session. It was an intensive program focusing on specific education needs since each nurse had some previous experience with DRG assurance programs. Second, the certified coder on the hospital team served as a resource and trainer in the field. The experienced coder reviewed the registered nurses' coding conclusions and provided feedback and training when necessary.

The third approach was a partnership with coding management in Allina's larger, metropolitan hospitals. The coding leaders who conducted the reviews in previous years were asked to participate in a quality assurance process that occurred prior to issuing final audit results. The hospital audit team submitted audit findings for the coding component of the review to one of the participating coding management teams for a quality assurance review. A coding leader would review the auditors' conclusions using the medical record and complete a feedback form indicating whether the reviewer agreed or disagreed with the auditors' conclusions. This was a very effective tool in gaining coding management buy-in to the audit process because coding management had the opportunity to assess the expertise of the auditors and develop a level of comfort with their coding.

After a year, coding management indicated it was no longer necessary to continue the quality assurance process because they felt the audit team had strong technical expertise in outpatient and inpatient coding. However, coding and operating management requested an opportunity to discuss conclusions prior to issuing the final report. The conclusion was to hold a "Detail Meeting" with management and discuss audit findings in a draft format. Detail Meetings are all day meetings. Management from each hospital department meets with the audit team for a minimum of one-half hour to discuss audit findings and ask questions. Management is provided with draft audit findings two weeks prior to the meeting and the expectation is that each manager reviews the findings using the medical records and to come prepared to discuss findings and potential solutions. By the end of the meeting, agreement is reached on the audit findings and the audit team issues a final report with recommendations for improvement. This process has provided Allina with an excellent opportunity to educate hospital managers on payer requirements and obtain buy-in to the entire audit process and findings.

The hospital audit team also works with management by participating on a system wide committee called the Coding Leadership Group (CLG). The CLG is responsible for resolving coding issues and developing coding policies and procedures. The audit team serves as a consultant to management and brings issues identified in various audits that management should address as a system. Participation on this committee has

fostered the relationship and rapport between Audit Services and coding management. It also provides Audit Services with the ability to provide input into the development of coding policies and procedures.

Professional and Clinic Services Reviews

Professional and clinic service coding is very different from inpatient and outpatient diagnosis, procedure and revenue coding. The focus is on evaluation and management (E/M) codes used to identify the level of service provided by a physician, nurse practitioner, physicians assistant or other professionals supervised by a physician. These codes are frequently referred to as the 1995 Documentation Guidelines for Evaluation and Management Services or the 1997 Documentation Guidelines for Evaluation and Management Services. The two sets of E/M guidelines were jointly issued by The Centers for Medicare and Medicaid Services (CMS), formerly HCFA, and the American Medical Association (AMA). Due to this distinct difference in coding, a clinic audit team was hired consisting of three certified coding professionals with extensive knowledge of E/M coding in a wide range of specialties. The audit team was similar to the team of coding educators conducting the reviews in earlier years. Recruiting success came again from networking within the organization, focusing on experienced E/M coders and coding educators interested in auditing full time.

Before Audit Services started the clinic team's audit plan in 1999, a series of meetings were held with coding educators. The purpose was to review existing E/M coding policies and procedures, discuss interpretation of the two sets of published E/M guidelines, and develop a collaborative relationship. One of the clinic team's main customers would be the coding educators. Once a clinic final report was issued, the coding educators would be responsible for taking the audit findings and recommendations and developing a corrective action plan that would focus on educating professional coders and providers on documentation requirements. The strategy of working with the coding educators was helpful because differences in opinion were identified and addressed prior to starting the audit process. Audit Services and coding education management believed it was important to maintain an ongoing dialogue about audit issues, hence, a monthly Auditor and Educator Meeting was established.

The Auditor and Educator Meeting is scheduled for two to three hours per month. The purpose of the meeting is to discuss recently published information about E/M guidelines, discuss new scenarios in operations identified by educators or auditors, evaluate forms for documenting services, and review coding policy developed by the coding educators prior to approval and implementation by operating management. This meeting has been helpful in building a relationship with the coding educators and obtaining operating management buy-in. The link to operating management buy-in is that they look to the coding educators to ensure the operation's best interest is considered throughout the entire audit process.

After a year, coding educator management and operations management requested a change in the audit process. The hospital audit team had moved to a "Detail Meeting" and clinic management requested the same process. Detail Meetings are scheduled for one to two hours with clinic management, lead physicians, coding educators, clinic senior management. The clinic manager and coding educator are provided with draft audit findings two weeks prior to the meeting and the expectation is that the clinic manager and coding educator review the findings using the medical record and to come prepared to discuss findings and potential solutions. The process is very similar to the hospital approach and has promoted management buy-in to the findings and solutions.

Summary

The reporting process for hospital and clinic reviews is similar. Prior to developing report templates in 1999, Audit Services met with customers for input on report structure and what type of data would be useful in managing the compliance program. Each year report structure and content is readdressed with the Compliance Program Directors, Compliance Managers, Accountable Executives, and the Corporate Compliance Officer.

Final reports are discussed with senior management and include a financial and audit criteria summary with recommendations for how issues can be addressed. Senior management has found this valuable as it gives them a high level assessment with potential solutions. Audit results are key to holding operations management accountable for improving processes that support accurate claims. The information from audit reports is routinely reported to the Allina Billing Oversight Committee and Audit Committee.

Allina management has appreciated the evolution of the process and the current Detail Meeting process, the opportunity to understand payer requirements, and the ability to identify solutions in a collaborative environment. The key to our success has been listening to customer needs and working with them to enhance audit processes.

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steadfast supporter of AHIA and the Board is delighted that we are able to recognize that support through an ongoing mutually beneficial alliance. This strategic partnership is what has allowed us to bring you the ACL training to be held in conjunction with the in-depth audit training seminars mentioned above. Both AHIA and ACL will market the alliance through various mechanisms, including recognition on our respective Web sites and in journals, newsletters and trade magazines. This will include links to each other's Web site and a joint logo, which is displayed below. I hope you will find this to be yet another valuable member benefit. Should you have any questions about this strategic partnership, please feel free to contact Randy Just at rjust@ahia.org.

I think we would all agree that New Perspectives is a vital and valued resource for our members. You probably also know that the journal doesn't magically appear. It takes a lot of hard work and coordination by staff at headquarters and the Editor of New Perspectives. As you know, Mark Ledman, having served as Editor for the past five years, recently stepped down from this position. The Association is grateful for all his tremendous efforts over the years and we thank him for his commitment to the organization. Regrettably, his replacement, Ginger Morrison, is not able to fulfill this role due to recent changes in her employment. That means AHIA is embracing another challenge and we need your help. It is imperative that we continue to advance the quality of this journal that Mark, and many others before him, have worked so diligently to develop. That can only happen with the involvement and commitment of dedicated individuals like you. Serving the Association in this capacity is a very rewarding experience and provides valuable networking contacts. If anyone is interested in serving on the Editorial Committee, or more importantly, serving as the Editor, I urge you to contact Pat Bogusz as soon as possible.

If you have not visited the AHIA Web site recently, I encourage you to take a look. We've been working diligently to upgrade our site to make it more user-friendly and provide added value to the membership. Watch for things like announcements about the annual conference and other educational opportunities as well as ways for you to get involved in the organization through the various committees. If you have ideas on ways that we can improve our Web site, please forward those thoughts to Pat Bogusz at AHIA headquarters. She can be reached via e-mail at ahia@ahia.org or by calling 888-275-2442.

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