The Importance of Internal Audits
By Marcia Vagar, MPH, RHIA, CCS, CCS-P

The OIG (Office of Inspector General) states: “The best evidence that a provider’s compliance program is operating effectively occurs when the provider, through its compliance program, identifies problematic conduct, takes appropriate steps to remedy the conduct and prevent it from recurring, and makes a full and timely disclosure of the misconduct to appropriate authorities.” To identify the problem areas, utilization of internal and external audits is the key. A good compliance plan that utilizes both internal and external auditors shows your facility’s desire to operate within the guidelines.

If discrepancies are found, the penalties applied will be less severe because you are showing due diligence to be in compliance. If done correctly, internal audits done as part of a proactive overall compliance plan ensures enough effort is being made to uncover and fix potential coding problems, documentation issues, and any billing issues that may be found during the audits before they become major issues.

Most healthcare organizations understand the urgency of internal and third-party audits but the effort appears most often to have to take a backseat to the other day-to-day operations of the organization. Internal coding audits require labor time to conduct them appropriately. With over 10 audit and fraud prevention programs being conducted by the federal government and quality organizations along with private payer requests HIM (Health Information Management) departments are busier than ever. The fear is that internal coding data quality audits will halt or at the least be severely cut due to all the demands of these external audits.

Facilities will need to adopt a standardized method that will measure coding quality performance. A valuable industry resource is the American Health Information Management Association’s (AHIMA’s) Benchmarking to Improve Coding Accuracy and Productivity book. This tool provides guidelines for measuring coding quality. The primary internal coding audit should serve as a baseline indicator of coding accuracy. It will identify root causes for coding errors, which should in turn decrease variance and increase reliability. The audit will also identify strengths and weaknesses of coders which will help facilitate the establishment of education goals.

Coding audits are primarily a function of HIM and compliance but the best method is to involve other individuals’ especially upper management. A strong team might be comprised of the following participants: the compliance officer, the CFO, case management, IT, a physician advisor, and HIM. The physician advisor would be an important member of the team because clinical documentation and reporting is important in the overall goal of improving accuracy.

The results of all audits must be shared with the coding team members and clinical documentation objective.

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specialists and used to define educational opportunities for the team members. In doing so this information may be used to build the next phase of the auditing program. Organizations should be looking to broaden their auditing goals to identify new areas that they may improve upon which may not have been included in the initial Facilities need to take an active approach in assuring compliance. Reimbursement Management Consultants, Inc. (RMC, Inc.) recommends regular staff audits. This may be done internally with auditing of 30 cases. If a coder codes more than one patient type it is important to audit the coder on 30 cases of each patient type they are responsible for coding. RMC, Inc. supports the dual (internal and external audits) approach to having a successful compliant audit program.

Best practice guidelines from AHIMA recommend facilities use a combination of internal and external coding audits for effective coding compliance. AHIMA recommends internal audits every quarter and external audits done at least once a year but if possible more often.

If you have any questions, concerns, or would like further information on this topic, please contact Marcia@rmcinc.org.

For more information please visit www.ahima.org, www.aapc.com, or www.oig.hhs.gov

Other references:
www.beckersasc.com
www.Advanceweb.com
www.radiologytoday.net

Marcia Vaqar, MPH, RHIA, CCS, CCS-P is a healthcare medical auditor and coding consultant who works with hospitals and healthcare organizations to help insure accurate and correct coding through education, auditing, and coding support. Before venturing out as a consultant and joining the staff of RMC, Inc. Marcia spent over twenty years as a coding manager, project manager/coordinator of Health Information Management Operations, Inpatient/Outpatient Coder, Health Information Coordinator, and Medical Record Administrative Aide. Today Marcia offers her extensive knowledge background to healthcare systems in cooperation with RMC, Inc. which includes but is not limited to coding; severity of illness data collection and verification; clinical documentation improvement; and coding management skills.

RAC Reviews aimed at Physician Practices

By Connie Eckenrodt, RHIT, CHC

Health Data Insights, the Recovery Audit Contractor (RAC) for Region D, has added new approved issues aimed specifically at physician practices. These are automated, or data-mining, reviews for determination of over/underpayment for Part B claims paid on or after October 1, 2007, and include:

- **Part B Duplicates - Automated Review** - Medicare does not pay for duplicate services or equipment. An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples include: duplicate processing of charges/claims; provider is overpaid because the FI or carrier processed the provider’s claim more than once.; overpayment to a provider caused by multiple processing of the same charge. IOM Pub 100-06, Chapter 3 § 10 and § 90 Physicians in the same group practice who are in the same specialty must bill and be paid for E&M services as though they were a single physician. If more than one E&M service is provided on the same day only one E&M service may be reported unless the services are for unrelated problems. The physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. IOM Pub 100-04 Chapter 12 § 30

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- **Co-Surgery not billed with modifier 62** - Improper payments exist when two surgeons perform surgery on the same patient; one surgeon added the co-surgeon modifier -62 and the other did not.

- **Global Days** - Under Medicare Physician Fee Schedule (MPFS) rules, **most surgical procedures include pre-operative and post-operative Evaluation & Management services**. These E&M services are referred to as ‘Global Days’. Procedures with MPFS global days values of 000 include only E&M services rendered on the day of the surgery. Procedures with 010 global days include E&M services on the day of the procedure and up to 10 post-operative days. Procedures with 090 global days include E&M services the day before, the day of the procedure and up to 90 post-operative days. **Physicians can indicate that E&M services rendered during the global period are unrelated to the surgical procedure by submitting modifiers 24 (Unrelated Evaluation and Management Service By Same Physician During Post-operative Period), 25 (Significant Evaluation and Management Service By Same Physician On Date of Global Procedure) and 57 (Decision For Surgery Made Within Global Surgical Period) on the E&M service.**

- **Procedures performed during the Global Period of other Procedures** - Medicare does not allow separate payment for additional procedure(s) with a global surgery fee period of 010 and/or 090 days if the service(s) is/are furnished during the postoperative period of a prior procedure and if billed without modifier “-58”, “-78” or “-79”. Separate payment in this situation is an overpayment.

- **NCCI Edits** — **National Correct Coding Initiative (NCCI) edits identify CPT/HCPCS code combinations that should not be reported together by the same provider for the same beneficiary and the same date of service. Each NCCI edit has an assigned modifier indicator. A modifier indicator of —01 indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of —11 indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances. Overpayments due to NCCI edits may be identified under the same claim number or under different claim numbers.**

- **Technical Component of Radiology** — **Carriers/MACs may not pay for the technical component (TC) of radiology services furnished to patients in inpatient or outpatient hospital settings.**

- **Not a New Patient** — **Providers are only allowed to bill the CPT codes for new patient visits if the patient has not received any professional services from the physician or physician group practice within the previous 3 years.** Medicare interprets the phrase —new patientl to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. New patient CPT codes are only payable for beneficiaries without office based face-to-face services in the previous 3 years. **RMC Note: If a physician is on-call for or covering for another physician, the patient’s encounter should be reported as it would have been by the physician who is not available. There is no distinction between new and established patients in the emergency department.**

Ms. Eckenrodt is the Director of Physician Coding & Compliance at RMC. With over 15 years in the HIM field, Ms. Eckenrodt’s focus has been on outpatient coding, with particular emphasis on professional fee coding and documentation improvement. Areas of expertise include: new provider coding orientations; individual and group coding education for providers and professional fee coders; pre-bill and retrospective coding audits; and risk assessment and focus review audits for internal compliance initiatives and compliance initiatives pursuant to federal investigations. Consulting has been provided in myriad settings, from small practices to large multi-specialty practice groups.
Because medical coding and billing have become so complex and the potential for financial and personal consequences so great, it is vital that organizations and individual coders follow a standardized code of ethics. A code of ethics provides guidelines for professional behavior that guides decision making, maintains integrity, and provides standardization in the coding process. The world of coding has changed significantly in the past few years especially in the area of fraud and abuse. The Office of Inspector General (OIG) has published guidelines for effective compliance programs to prevent fraud and abuse and these include focus areas for accurate and complete coding/billing.

In September, 2008, the American Health Information Management Association (AHIMA) revised the Code of Ethics for coders, which was last published ten years ago. The American Academy of Professional Coders (AAPC) also has a code of ethics that promotes adhering to the highest standard of service consistent with exemplary work. In the AHIMA code of ethics, there are 11 standards encompassing accuracy, documentation, coercion, confidentiality and other behaviors that coders may come across in our daily work.

1. Apply accurate, complete and consistent coding practices for the production of high-quality healthcare data.

2. Report all healthcare data elements (e.g. diagnosis and procedure codes, present on admission indicator, discharge status) required for external reporting purposes (e.g. reimbursement and other administrative uses, population health, quality patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules and guidelines.

3. Assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules and guidelines.

4. Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g. present on admission indicator).

5. Refuse to change reported codes or the narratives of codes so that meanings are misrepresented.

6. Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.

7. Facilitate interdisciplinary collaboration in situations supporting proper coding practices.

8. Advance coding knowledge and practice through continuing education.

9. Refuse to participate in or conceal unethical coding or abstraction practices or procedures.

10. Protect the confidentiality of the health record at all times and refuse to access protected health information not required for coding-related activities (examples of coding-related activities include completion of code assignment, or other health record data abstraction, coding audits, and educational purposes).

11. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices and fosters trust in professional activities.

Ethical practice in coding can be achieved in many ways including routine auditing, maintaining an advanced coding credential, and making a professional commitment to excellent job performance. By adhering to a high standard, public confidence in the accuracy and integrity of information is bolstered.

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is maintained in the profession which leads to better quality work and employee retention. Both AHIMA and the AAPC will revoke the credentials and membership of anyone found to be guilty of unethical behavior and conduct.

If you have any questions, concerns, or would like further information on this topic, please contact Judy Terry at judyti@rmcinc.org.

References:
American Health Information Management Association (AHIMA). www.ahima.org
American Association of Professional Coders (AAPC). www.aapc.com

Judy Terry RHIA, CCS has more than 30 years of experience in the field of Health Information Management and is currently working as Director of Review Services for RMC. She earned her Bachelor’s Degree at Loma Linda University and since that time she has enjoyed working as an HIM Director and a consultant both to long term care facilities and hospitals. She lives in Vancouver, Washington and is currently pursuing a Master’s Degree in Public Health.

Mandatory Compliance Programs for Physician Practices
By Connie Eckenrodt RHIT, CHC

The requirement for an effective compliance program for healthcare organizations is transitioning from voluntary to mandatory under H.R. 3590, the recently enacted “Patient Protection and Affordable Care Act.” The PPACA requires providers and suppliers who are enrolled in Medicare, Medicaid and/or Children’s Health Insurance Program (CHIP) to establish and maintain the core elements of a compliance program, the standards and timing of which will be determined by regulations issued by the Secretary of Health and Human Services (HHS), in consultation with the Office of Inspector General (OIG).

The Office of Inspector General (OIG) has published a Compliance Program Guidance for Individual & Small Group Physician Practices which recommends an effective compliance program contain the following seven essential components:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication, and
- Enforcing disciplinary standards through well-publicized guidelines

You should also have a Code of Ethical Conduct which sets forth the expectations of ethical behavior for all personnel in your practice.

With increased focus on reducing fraud, waste, and abuse in healthcare, government and third-party payer audit requests are on the rise. Don’t put your head in the sand! Develop and implement compliance program policies and procedures that include regular coding and documentation audits. Identify potential coding and billing errors and correct them now to reduce the likelihood of a payer audit. RMC has qualified coding and compliance professionals to assist you in all facets of your compliance program, including development of policies and procedures, coding and documentation audits, and education, as a key partner in your practice’s compliance initiatives.

2011 Audio Conference Schedule
January 20th “Sepsis” with Dana Brown
February 17th “Diabetes” with Judy Terry
March 17th “Injections and Infusions Basics” with Jane Barta
April 21st “Pregnancy Coding” with Stacy Hardin
May 19th With Connie Eckenrodt
June 16th “CVAs and TIs” with Marcia Vaqar

Email: kristin@rmcinc.org for more details!
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12042 SE Sunnyside Rd #452 Clackamas, OR 97015
800.538.5007
www.rmcinc.org

Questions? Email Kristin Gibson: kristin@rmcinc.org

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