The Importance of Internal Audits

By Marcia Vaqar 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 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 objective.

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.

(Continued on following page…)
**Documentation of Body Mass Index (BMI) and Pressure Ulcer Stages**

*By Stacy Hardin, CCS*

Per ICD-9-CM Official Guidelines for Coding and Reporting, Fourth Quarter 2008, Chapter 16… For the Body Mass Index and Pressure Ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often document the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

The BMI and pressure ulcer stages should only be reported as secondary diagnoses. **As with all other secondary diagnosis codes, the BMI and pressure ulcer stage codes should only be assigned when they meet the definition of a reportable additional diagnosis.** (See Official Coding Guidelines, Section III, for Reporting Additional Diagnoses).

Effective October 1, 2008, a new subcategory (707.2x) has been created to report pressure ulcer stages. Prior to this change, the ICD-9_CM classified pressure ulcers by site but did not distinguish the stages. The appropriate site of the ulcer (707.00-707.09) should be assigned first, followed by a code for the ulcer stage (707.20-707.25). The codes in subcategory 707.2x for staging apply only to pressure ulcers (subcategory 707.0x). In addition, the code descriptor for codes in subcategory 707.0x have been revised from “decubitus ulcer” to “pressure ulcer”.

**BMI should only be reported if it has clinical significance for the patient encounter.** Per Official Coding Guidelines, the BMI value may be picked up from the dietician’s documentation. However, the provider must document a clinical condition, such as obesity, to justify reporting a code for the body mass index. To meet criteria for reportable secondary diagnosis, the BMI would need to have some bearing or relevance in terms of patient care. (Refer to Coding Clinic, Fourth Quarter 2008 and the Official Coding Guidelines Section III for additional information.)
Hospitals have been assigning the “Discharge Disposition” code for a very long time (with some modifications). Even though it appears straightforward, it can be very challenging. Below you will find the official list. RMC Recommends that hospitals do training/reminders to staff on a regular basis. And also do audits regularly to ensure compliance with these very important code assignments.

All facilities should have a mechanism in place to assure the patients intended discharge plans occurred. All too often patients are sent home with home health, but decline services. A facility is responsible for the discharge disposition to be accurate within 3 days of discharge. Revenue can be affected, and for compliance purposes accuracy of the Discharge Disposition is of utmost importance.

The Inpatient Prospective Payment System for hospitals (IPPS) relies on correct discharge disposition codes for appropriate DRG assignment and reimbursement. Following is a brief review of each code.

**01 - Discharge to Home or Self Care (Routine Discharge)**
Jail or law enforcement, group home, foster care, assisted living facilities that are not state-designated.

**02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care**
Discharges or transfers to long-term care hospitals should be coded with discharge status Code 63.

**03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.**
This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. Code 03 should not be used if the patient is admitted to a non-Medicare certified area.

**04 - Discharged/Transferred to an Intermediate Care Facility (ICF)**
This can be used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or for discharges/transfers to state designated Assisted Living Facilities.

**05 - Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List**
Cancer hospitals excluded from Medicare PPS and children’s hospitals are examples of such other types of health care institutions.

*Effective, per NUBC, on April 1, 2008*

**05 - Discharged/Transferred to a Designated Cancer Center or Children’s Hospital**
Usage Note: Transfers to non-designated cancer hospitals should use Code 02.

**06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care**
Written plan of care for home care services, Discharged/transferred to a foster care facility with home care

**07 - Left Against Medical Advice or Discontinued Care**
Patient leaves against medical advice or the care is discontinued, patients who leave before triage, or are triaged and leave without being seen by a physician.

**09 - Admitted as an Inpatient to this Hospital**
Medicare outpatient claims only; applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

(Continued on following page…)
“Discharge Dispositions” Continued...

20 - Expired

30 - Still Patient or Expected to Return for Outpatient Services
It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

43 - Discharged/Transferred to a Federal Hospital
Discharges and transfers to a government operated health care facility including: Department of Defense hospitals; VA hospitals; Psychiatric services at a VA Hospital, or VA nursing facilities.

50 - Hospice Home
Use if the patient went to his/her own home or an alternative setting that is the patient’s “home,” such as a nursing facility, and will receive in-home hospice services.

51 - Hospice medical facility
Use if the patient went to an inpatient facility that is qualified (or remains at same hospital under hospice care) and the patient is to receive the general inpatient hospice level of care.

61 - Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
Patients discharged/transferred to a SNF level of care within the hospital’s approved swing bed arrangement.
When a patient is discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Patient discharge status Code 61. Swing beds are not part of the post acute care transfer policy

62 - Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions.

64 - Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare
Nursing facility that has no Medicare certified beds. If any beds at the facility are Medicare certified, use either Patient discharge status Code 03 or 04,

65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
Transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit (except Federal hospital)

66 - Discharged/Transferred to a Critical Access Hospital (CAH)
Transfer to a critical access hospital (CAH) for inpatient care. Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with Patient discharge status Code 61.

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

If you have any questions, concerns, or would like further information on this topic, please visit the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles or contact Judy at judyt@rmcinc.org

Judy Terry RHIA, CCS
Judy has more than 30 years of experience in the field of Health Information Management and earned her Bachelor’s Degree at Loma Linda University. She is certified as an RHIA and CCS. 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.
An announcement was made during September by the ICD-9-CM Coordination and Maintenance Committee that it will suspend regular updates to the ICD code sets in 2012 and 2013. It is hopeful that this will help ease the healthcare industry’s transition to ICD-10. This is being done to allow for organizations to focus on the system change without managing code updates at the same time.

Next year October 1, 2011 will be the last full updates and then the partial freeze will take place in 2012 and 2013. The timeframe for regular updates resuming will be in 2014. The timeline is planned as stated below:

- October 1, 2011: Normal regular updates will be made to the ICD-9-CM and ICD-10 code sets.
- October 1, 2012: There will be limited code updates made to the ICD-9-CM and ICD-10 code sets. This will be allowed to help capture new technologies and diseases.
- October 1, 2013: An allowance for limited code updates will be made to capture new technologies and diseases. BUT there will be no updates to ICD-9-CM.
- October 1, 2014: The regular updates to ICD-10 will resume.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Section 5039a)] required that limited updates in 2012 and 2013 be allowed during this timeframe.

The committee will continue meeting twice a year during the partial freeze. During the meetings the committee will be asking for comments on whether requests for new diagnosis or procedure codes should be created for the capturing of new diseases or new technologies that have evolved. If a new code request should be determined to be not an essential update will be evaluated for implementation on or after the October 1, 2014 which is when regular updates will resume.

Please visit the Summary Report—ICD-9-CM Coordination and Maintenance Committee September 15-16, 2010 for more information and discussion on this topic.

http://www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

Marcia Vaqar, MPH, RHIA, CCS, CCS-P  
Director Coding Compliance Services

2011 AUDIO CONFERENCE SCHEDULE

- March 17th “Injections and Infusions Basics” with Jane Barta
- April 21st Pregnancy Coding” with Stacy Hardin
- May 19th Physician Coding Topic With Connie Eckenrodt
- June 16th “CVAs and TIAs” with Marcia Vaqar

FREE for RMC Clients/Staff.  
$25/facility or $10/individual per session.  
Email Kristin@rmcinc.org for more information or to register!

Injection and Infusions Coding Tip:

When an outpatient is treated with an insertion of a Foley catheter (51702) and a separate IM injection, such as an antibiotic or pain medication, be sure to use a -59 modifier on the CPT for the IM injection (96372-59), when coding for the facility.
CROSSWORD FUN WITH JANE!

Surgical Terms and Techniques
Jane Barta, RHIA

Across
2. Moving or rotating bones into proper alignment when there has been a fracture.
7. Abbreviation for the left arm.
9. Technique of visually examining the interior of a hollow body or organ with a lighted instrument.
10. Technique using heat or warmth for diagnostic or therapeutic procedures.
13. External skeletal apparatus that attaches directly to bone to hold fragments in a fixed position.
15. Making tiny fractures in articular cartilage to cause new cartilage to develop.
17. Removal and examination of tissue from a living body for diagnostic purposes.
18. A seam used in surgery to join two tissues together.

4. Access to inner organs or other tissue done via needle puncture of the skin.
5. Removing devitalized or dead tissue from a wound bed.
6. Procedure done through an incision in the skin and subcutaneous tissues.
8. Removing of an organ or tissue by cutting away.
11. The process of using either extreme heat or extreme cold to cut or seal body tissue.
12. Certified Registered Nurse Anesthetist
14. Abbreviation for one of the legs.
16. Manipulation of a fracture without an incision or open wound to visualize the fracture site.

Down
1. Surgical reconstruction or replacement of a malformed or degenerated joint.
3. Withdrawing fluid with suction from a cyst.
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REIMBURSEMENT MANAGEMENT CONSULTANTS, INC.
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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