Benchmarking Coding Quality

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Practical Tools for Seminar Learning

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**Presentation Objectives**

- Discuss Findings and Recommendations from the AHIMA E-HIM Work Group on Benchmark Standards for Coding
  - Focus on Quality
- Review best practice guidelines for coding audit review methodology
- To define the formula for calculating coding accuracy
- Discuss guidelines, regulations, documentation, and processes that support coding quality

**Polling Question #1**

Have you established quality expectations for your coding staff?

*1 Yes
*2 No
*3 Don’t Know
Clinical Coding Quality

- Quality coding influences many areas in the healthcare industry including:
  - Benchmarking
  - Reimbursement
  - Clinical and financial decision-making
  - Public health tracking
  - Healthcare policies
  - Research

- Most recently, coding has been moving to the forefront with issues related to quality of care and publicly reported data

Standards for Coding Quality

- Healthcare organizations must adopt a standardized method to:
  - Measure coding quality performance
  - Standardize definitions for how to count coding variance
  - Standardize a method for classifying and reporting variances
Standards for Coding Quality

- AHIMA Work Group on Benchmark Standards for Clinical Coding Performance Measurement convened in 2007
  - A subgroup was charged with addressing coding quality
  - To evaluate the current state of coding performance measurement
  - To provide standard benchmarks/best practices for the above

Current State - Survey Findings

- “Survey on Coding Quality Measurement: Hospital Inpatient Acute Care”
- Coder and physician documentation are the two main reasons for coding error
- Coder errors
  - Complication/comorbidity code assignment
  - Principal diagnosis code assignment
  - Secondary diagnosis code assignment
- Coder errors related to query policies
  - Lack of a clear understanding of clinical indicators for the condition being queried
  - Writing unnecessary queries
  - Lack of follow-up for inappropriate queries initiated by clinical documentation specialist
**Current State - Survey Findings**

- Coding errors due to physician documentation
  - Vague documentation that leads to nonspecific code assignment or the need to query
  - Lack of documentation to support a cause-and-effect relationship between two conditions
  - Physician not concluding with a definitive diagnosis (after study) as the reason for admission
  - Conflicting or inconsistent documentation

- The top two reasons for coding errors related to physician response to queries are a delayed response followed by no response to queries
- Systems, policies, and procedures are another cause for coding errors
  - Codes not crossing to the UB-04
  - Codes assigned by chargemaster incorrectly
  - Payers who do not follow official coding guidelines
  - These types of coding errors should not be attributed to the coder or physician
Polling Question #2

How often do you perform comprehensive audits, either internally or externally?
* 1 Monthly
* 2 Quarterly
* 3 Annually
* 4 Bi-annually
* 5 Other

Best Practice for Coding Audits

- Review best practice guidelines for coding audit review methodology
  - Frequency of reviews
  - Which financial classes to include
  - Who performs the review
  - Types of reviews
  - Record sampling techniques
How Often Are Reviews Performed

- At a minimum bi-annual internal reviews
- Best practice is quarterly
- Annual external audits

When Are Reviews Performed

- Both pre-bill and post-bill
  - Emphasis on pre-bill
- Utilize electronic compliance process to facilitate pre-bill reviews
**Who Performs the Review**

- Credentialed and qualified internal and external coding auditors
- Depending on your organization reviews can be conducted by
  - Coding Manager
  - Lead coder
  - Compliance Department

**Which Financial Classes Are Included In The Review**

- Best Practice suggests all financial classes
  - Focus on coding compliance for all payers
  - Additional focus on MS-DRG assignment for Medicare cases
What Types Of Review Are Performed

- Types of reviews
  - Representative sample
  - Focused review
  - Both inpatient and outpatient cases
- A representative sample is a selection of records at random
- A focused review is a selection of records from a list of pre-identified problem areas

Inpatient Includes

- Acute care inpatient
- Long-term acute care (LTAC)
- Psychiatric
- Rehabilitation
- Nursing Facility (SNF, NF)
- Home Health Agencies for principal diagnosis assignment
### Outpatient Includes

- Any hospital-based outpatient services
  - Ancillary outpatient
  - Emergency department or urgent care
  - Observation
  - Same-day-surgery or special procedure including interventional radiology
  - Ambulatory clinics

### Focused Reviews

- Focus on areas that cause the most risk
  - New coders - 100% for at least 3 months
  - High risk MS-DRGs
  - POA/ HAC conditions
  - RAC initiatives
  - High volume/ high cost outpatient procedures
Examples of Inpatient Focus Areas

- Debridement
- Decubitus ulcer
- Sequencing of COPD and pneumonia
- Heart Failure
- Pleural effusion with CHF
- Sepsis/UTI
- Extensive OR procedures with unrelated principal Diagnosis, MS-DRGs 981, 982, 983
- Malnutrition as a CC
- Mechanical ventilation
- MS-DRG cases with one CC/MCC

Examples of Outpatient Focus Areas

- Bone Marrow Biopsies
- Coagulopathy
  - Principal diagnosis documented as “Coumadin-induced coagulopathy”
- Modifiers 59 and 25
- Debridement and wound care
- Endoscopy
- Facility E/M coding
- Observation
Record Sampling Techniques

- Timeframe:
  - Pull records starting from the date of scheduled review back to one month after the education date from the results of the last audit

- Number of records per review:
  - Representative or random sample:
    - Pull records in consecutive order by the last digit of the account number
    - 2% of the required productivity standards per patient type by coder
  - Focused sample:
    - Pull records in consecutive order by type of focused review
    - 30 records or all records in the timeframe if less than 30
Today’s challenge – to be more consistent in benchmarking coding quality
- Identify root causes for coding errors to decrease variance and increase reliability
- Identify strengths and weaknesses of coders to target education
- To ensure all codes reported represents quality data

At a minimum, 95% is best practice for coding quality standard
- Types of audits to determine coding quality
  - Record-over-Record
  - Code-over-Code
Polling Question #3

Which approach do you use for measuring coding quality?

*1 Record-over-Record
*2 Code-over-Code
*3 Other method
*4 Don’t know

Record over Record Approach

- Sample number of charts are reviewed
- Errors counted typically represent DRG error, PDX error, complication/comorbidity
- Errors noted, but not counted, typically represent secondary diagnoses and procedures that do not impact reimbursement
- Educational efforts remain on DRG related issues
Record-over-Record Approach

- **Advantages**
  - Less labor intensive, widely recognized, focus on one statistic

- **Disadvantages**
  - More subjective – May not have definition of what counts as an error. Some organizations adjust the accuracy rate based on the type (or the impact) of error
  - Educational opportunities are not easily identified

Code-over-Code Approach

- Sample number of charts are reviewed
- Errors counted are reported per category - DRG, all diagnoses, all procedures, Overall
- Errors counted are defined as revised, added, or deleted
- Errors counted can be explained as what type (coding convention, coding guideline, etc.)
**Code-over-Code Approach**

- **Advantages**
  - More specific categories that includes an overall accuracy level
  - More objective - errors are more clearly defined
  - Identify trends for education or other process improvements
  - Reflects current coding practices for quality of reported data
  - Supports the audit function more appropriately

- **Disadvantages**
  - More time consuming, represents a change in thinking and learning curve for auditors

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**Benchmark Survey Results**

- Based on the AHIMA 2007 Coding Benchmark Survey,
  - 61% of the 322 respondents monitored coding quality by the total number of records reviewed as the denominator and the total number of records with errors as the numerator
  - only 25% of the 322 respondents based their coding quality on the total number of codes assigned
Let’s Compare Methods

- **IP Example #1**
  - Sam had the following errors identified in a random audit sample of 25 records
    - 1 DRG, 2 PDX, 38 SDX, 1 SP
  - **Record-over-Record approach**
    - 92% accuracy - 1 DRG change (1 PDX change); 1 PDX change (no DRG change)
  - **Code-over-Code approach**
    - DRG: 96%
    - PDX: 92%
    - SDX: 62%
    - PP: 100%
    - SP: 83.33%
    - Overall ICD-9-CM Accuracy: 70.63%

Let’s Compare Methods

- **IP Example #2**
  - Julie had the following errors identified in a random audit sample of 25 inpatient records
    - 4 DRG, 2 PDX, 5 SDX, 1 PP
  - **Record-over-Record approach**
    - 84% accuracy - 4 DRG changes (2 PDX changes, 1 SDX (C/C), 1 PP)
  - **Code-over-Code approach**
    - DRG: 84%
    - PDX: 92%
    - SDX: 95.15%
    - PP: 83.33%
    - SP: 100%
    - Overall ICD-9-CM Accuracy: 94.44%
Let’s Compare Methods

- **OP Example #1**
  - Anne had the following errors identified in a random audit sample of 25 outpatient records
    - 2 APC, 2 1st Listed DX, 15 SDX, 3 CPT
  - **Record-over-Record approach**
    - 92% accuracy - 2 charts (1 APC, 1 1st Listed DX, and 1 CPT in error) and (1 1st Listed DX and 1 CPT in error)
  - **Code-over-Code approach**
    - APC: 90%
    - 1st Listed DX: 92%
    - SDX: 83.33%
    - CPT: 85.71%
    - Overall Accuracy (ICD-9-CM and CPT): 85.29%

Let’s Compare Methods

- **OP Example #2**
  - Sue had the following errors identified in a random audit sample of 25 outpatient records
    - 8 APC, 2 SDX, 8 CPT
  - **Record-over-Record approach**
    - 68% accuracy - 8 charts had APC/ CPT coding errors
  - **Code-over-Code approach**
    - APC: 68%
    - 1st Listed DX: 100%
    - SDX: 97.40%
    - CPT: 68%
    - Overall Accuracy (ICD-9-CM and CPT): 92.13%
Code-over-Code Category Breakdown

- **Inpatient**
  - DRG, PDX, SDX, PP, SP, Overall Accuracy (ICD-9-CM codes)

- **Outpatient**
  - APC, 1st Listed DX, SDX, CPT, Overall Accuracy (ICD-9-CM and CPT codes)

Code-over-Code Key Terms

- Correct Code
- Coding Error
  - Revised Code
  - Added Code
  - Deleted Code
**Code-over-Code**

**Key Definitions - Correct Code**

- Correct code is any code without a coding error (not revised, not added, or not deleted by the auditor). This applies to all codes.

**Code-over-Code**

**Key Definitions - Coding Error**

- Coding error is any code that is revised, added, or deleted.
**Code-over-Code**
**Key Definitions – Revised Code**

- Revised code applies to any of the following:
  - PDX/ PP:
    - resequencing the PDX/PP to SDX/SP and then adding a PDX/PP;
    - deleting the PDX/PP and then adding a PDX/PP;
    - deleting the PDX/PP and then resequencing a SDX/SP to PDX/PP;
  - SDX/SP:
    - deleting one code and revising the second code to report the combination code for the condition or procedure (300.00 and 311 being validated, auditor deletes one code and revises second code to 300.4);
    - revising one code to more accurately reflect the condition (496 being validated, auditor revises to 491.21) or modifying the fifth digit (45.13 being validated, auditor revises to 45.16);
    - deleting one code and adding one code in its place (delete V10.3 and add V16.3)
**Code-over-Code**  
**Key Definitions - Revised Code**

- Revised codes are counted as **one error** or **one revision** when the **diagnosis** or **procedure** being validated requires any type of revision

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**Code-over-Code**  
**Key Definitions - Added Code**

- Added codes are not reported by coder but meet secondary diagnosis or procedure reporting guidelines. This includes diagnosis codes added to more completely reflect a condition. Such as in sepsis, the auditor adds 995.91; or the auditor adds a manifestation code, or the auditor adds a secondary diagnosis documented and treated but is not coded
- Auditor counts one error for each code added
**Code-over-Code**  
**Key Definitions - Deleted Code**

- Deleted codes are reported by coder but do not meet secondary diagnosis or procedure reporting guidelines.
- Auditor counts one error for each code deleted

**IP Formula - # Reviewed per record = 1**

- DRG, PDX, PP
- Numerator: # revised
- Denominator: # reviewed
- After dividing, multiply the answer by 100 to report the error rate. To report the accuracy rate, subtract the error rate from 100.
- For example,
  - 2/25 DRGs incorrect - 92% accuracy
  - 0/25 PDX incorrect - 100% accuracy
  - 1/7 PP incorrect - 86% accuracy
**OP Formula - # Reviewed per record = 1**

- 1st Listed DX
- Numerator: # revised
- Denominator: # reviewed
- After dividing, multiply the answer by 100 to report the error rate. To report the accuracy rate, subtract the error rate from 100.
- For example, 2/25 1st Listed DX incorrect - 92% accuracy

**IP Formula - # Reviewed per record could be >1**

- SDX, SP
- Numerator: total # of errors (revised + added + deleted)
- Denominator: total # of codes reviewed + revised + added - deleted
- After dividing, multiply the answer by 100 to report the error rate. To report the accuracy rate, subtract the error rate from 100.
- For example, 45/220 SDX incorrect - 80% accuracy; 2/15 SP incorrect - 87% accuracy
**OP Formula - # Reviewed per record could be >1**

- APC, SDX, ICD-9-CM Procedure, CPT
- Numerator: total # of errors (revised + added + deleted)
- Denominator: total # of codes reviewed + revised + added - deleted
- After dividing, multiply the answer by 100 to report the error rate. To report the accuracy rate, subtract the error rate from 100.
- For example, 2/20 APC incorrect - 90% accuracy; 5/95 SDX incorrect - 95% accuracy; 3/20 CPT incorrect - 85% accuracy

**Identifying Educational Opportunities**

- When a code is revised, added, or deleted - indicate what coding error category so education can be targeted
- For example,
  - Coding conventions
  - Official Coding Guidelines
  - Official Coding Advice
  - Hospital-specific coding guidelines, including post-discharge queries
  - Clinical Decision Making
### Overall Accuracy - IP

- **Numerator:** total # of errors for all ICD-9-CM diagnoses and procedures (revised + added + deleted)
- **Denominator:** total # of ICD-9-CM diagnoses and procedure codes reviewed + revised + added - deleted
- For example,
  - 1/25 PDX, 15/150 SDX, 1/10 PP, 0/5 SP = 17 total errors out of 190 reviewed codes
- 91.05% Overall ICD-9-CM Accuracy

### Overall Accuracy - OP

- **Numerator:** total # of errors for all ICD-9-CM diagnoses and procedures and CPT/HCPCS (revised + added + deleted)
- **Denominator:** total # of ICD-9-CM diagnoses and procedure codes and CPT/HCPCS reviewed + revised + added - deleted
- For example,
  - 1/25 1st Listed DX, 10/75 SDX, 1/10 CPT = 12 total errors out of 110 reviewed codes
- 89% Overall Accuracy
Case Study Example #1

- Sam - SDX Accuracy 62% (38 incorrect) - Target is 95%
- Re-educated on coding chronic diseases - Official Guidelines Sect 3
- Re-educated on coding tobacco abuse per hospital specific policy
- Re-educated on coding of BMI from Dietician documentation
Case Study Example #2

- Sue - CPT Accuracy 68% (8/17 incorrect) - Target is 95%
- Re-educated on size of excision
- Re-educated on reading entire body of operative report - was missing biopsies
**Where to start?**

- Benchmark tools for IP and OP in Book
- Excel computer skills
- Clear understanding of errors and classification of educational opportunities
- Use method with your next audit and compare results to previous audit

**Supporting Coding Quality**

- Guidelines, regulations, documentation, and/or processes that support coding quality
Guidelines

  - Section 1: Conventions, general coding guidelines, and chapter specific coding guidelines.
  - Section 2: Selection of principal diagnosis (IP)
  - Section 3: Reporting additional diagnoses (IP)
  - Section 4: Diagnostic Coding and Reporting Guidelines for Outpatient Services (OP)
  - Appendix I: Present on Admission (POA) reporting guidelines (Inpatient)

- AHA Coding Clinic for ICD-9-CM
- AHA Coding Clinic for HCPCS (OP)
- Medicare Post Acute Transfer DRG Rule (IP)

Documentation

- Initial physician assessments and orders
  - ED notes
  - H&P
  - Consultations
  - Orders

- Diagnostic and therapeutic treatment
  - Test results
  - Diagnostic reports
  - Operative and procedure reports

- Other:
  - Nursing notes
  - Ancillary testing results
  - Other clinical department supporting documentation
Documentation - Inpatient

- Survey:
  - 66% use the discharge summary for coding
    - 23% require the discharge summary meaning they would not code the record without it
    - 50% - 56% will recheck the coding in record when the summary is received

- Best Practice
  - Establish process Records coded without a discharge summary that at the time of the audit had the discharge summary and included identified coding recommendations based on documentation in the discharge summary are referred for potential rebilling and identified as a compliance issue with action plan follow-up

Documentation Improvement Techniques

- Develop Clinical Documentation Improvement Programs (CDIPs)
- Improve Physician Communication Process
- Educate all providers
Additional Items That Support Coding Quality

- Complete, accurate, consistent, legible, and timely documentation
- Established process to track, trend, report and initiate action plans for identified quality issues related to documentation delays or non-response to queries
- Access to current coding books and/or encoder
- Access to official coding sources
- Access to medical dictionaries, Merck manual, anatomy and physiology book, drug book, or the applicable payer manuals

Review internal coding policies and procedures annually.
  - Identify root cause for declining accuracy scores
  - Educate and train coders on a regular basis
- Follow the OIG Compliance Program Guidance for Hospitals
Items That Negatively Impact Coding Quality

- Ambiguous, incomplete, conflicting, and illegible documentation
- Image quality when scanning systems are utilized
- Insufficient new hire coder orientation and training program
- Final billing expectations
- Non-coding tasks
- Insufficient audit and education program

Quality Training for Coders

- Coding roundtables
- AHIMA audio seminars
- Self-study instruction
- Stress how the coder can improve accuracy through education
Quality Training for Physicians

- Get a physician champion to generate physician support and serve as liaison between coder and physician
- Provide training
  - Department or quarterly department meetings
  - HIM sponsored meetings
  - One-on-one
- Stress what’s in it for the physician
  - Relate documentation requirements back to physician quality reporting, pay for performance initiatives, and physician quality report cards

Conclusion

- Reporting root cause consistently will reflect the quality and consistency of coded data
- Utilize a benchmarking tool - recommend code over code to calculate your accuracy rate
- Implement corrective action plan which includes education to coders, physicians and clinicians
- Monitor the effectiveness of the educational sessions through follow-up reviews
Resources

- “Collecting Root Cause to Improve Coding Quality Measurement” *Journal of AHIMA*, March 2008
- Wilson, Donna and Dunn, Rose. *Benchmarking to Improve Coding Accuracy and Productivity*. AHIMA publication. 2008

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