

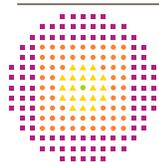
## White Paper

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# Best Practices in Coding Audits

Leveraging Coding Audits to Document Care Quality and  
Optimize Financial Performance in a Value-Based World

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## Executive Summary

While many providers might view coding audits as a necessary evil, an effective auditing program yields many distinct benefits. Given the intricate nature of coding rules and the myriad ways they can influence an organization's financial performance— for better or worse— code auditing makes a great deal of sense.

Regardless of the depth/breadth of your service offerings, coding serves as the foundation of your financial performance. And the more diverse your portfolio, the more interdependencies and complexities exist within the coding needed to accurately reflect the care delivered and respective reimbursement. By understanding these tenets of an effective code auditing program, you can align the resources and processes needed to accurately document care quality and be reimbursed accordingly.

### The benefits of investing in a coding audit program include:

- › Accurate reimbursement
- › Accurate reporting & data
- › Coder education & development
- › Increased compliance

## Why Audit at All?

As providers navigate ever-increasing revenue cycle complexity, what is the virtue of expending effort and dollars on an audit of coding? Medical coding is characterized by thousands of rules and interdependencies. Small details in the documentation can have meaningful impacts on the ascribed coding, and thus material impacts on the appropriate reimbursement for the encounter. There are many benefits to a strong coding audit program, which fall into four broad categories:

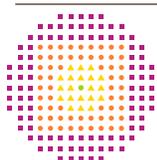
- 1) accurate reimbursement
- 2) accurate reporting & data
- 3) coder education & development
- 4) increased compliance

### 1 Accurate Reimbursement

Clearly, having an encounter appropriately coded directly impacts the reimbursement for that specific encounter. By identifying and correcting over- and under-coding, an encounter is appropriately reimbursed and financial performance is improved via faster payment and reducing the expense/disruption of appealing denials. Beyond individual encounters, coding also drives metrics which further impact reimbursement, such as case mix index (CMI).

*In addition to increasing coding accuracy, an effective audit program will enable better internal decision making and more precise external reporting.*

CMI is the relative value assigned to the effort/ resources needed to care for patients with specific conditions. Medicare uses CMI to calculate reimbursement for services.



**2 Accurate Reporting and Data**  
Coded data also has broad analytical utility across an organization. Accurate coding is paramount to ensuring metrics such as severity of illness and risk of mortality are correctly reflected. In today's world, coded data has far reaching implications ranging from the support of managed care contract negotiation to scorecards and comparison studies (e.g., Healthgrades, PQRS, etc.). In addition to increasing coding accuracy, an effective audit program will enable better internal decision making and more precise external reporting.

**3 Coder Education and Development**  
The transition from ICD-9 to ICD-10 marked a substantial shift in the coding environment. While standard shifts are relatively rare events, the coding environment is very fluid. New codes are regularly added and new guidance regularly released. Within this dynamic environment, it is important to identify recurring errors and provide targeted training. Through the use of auditing, organizations can continually review coding for trends that identify recurring errors. More progressive audit programs will package and return that information to coders in the form of actionable feedback for ongoing development.

**4 Increased Compliance**  
Lastly, an audit program forms the backbone of a robust coding quality compliance platform – something all providers should have in place. There are numerous regulatory agencies and agents examining coding quality today. The combination of natural intricacy

and large volume makes 100% coding accuracy a constant target rather than a regular reality; however, demonstrating a commitment to that target is a necessity in today's regulatory environment.

The good news is that a well-designed audit program can serve all four of these areas for healthcare providers.

Having confirmed the importance of establishing a strong audit program, what follows will guide providers in crafting a program which brings benefits that offset the cost of the program many times over.

## Establishing the Scope

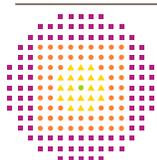
Providers today are likely coding encounters across multiple modalities of care, potentially for both the facility and the professional. The most common scopes for an audit are:

- › Inpatient MS-DRG
- › Inpatient APR-DRG
- › Hospital outpatient APC
- › Hierarchical condition category (HCC), and
- › Professional fee (Pro-fee)

All of these payment methodologies pose varying degrees of risk for material errors in coding.

While on a case-by-case basis, the potential financial impact is greater for inpatient encounters, the sheer volume of outpatient and professional fee coding can mean that material errors in those areas could total more than those from inpatient.

In short, a well-rounded audit program should be evaluating the coding accuracy of all encounters, regardless of treatment setting.



## Ensuring ROI

Clearly, auditing 100% of coded encounters would be prohibitively expensive and inefficient, so how should a provider organization establish the appropriate scope for their audit work?

The best approach is to perform targeted audits on a sample of accounts. The most efficient sample size is the smallest one that best reflects an accurate representation of their coding accuracy and risk. Given the large volume of overall encounters in the average provider organization, a good rule of thumb is to audit:

- > 2% of inpatient encounters
- > 1.25% of outpatient and professional encounters

Establishing the size, however, is only one aspect of efficient auditing. The sample selection methodology is equally important.

## Sampling Method

There are three categories of sampling methodology: random, stratified random and focused. A random sample is, as the name would suggest, random. It is important, however, to ensure that in making a random sample, you end up with a subset of encounters that are broadly representative of your encounter population. A random sample could result in only a few encounters from a specific coder. Providers should consider stratifying their random sample to make sure that departments and coders are proportionately represented. A stratified random audit approach provides the organization with the ability to review designated DRGs, coders,

providers or ICD/CPT codes without drilling down into account-specific detail. While this approach is more meaningful than a true random sample, it does not deliver the details that a focused audit approach generates.

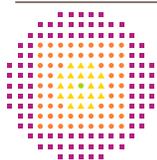
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A random sample, however, will still result in many accounts being audited where there was no real risk of errant coding. A better path does exist. A focused sample, much like a random one, is aptly named. It can be focused in whole or in part; for example, a provider could pull a random sample that also overweights an area where they know problems have existed in the past.

A focused sample can also be manually focused or technology-enabled. A manually focused selection sample relies on the experience of the sampler to direct the account selection, be it at a new coder, a coder moved to a new area or one who has struggled with accuracy in the past. A technology-enabled focused sample selection methodology uses rules-based software algorithms to identify accounts with a high probability of having coding and documentation errors. In either instance, if properly executed, a focused sample should increase the efficiency of the overall audit. However, a word of caution is warranted: if utilizing a manually focused sampling approach, a provider may be focused on previous issues while missing new problems that are impacting current



performance. The best practice is a technology-enabled sampling methodology that data mines the entire population of encounters and flags those that have the greatest potential for both reward and risk.

## Frequency

There are two primary reasons to perform audits on a more, rather than less, frequent cadence. The first is the 60-day Medicare re-billing rule broadly in place. If an error is discovered in coding that, once corrected, results in a higher reimbursement to the provider, in most instances the provider only has 60 days to re-bill the higher amount. After 60 days, corrections that result in increased Medicare DRG payment are no longer accepted and the additional reimbursement is lost forever.

The second factor reinforcing the need for more frequent auditing is that the training can be performed closer to when the coding error occurred. If audits are performed monthly, then new patterns of errors can be detected and subsequent training can be provided. If audits are only occurring quarterly or semi-annually, those undetected errors may have compounded over time, increasing the financial impact.

Audits can be performed prior to or after the bill is dropped. For those providers who opt for post-billing coding audits, the more frequent the audits, the better, with a monthly cadence being the best practice to assess and act on the results.

## Pre- vs. Post-Billing

All providers should consider placing their audit process immediately after coding and prior to the bill being submitted. First and foremost, this allows for immediate and continuous feedback for the coders themselves, ensuring that the isolated errors do not become a recurring challenge.

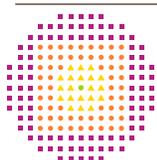
In addition to the training value of immediate feedback, pre-billing audits can identify coding errors that would ultimately result in denials or re-billing when discovered later. High volumes of re-billing increase the risk of external audits from regulators and payers, and overturning denials is an expensive and time-consuming process.

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While there is understandable reluctance to inserting another step between care delivery and bill drop, the value brought by auditing coding prior to billing can far outpace the cost of the approach. A well designed, technology-enabled pre-bill audit process can result in minimal billing delays while avoiding the cost/ disruption of future denials and re-billing efforts.



## Internal vs. External Resources

From a compliance perspective, the best practice is certainly to engage a third-party firm of experts to conduct your coding audits. Leveraging a third party can eliminate any appearance of conflicts of interest in working with regulators, while also providing an objective perspective free from internal influence.

Beyond compliance, fresh eyes are always helpful to reveal potential issues in your organization. Engaging with a firm that brings not only outside expertise and service capacity but also enabling technology for your in-house audit efforts can deliver financial performance improvements that dramatically offset their fees.

**Optimized documentation and coding processes are paramount to your organization's financial performance. Establishing and following these best practices will deliver sustainable improvements that help fund your mission to serve your community.**

## Conclusion

Accurate coding is an ongoing process, not a destination, and providers are leveraging audits in different ways based on their unique circumstances. Some are not leveraging any form of auditing currently, while others may have robust internal audit programs in need of fine tuning based on industry best practices such as those described here.

Like most complex processes, your chances of getting the best results from a new or existing code auditing operation can be dramatically improved by getting input from seasoned veterans. Leveraging the insight of experienced professionals who are familiar with the regulatory requirements as well as the provider-based considerations will help ensure the best strategic and operational approach is developed and executed accordingly.

The Coding Audit Solutions leadership at Streamline Health features a collective 80+ years of experience in medical coding and revenue integrity audits. And they're backed by innovative technology that will help you automate and simplify the overall process for faster, sustainable improvements.

**[Contact Streamline Health today to find out how our Coding Audit Services and Technology solutions can help you confirm compliance and optimize reimbursements across your enterprise.](#)**

