Part B Insider (Multispecialty) Coding Alert

Inpatient Coding: Distinguish the Fine Line Between Inpatient and Outpatient Stays

Misunderstood documentation could lead to accusations of overpayments.

It's been said that communication is the key to success in love, in business, and more than ever, in medicine. The how, what, when, where, and why of documenting care is directly related to the patient's health and your practice's livelihood. Though the lines between Medicare's Part A and B can be fuzzy sometimes, providers need to understand the significance of clear and concise notes, signed reports, and wording—or they could face paybacks to the government.

Background. The OIG published a report Monday about a Lafayette, LA hospital that had received $287,257 in overpayments—though the original estimated amount was closer to $4 million—in 2013 and 2014 for a variety of infractions.

Of the 134 Medicare claims reviewed, the OIG discovered errors in 69 of the 103 inpatient claims. Among those, 55 were billed incorrectly as Medicare Part A when they should have been Part B while 11 concerned the wrong diagnosis related group (DRG) codes. Of the final three claims, one focused on overbilling for sterile supplies and the other two centered on patients' admission by uncertified staff.

Although this issue doesn't seem particularly egregious, the reality is that miscoding results in the misuse of government funds, and could cause trouble. The one solution is proper record-keeping. "Documentation is an essential factor in the success or failure of the coding process," says **Nikki N. Taylor, MBA, COC, CPC, CPMA**, an auditor with TCI Consulting & Revenue Cycle Solutions, "Provider documentation must provide a clear and complete picture of what occurred during the visit which will allow the coder to properly code the case."

Dually Noted

Mistakes happen, but ensuring that your documentation is metaphorically bulletproof helps to eradicate these types of common errors. In a healthcare setting like this large hospital in Lafayette, the pace can be extremely fast; moreover, shortcuts, omissions, and abbreviations can lead to audits and Medicare payment reversals.

"From experience, providers will often omit key information from the medical record documentation and assume that the person reading the documentation does not need a detailed account of the visit," says Taylor. Oftentimes, coders will enquire about the mixed messages, but sometimes they don't, and that can lead to trouble.

The question about whether a patient's care should be billed as inpatient or outpatient can easily be resolved by coders, who stay aware of the constant changes to Medicare, the varied codes, and rules and regulations particular to the venue where care is given. Unfortunately, providers' notes can be vague, and if you, as the coder, aren't vigilant, "bad habits may develop," says Taylor.

"Inpatient coders sometimes face more stress in dealing with quotas which may cause them to need to code faster, thus not paying enough attention to the documentation," says Taylor. However, she also mentions that this is an issue with outpatient coders, too, and they "must hold the providers accountable when documentation is lacking."

DRG Dispute

Of the 11 DRG code disputes, one highlights the importance of defensible documentation when the auditors get finicky. In this case, which concerned a patient with heart problems, the hospital billed the principal diagnosis code 433.10 (Occlusion and stenosis of carotid artery without cerebral infarction) with a primary procedure code 38.12 (Endarterectomy, other vessels of head and neck).

As this incident was investigated, the auditor stated that the patient was not admitted to the hospital "prior" to this care, which is an "inpatient only procedure." Luckily, after a thorough search through the provider's notes, an inpatient order was discovered that verified the physician's original DRG codes.

This reaffirms the importance that if the coders don't get all of the provider's documentation up front, errors will arise. Coders can only process what they are given.

Here's why an internal audit helps: Healthcare has become extremely complicated over the past 20 years, and in order to stay fiscally sound and remain in compliance with the necessary standards, practices and hospitals must check themselves regularly. Both internal and external audits done annually allow you and your staff to see where you need improvement. Your results might show that your practice continually makes coding errors by using the wrong modifiers or drops the ball when it comes to enforcing HIPAA.

Taylor recommends that providers take advantage of auditing as a tool to overcome "poor coding habits and poor documentation." She says that regular auditing helps both providers and staff align and maintain their policies and procedures, ensuring that care and coding are in compliance.

The following things can be gained from an annual audit, Taylor advises:

- Rectifies coding controversies.
- Measures the quality of your patient care.
- Reforms staff compliance issues.
- Promotes the need for education of both providers and coders.
- "Assists with charge capture."
- Provides you with the data necessary to combat "government scrutiny."

Resource: For more information about this OIG report, visit http://oig.hhs.gov/oas/reports/region6/61500022.pdf.