Codify
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Home Health ICD-9/ICD-10 Alert

CODING AUDITS: Consider These Key Elements For Effective

Self assessment protects you from unpleasant surprises.

It's too late to conduct a coding audit when the feds are knocking on your door. Here's how to head them off at the pass.

Many providers wait until the intermediary asks for their records before auditing, and then try to correct reimbursement errors, experts say. But that could put you at risk for fraud charges.

Why audit? For most home health agencies, coding errors are a big problem, says consultant **Barbara Citarella** with Staatsburg, NY-based **RBC Limited**. Even when an agency hires a coder, she is likely to have in-patient or out-patient coding training and experience, and there is a steep learning curve to move to home care coding, Citarella tells **Eli**.

HHAs are beginning to understand the importance of correct diagnosis coding for profitability under the prospective payment system. And because diagnosis coding affects reimbursement, it is under the **Centers for Medicare & Medicaid Services**' microscope in the ongoing fight against fraud. So if you can find coding errors on your own, you're likely to increase agency profitability and prevent heightened scrutiny from your fiscal intermediary, experts say.

Audit options: Resources may dictate how you conduct coding audits. Option 1: Some agencies audit each episode after the clinician completes the assessment. This process can be part of a general pre-billing audit on each patient or on those patients with high-risk diagnoses. Option 2: Other HHAs choose to periodically review the records to validate coding accuracy. In both audits, you determine if the diagnosis coding follows coding conventions and if the information in the medical record supports the codes selected, explains **Judy Adams** with Charlotte, NC-based **LarsonAllen Health Care Group**.

How often to audit: If you choose option two and periodically audit records, you need to decide how often to schedule your audits. If your coding audit shows no problems, auditing once or twice a year hould be sufficient, says **Rita Rich**, a senior coding compliance analyst with **LifePoint Hospitals** in Brentwood, TN. But if you've uncovered problem areas or had staff changes, auditing again after three months makes sense, she tells **Eli**.

Many agencies include coding audits in their quarterly compliance audits, experts report.

Who should audit: HHAs could use their in-house expert for either audit option, Adams tells **Eli**. This person might be a clerical staff member, a clinical supervisor/manager, a quality improvement staffer or a coding specialist, she adds.

But it is important that the coding auditor have a thorough understanding of diagnosis coding, OASIS and how documentation should support the codes chosen, experts warn. And if the same person audits who did the initial coding, your audit may not be as effective. It may not catch misunderstandings or other repeated errors.

Agencies also could use a consultant for the audit or call on their facility's audit group, if they are hospital-based or connected with a multi-agency company, Rich suggests. But the auditor must understand coding in the home health setting.

Experts Offer 4 Audit Tips

If you're wondering how to get started in your coding audits, experts suggest these tips:

1. Develop a worksheet. Using a worksheet that prompts you to check the various documentation items required and

any crucial coding conventions makes your audit more consistent, Rich says. You can have a basic audit tool and "tweak it for a specific audit focus," she notes. A spreadsheet where you log each chart you review and note any necessary coding changes will give you financial estimates for the over- or underpayments involved and will help you pick up patterns of errors, Rich says.

2. Focus on codes that have the most financial impact first. When you select your audit sample, you can use a random sample of all patients or you can narrow your sample to focus on certain codes, Citarella says. Some codes that often are problematic are diabetes, wounds and strokes, she notes.
Codes with significant financial impact are at high risk for problems with undercoding or upcoding, so it's essential to get them right, Rich suggests. Physician documentation is especially important with these case mix codes, she adds.

3. Document the original diagnosis codes and any corrections. Be sure to document the rationale for any changes, Adams advises. Discuss potential changes with the assessing clinician and follow your agency requirements for correcting information.

Warning: Remember, any changes need to be agreed upon and preferably made by the original clinician, because she is ultimately responsible for diagnosis selection decisions, Adams says.

4. Note any patterns of error in diagnosis coding. The reviewer can determine where home health staff may need additional training and can arrange a time to discuss the findings with staff, Adams advises. Having staff review the coding errors you discover also lets staff educate the reviewer about different points of view, Rich says. This review can be especially helpful if the person doing the coding audit is from a coding background other than home health, experts say.