Health Information Compliance Alert

Coding Compliance: TOP 9 CODING COMPLIANCE TARGETS

When it comes to coding compliance, experts say it's best to keep a low profile.

There are simply too many potential dangers to guard against, so the best strategy is to avoid from the start the kind of scrutiny that will have fraud enforcers combing through your documentation.

While watchdogs like the **HHS Office of Inspector General** offer yearly work plans that they claim spotlight their fraud targets for the upcoming year, even those documents can be overwhelming. The best advice comes from the coders and consultants who are in the field and know what practices are drawing unwanted attention.

Our experts say that paying special attention to the following coding issues will save you from some serious coding compliance headaches in the coming year:

1. Evaluation and management. E/M coding has become a lot tougher in recent months. "With two sets of documentation guidelines on the physician side and the facilities allowed to create their own systems for assigning codes it can be really complex to come up with the most correct E/M code," says **Sue Prophet**, director of coding policy and compliance for the**American Health Information Manage-ment Association**. "It's certainly an area the fraud enforcers are going to be taking a look at."

2. Outpatient CPT surgery coding. "Because people are still getting used to the outpatient prospective payment system, both the surgical CPT coding that the HIM staff would be assigning and the CPT codes that are assigned to the Chargemaster are major issues," warns Prophet.

3. Diagnosis-related group coding. It's not a new issue, but DRG upcoding is still "easy pickings" for fraud fighters, says **Terry Paronish**, a senior manager with the consulting services group of **3M Health Information Systems**. Pneumonia, septicemia, gastroenteritis and respiratory failure are likely candidates to raise red flags.

4. Short-stays. Compliance officers should be wary of patients who are moved from inpatient status to outpatient observation after only one day. "We're seeing the government come in and look at those one-day length of stays at a much higher level of scrutiny," says Paronish.

   Make sure the patient is in the correct site of service to begin with, Paronish counsels. Often fraud fighters are determined to show that observation is where the patient should have been all along.

5. **Consecutive inpatient stays.** Fraud enforcers are going to take a long look at patients who are discharged and readmitted immediately, says Paronish. The OIG worries that providers aren't billing properly in these situations and has promised to scrutinize whether they're taking more Medicare dollars than they're entitled to.

   Patients whose inpatient stays are almost back to back also will lead to reviews, Paronish warns. "Frequent flyer" admissions i.e., separate admissions for patients with consecutive inpatient stays are likely to draw unwanted scrutiny.

6. **Inconsistent diagnosis.** Diagnosis problems affect providers across the health care spectrum, but home health agencies seem to face particularly harsh scrutiny, says **Prinny Rose Abraham** with Minneapolis-based **HIQM Consulting**. Typical issues include a diagnosis that isn't sequenced, two diagnoses listed as primary, a diagnosis not specified as acute or chronic, or one not supported by the patient's Outcome and Assessment Information Set severity rating.

7. Partial Hospitalization. A patient's condition must be fairly severe to warrant admission to a PHP. "Partial hospitalization is supposed to mean that the patient would have been an inpatient if not for the program," counsels Paronish. Hospitals must be certain to document that the patient met the PHP criteria because "this will be a big issue in the coming year."

8. Coding templates. "Cookie cutter documentation really tends to raise a red flag," warns **George Alex**, managing partner of Baltimore-based consulting firm **Iatro, LLC**. In general, templates aren't a bad idea, but "there's some concern of whether the physicians are actually performing what's contained in the documentation template or whether they're just plugging in that information in order to reach higher levels of coding."

9. PATH issues. "Physicians at teaching hospitals are really being scrutinized" still counsels Paronish. She says enforcers are asking three questions: "Was the teaching physician present at the service?"; "Did the provider meet the criteria for documenting that the physician was at the service?"; and "Was the level of bill appropriate to the documentation?"