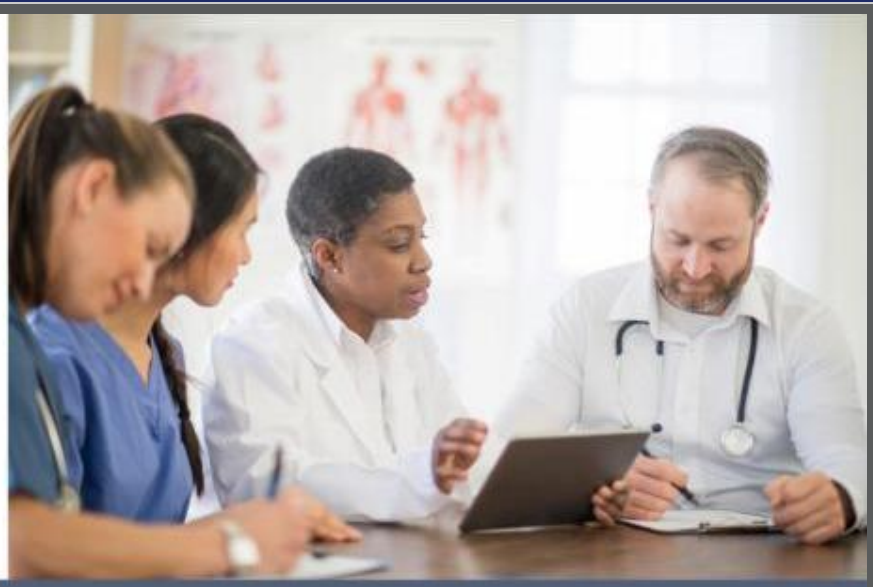

Weekly Auditing and Compliance Tip

National Alliance of Medical Auditing Specialists | 877-418-5564 | namas.co | namas@namas.co

June 9, 2017

Don't Overlook Diagnosis Codes During Coding Audits

Coding auditors focus much of their attention exclusively on CPT codes during the review process. After all, codes reported for E&M visits, surgical procedures and diagnostic services are what generate revenue to the provider or facility. Even more importantly, errors in reporting these services are frequently what give rise to payer reviews, denials and investigations for inaccurate billing practices. Reported diagnosis codes on a billing claim are often given only cursory consideration when compared to the documented record. Unless a review is targeted for ICD-10-CM accuracy, auditors do not have time or, in rare cases, the clinical expertise to carefully dissect the clinical encounter to compare the documented conditions to the assigned diagnosis codes. Performing professional audits without giving sufficient consideration for the diagnosis codes however, ultimately results in an incomplete audit and denies the client an opportunity to receive valuable feedback and education for documentation improvement. The healthcare industry is shifting and the changes are led by focusing on the delivery of quality care. It is the diagnosis code that identifies and defines the severity of illness and helps drive home the message of medical necessity for rendered services. Increasingly, payers are looking to risk

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adjustment methods such as the CMS Medicare Advantage Hierarchical Condition Categories (or HCC's) to determine payment rates. Without accurate clinical documentation and appropriate diagnosis code reporting, the transition to quality will be stymied.

Accurate documentation to support a true picture of patient illness is meaningless if the reported codes are inaccurate, nonspecific, or simply excluded from a claim or reported to the payer. As an example, it is common to find code E11.9 (Type 2 Diabetes Mellitus without complication) reported for diabetic patients. Review of the documentation however, reveals the patient to have an abnormal foot examination consistent with diabetic peripheral neuropathy and the accurate condition should be reported with ICD-10-CM code E11.42 (Type 2 Diabetes Mellitus with diabetic polyneuropathy). Reporting ICD-10-CM codes that are clinically precise and specific but are not supported by the medical record creates a false impression for severity of illness that can easily overstate the patient's overall health risk. An example of this might be a reported code of F33.2 (Major depressive disorder, recurrent, moderate) yet the record is documented with nothing more specific than "depression, stable and will continue current dose of Paxil." The reported code incorrectly overstates the severity of illness (with risk adjustment value) yet the specificity is not supported by the clinical documentation.

Professional auditors should include sufficient time in the review process to validate the accuracy of the clinical record and the reported diagnosis codes as a component of the audit process. Provider education and feedback regarding discrepancies in reported or assigned diagnosis code and the medical record will assist providers in improving their documentation to help ensure accuracy and quality in the clinical record. Be sure to know the Coding Guidelines for diagnosis code reporting and stay current with updates to the ICD-10-CM code set. Lastly, as a professional, be certain your clinical skills are up-to-date and that you are prepared with adequate resources to research unfamiliar terms. With over 70,000 codes in the ICD-10-CM code set, it is impossible to know all the associated pathophysiology to support their uses but we must know where to look for information that guides us - after all, our job is to be expert in all things coding and auditing!

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This Week's Tip Written by:

Betty Stump, MHA, RHIT, CPC, CCS-P, CPMA, CDIP Betty is a CDI Senior Consultant for Optum360 Consulting

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NAMAS Calendar of Events

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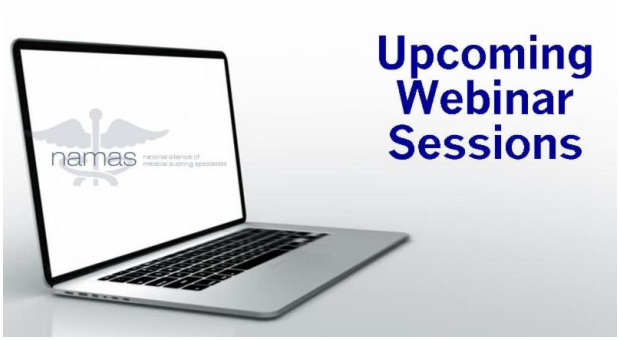

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How to Create a Quality Assurance Program
Speaker: Scott Kraft
June 13, 2017
2pm EST

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We Had a HIPAA Breach: Now What?
Speaker: Kelly Ogle
June 20, 2017
2pm EST

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Hands On: Auditing ER Services
Speaker: Stephanie Allard
June 27, 2017
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