Developing a Coding Compliance Program

Objectives

At the completion of this chapter, the learner should be able to:

- Identify the seven key components of a corporate compliance program.
- Describe the importance of a corporate compliance program and the purpose of a coding compliance program.
- Discuss the purpose of the Office of Inspector General's compliance guidance for health care entities and identify key elements.
- Describe the difference between "mandatory" and "permissive" offenses.
- Discuss the roles of the coding compliance manager and the coding compliance committee.
- Identify areas that should be defined within coding compliance policies.
- Discuss the importance of coding compliance education.
- Recognize the importance of coding accuracy and distinguish between coding and documentation errors.
- Explain differences in coding certification and professional coding organizations.
- Identify the coding resources that must be kept up to date.

Key Terms

chargemaster
code of conduct
coding certification
coding compliance
coding compliance education
Coding Compliance Manager

coding resources
compliance officer
compliance program
Comprehensive Error Rate Testing (CERT) program
corporate compliance program

mandatory exclusions
OIG Compliance Guidance
outcomes
outcome indicators
permissive exclusions
process

Recovery Audit Contractors (RACs)
structure

Integrating Coding and Corporate Compliance

Corporate businesses and health care organizations alike may be subject to criminal and civil actions under a variety of federal and state laws, including the False Claims Act, the Wire and Mail Fraud Act, securities and employment laws, and a number of others. In today's business market, many organizations have adopted **corporate compliance programs** to educate everyone from top executives to line-staff employees on the laws and regulations that affect their operations. A corporate compliance program can prevent both intentional and accidental wrongdoing and can be viewed positively by investigators and the courts, often reducing civil or criminal penalties. The mere existence of a compliance program, however, does not excuse any corporation of wrongdoing. In fact, a poorly planned and executed compliance program can be viewed worse than having no compliance program at all.

Health care providers need to address many of the same compliance concerns as their corporate counterparts. In addition to the laws and regulations already in existence, health care providers face continuing enforcement initiatives from the Centers for Medicare & Medicaid Services (CMS), the Office of Inspector General (OIG), the United States Department of Justice (DOJ), and various national and state accreditation bodies. In addition to conducting federal and state payer oversight, private payers are also engaged in reviewing and auditing health care services for quality, medical necessity, and health care financial waste. Health care organizations today must have a comprehensive corporate compliance program that embodies accountability, responsibility, investigation, and education.
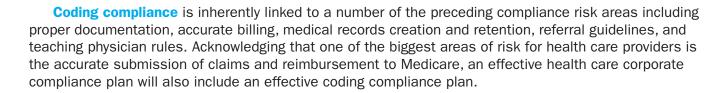
A health care provider's **compliance program** will consist of various policies and standards and will vary depending on the specific entity. Generally, corporate compliance programs include policies and procedures designed to define and identify laws and regulations, correct identified problems, and put controls in place to prevent future problems. Policies may address a variety of compliance issues including:

- Fraud and abuse awareness
- Whistle-blower protections
- HIPAA privacy rules
- Referral guidelines
- Teaching physician rules
- Coding and documentation
- Billing and reimbursement
- Misuse of funds and property
- Antidumping regulations
- Conflicts of interest
- Labor laws
- Researching compliance issues
- Marketing
- Medical records creation/retention
- Patient risk identification (e.g., medical error reduction, medication safety, patient safety)
- Business associates agreements
- Security of health information

Coding compliance is inherently linked to a number of the preceding compliance risk areas including proper documentation, accurate billing, medical records creation and retention, referral guidelines, and teaching physician rules. Acknowledging that one of the biggest areas of risk for health care providers is the accurate submission of claims and reimbursement to Medicare, an effective health care corporate compliance plan will also include an effective coding compliance plan.

OIG Compliance Guidelines

There is **OIG compliance guidance** for several specific health care areas including hospitals, physicians, nursing facilities, pharmaceutical manufacturers, ambulance suppliers, hospices, durable medical equipment manufacturers, and home health agencies. The OIG also publishes an annual work plan that outlines activities that the OIG will be reviewing. These resources, along with the results and summaries of audits that the OIG has performed, are located on the OIG Web site at www.oig.hhs.gov. Although there may be subtle differences in the compliance guidance publications, there is a common theme that the OIG outlines in seven basic compliance elements. These elements stem from the federal sentencing guidelines, which are detailed policies and practices that the federal criminal justice systems use to prescribe appropriate sanctions for offenders convicted of federal crimes. The seven elements include the following:

1. Establishing compliance standards through the development of a **code of conduct** and written policies and procedures

   a. The code of conduct is a general organizational statement of ethical and compliance principles that guide the entity's operations.

   b. The code is similar to a constitution, in that it details the fundamental principles, values, and framework for action within an organization.

   c. The code of conduct articulates a commitment to compliancy by management, employees, and contractors and summarizes the broad ethical and legal principles under which the organization operates.

   d. The code of conduct should include a requirement that professionals follow the ethical standards dictated by their respective professional organizations.

   e. The code of conduct should be brief, easily readable, and cover general principles applicable to all members of an organization.

   Compliance policies and procedures should be developed to assist employees in carrying out their job responsibilities as well as the mission and objectives of the organization. Policies need to be consistent with applicable federal and state regulations. According to the OIG Program Guidance for Hospitals, policies and procedures should be:

   - Clearly written, with relevant day-to-day responsibilities

   - Readily available to individuals who need them

   - Monitored and reevaluated on a regular basis

   - Distributed to all directors, officers, managers, employees, contractors, and medical and clinical staff members

   Compliance policies and procedures should include risk assessment tools that assist an organization in identifying its weaknesses and areas of risk. The risk assessment tool should

reflect federal and state regulations, the OIG work plan, internally identified risk areas, and areas of risk and liability identified through the CMS Conditions of Participation (CoPs) and associations such as The Joint Commission.

2. Assigning compliance monitoring efforts to a designated **compliance officer** or contact

    a. The compliance program/department should be led by a qualified compliance officer, who is supported by a compliance committee. According to the OIG, the individual leading the compliance program should be "trustworthy." Furthermore, "The organization must have used due care not to delegate substantial discretionary authority to individuals who the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in illegal activities" (www.oig.hhs.gov).

    b. The purpose of the compliance department is to ensure compliance with federal and state regulations and to monitor the organization's compliance program.

    c. The compliance committee is minimally composed of senior leadership, legal representatives, physicians, and the compliance officer.

3. Conducting comprehensive training and education on practice ethics and policies and procedures

    Organizations that fail to provide adequate training and education for their staff risk liability for violation of health care fraud and abuse laws. Each individual employee or contractor of an organization requires the skills necessary to perform his or her job responsibilities. This may include required annual compliance training for staff in specific areas, or general education provided to all staff. According to the OIG, "The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required." The training and education needs to be routinely reviewed to ensure it is up-to-date and reflects the objectives outlined in the compliance program. Training should be based on trends identified internally as well as those identified by outside sources such as the OIG, CMS, and health care accrediting bodies. Training should be well documented, identifying the specific session, length, date the education took place, and the individuals who attended.

4. Conducting internal monitoring and auditing focusing on high-risk billing and coding issues through performance of periodic audits

    Audits should be regularly conducted to ensure that the organization is correctly submitting claims and accurately assigning codes. The compliance plan should include specific details about how issues are identified, audited, corrected, and continuously monitored. Components of a coding compliance program are discussed later in this chapter.

5. Developing accessible and open lines of communication

    Open communication is vital to the identification of potential areas of compliance risk. There should be internal processes in place for reporting instances of potential fraud and abuse. The OIG encourages an organizational culture of open communication without fear of retaliation. Many organizations have established hotlines or other similar mechanisms such as comment boxes so that issues can be reported anonymously. All staff, outside contractors, patients, visitors, and vendors should have the ability to report potential compliance issues.

All issues identified through these lines of communication need to be investigated and resolved. The results of internal investigations should be shared with administration and relevant departments on a regular basis. Policies and procedures should be updated to ensure that issues do not recur.

A compliance program that contains internal reporting processes and procedures will enable employees to freely report issues or concerns. An effective reporting mechanism can reduce the possibility of whistle-blower suits that often occur in organizations that limit or prohibit the communication of potential problems.

6. Enforcing disciplinary standards through well-publicized guidelines

Including enforcement and disciplinary methodologies in the compliance program will assist in creating a culture that encourages appropriate ethical behavior. These actions also add credibility and integrity to compliance programs. Disciplinary policies and procedures should be readily available to all staff and included in orientation and training packages. The following are components of appropriate disciplinary actions:

- Methods of disciplinary action may include warnings (oral), reprimands (written), probation, demotion, temporary suspension, termination, restitution of damages, and referral for criminal prosecution.

- Violations should be consistently applied, with provisions given for extraordinary circumstances. Grievous violations may include termination.

- Violations should be thoroughly investigated and documented, including the date of the incident, names of responsible parties, and follow-up actions.

- Policies should include disciplinary actions for those who were aware of violations but failed to report them.

- Potential employees should be checked against government sanctions lists, including the OIG's List of Excluded Individuals/Entities and the General Services Administration's (GSA's) Excluded Parties Listing System. Current employees should be routinely checked to ensure they have not been excluded from the Medicare program.

Individuals or entities may be excluded from Medicare and other health care programs, such as state Medicaid programs, for a number of violations. During fiscal year 2006, three thousand four hundred twenty-two (3422) individuals and entities were barred from participating in Medicare and other state and federal health care programs. Exclusions vary from a few years to permanent exclusion and are based on the nature and seriousness of the offense. Federal guidelines outline minimum exclusionary periods. Offenses are considered either "mandatory" or "permissive." **Mandatory exclusions** must be applied on conviction of violation of certain state or federal health care fraud and abuse laws. **Permissive exclusions** are partly discretionary and may be imposed by a court of law, licensing board, or other agency.

The minimum period of exclusion for a mandatory exclusion offense is five years. If there is one prior conviction, the exclusion will be for ten years. If there are two prior convictions, the exclusion will be permanent. The following are examples of mandatory exclusion offenses:

- A criminal offense related to the delivery of an item or service under Medicare or Medicaid

- A conviction under federal or state law of a criminal offense relating to the neglect or abuse of a patient

- A conviction under federal or state law of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct against a health care program financed by any federal, state, or local government agency

- A conviction under federal or state law of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance

Under a permissive exclusion, individuals or entities may be excluded for a minimum of three years on conviction of the following offenses, for example:

- Interference with, or obstruction of, any investigation into certain criminal offenses

- Submission of claims for excessive charges, unnecessary services, or services that were of a quality that fails to meet professionally recognized standards of health care

- Failure to disclose information required by law

- Failure to supply claims payment information

- Defaulting on health educations loans or scholarship obligations

7. Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate governmental entities

Once a potential compliance issue has been suspected or identified, appropriate steps must be in place to thoroughly and promptly investigate the matter. Investigations should try to identify the root cause of the problem and then promptly initiate corrective measures. If the potential problem is a billing or coding error, for example, measures should be taken to immediately reduce the possibility of further errors. If the discovery identifies that an overpayment occurred, the overpayment should promptly be reported and repaid. As appropriate, referrals to the appropriate law enforcement agency should be made.

As noted earlier, an effective compliance program that works to prevent and detect violations can be viewed positively during an investigation. This is especially true for considerations in permissive exclusionary offenses. An effective compliance program can demonstrate the trustworthiness of the provider. Other considerations include the provider's past history of misconduct, response to allegations, willingness to modify practices, repayments, and acknowledgment of wrongdoing. The following factors may be considered:

- Was there any voluntary disclosure by the provider?

- Were overpayments repaid?

- What changes were made in response to identified problems?

- How long had the compliance program been in effect?

- What problems did the compliance program detect?

- What measures were taken to reduce the possibility of further violations?

- Are staff sufficiently trained in policies and procedures pertaining to Medicare and other state and federal health regulations?

- What are the qualifications of the compliance officer and others involved in the compliance program?

The Coding Compliance Program: Developing Policies and Procedures

An effective coding compliance program should be an integral part of a health care organization's corporate compliance program. A coding compliance program is a valuable asset to the health care entity, because it assists the organization in meeting its obligations to payers, employees, shareholders, and the community. Whereas corporate compliance programs probably do not include the detailed policies and procedures that specifically address complex coding and billing issues, a coding compliance program can provide these necessary guidelines. The coding compliance program should complement the overall organization's corporate compliance program, and should include the support of administration. It is important to note that a single model coding compliance program will not fit every organization's needs. The size and type of the facility, as well as the framework of the coding processes, will affect the structure of the coding compliance program.

An effective coding compliance program will be continually evaluated and reevaluated. It is understood that rules will change, new reimbursement methodologies will be adopted, codes will change, new laws will be enacted, and there will be employee turnover. One method used to assess the effectiveness of the compliance plan is a compliance scorecard. The scorecard can measure specific processes and serve as a motivational tool for employees and managers. Scorecard items should be reviewed and approved by staff and administration. Some scorecard items for a coding compliance department may include the following:

- Coding accuracy goal of 95%

- Reduction in billing/claim errors (measured as a percent of total claims billed)

- 100% participation in coding and documentation educational programs

- Turnaround time to complete audits (measured in days, weeks, months, etc.)

- Attainment by all coding staff of the necessary continuing education units (CEUs) to maintain coding certification

The effectiveness of the coding compliance program should not be based solely on performance in a single area. For example, the coding accuracy of ancillary services cannot be compared with the coding accuracy of inpatient hospital coding. Similarly, poor audit results in one particular area do not mean that the coding compliance program is poor. Identifying problems and addressing them are indicative of an effective coding compliance program.

The results of a well-developed and well-executed coding compliance program, along with dedicated educational efforts, will be that coding will improve over time, documentation will support the medical necessity of charges, denial rates and physician queries will decline, and all employees will have received the training they need to perform their job responsibilities in a compliant manner. However, to reach this goal the program must be effectively managed with operational policies and procedures that are owned and adopted by all employees.

The OIG has recommended that to be effective, both coding compliance programs and corporate compliance programs be continually assessed and monitored. The effectiveness of a program is the measurement of various **outcome indicators** and may include billing and coding error rates, identified overpayments and underpayments, and audit results. The focus on examination of the compliance program is a crucial activity that examines the underlying **structure**, **process**, and **outcomes** of the program. *Structure* measures refer to the capacity of the program to prevent and detect violations

Table 5-1 Structure, Process, and Outcome of an Effective Coding Compliance Program.

Structure	Process	Outcome
Does the coding compliance department have a code of conduct?	Include the code of conduct within the coding compliance policy. Staff sign attestation that they have reviewed the policy annually.	Coding staff observe the code of conduct.
Does the coding compliance department regularly report auditing results? Have results been effectively communicated to coding, billing, and clinical departments?	Audits results are presented at quarterly Compliance Advisory Committee meetings. Results are shared with responsible departments promptly.	Audit findings are reported and education is initiated.
Is the necessary education performed to address compliance issues?	Following reporting of auditing results, training sessions are scheduled.	Education is conducted; errors are reduced.
Have auditing and education improved the results? Have processes changed as a result of audit findings?	Perform follow-up audits to access the effectiveness of retraining.	Additional training is performed as needed; errors are reduced.
Is the coding compliance department properly organized? Do employees have the necessary qualifications to accurately assess coding?	Coding compliance staff maintain coding certification. Review staff credential maintenance on an annual basis.	Coding staff receive timely updates on coding and regulatory changes, reducing the potential for coding errors.
Does the coding compliance department have sufficient resources (staff, budget), training, authority, and autonomy to carry out its mission?	Budget will contain sufficient resources for accurate coding including resources, training, continuing education opportunities, computer software, auditing, and consultation services. The department will assist with coding services as applicable.	The coding compliance department will be the health care facility's expert resource for coding advice. Adequate resources reduce the potential for coding errors.
Are coding compliance issues thoroughly investigated, researched, and documented?	Reviews are based on pre-identified risk areas such as the OIG work plan. Issues are identified internally and externally. Coding and regulatory guidelines are thoroughly researched.	A thoroughly investigated review demonstrates accuracy and competence. Proper education can be conducted.
Does a relationship exist between the corporate compliance program, the coding compliance committee, and the coding compliance department?	Committee structures will be multi-disciplinary including coding, business management services, administration, and providers as appropriate.	Communication among the various departments helps to ensure effective working relationships and follow through on compliance issues.

of law. *Process* measures refer to the manner in which the program seeks to prevent and detect violations of the law. *Outcomes* measures refer to the observable, measurable results related to preventing and detecting violations of law and creating a compliant culture.

Table 5-1 displays the structure, process, and outcome measures as they relate to a coding compliance program.

Fraud and abuse violations, Medicare review programs, and most recently, the development of the Medicare **Recovery Audit Contractor (RAC) program** have brought to the forefront the importance of good coding and documentation. In 2003, Medicare instituted the **Comprehensive Error Rate Testing (CERT) program**. The CERT program measures the error rate for claims submitted to Medicare Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs). Another program that monitors the accuracy of Medicare payments is the Hospital Payment

Monitoring Program (HPMP). This program measures the error rate for the Quality Improvement Organizations (QIOs).

The CERT program reduced the errors in Medicare reimbursement from 9.8% in 2003 to 3.9% in 2007. Although the reduction in the error rate was significant, Medicare determined that the 3.9% equated to $10.8 billion in Medicare overpayments and underpayments.

Also in 2003, under section 305 of the Medicare Prescription Drug Improvement and Modernization Act, Congress directed the Department of Health and Human Services (HHS) to conduct a three-year demonstration program using **Recovery Audit Contractors (RACs)**. The demonstration program operated in New York, Massachusetts, Florida, South Carolina, and California and ended in 2008. The RAC reviewers found more than $1 billion in improper payments to the Medicare program. In 2006, Congress passed legislation to make the RAC program permanent and required expansion to all 50 states by no later than 2010.

The RAC program identified a number of sources for the errors including excessive units of service billed, incorrect discharge disposition, medical necessity, and coding. Although the largest percentage of errors was medical necessity (62% based on the audit findings through March 27, 2008), coding contributed to greater than 25% of all errors found. Incorrect assignment of the principal diagnosis contributed to 14% of the errors, and incorrect procedure codes contributed to 12% of the errors. Some coding errors identified included respiratory system diagnoses with ventilator support, excisional debridement, pneumonia, sepsis, and circulatory system diagnoses.

Programs such as CERT and RAC demonstrate the need to establish coding policies that address internal and external auditing and accuracy. Policies should address coding processes when auditing is performed "prebilling," such as for assessing individual coder accuracy or addressing specific problem areas. Policies should also include measures to be taken when a "postpayment" review occurs, such as in the case of CERT or RAC reviews.

It is important that the coding compliance program include policies that help ensure accurate coding and billing as well as stress the importance of good documentation. Policies should incorporate documentation requirements, payer policies, and coding guidelines. The policy will generally include an overall policy statement regarding the organization's commitment to compliant coding and a direction that coders observe official coding guidelines. The following checklist can be used to address specific policy issues and serve as a basis for reviews:

- Is the importance of provider documentation emphasized? The provider's documentation must support every code assigned. In the ICD-9-CM Official Guidelines for Coding and Reporting, "provider" means physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis.

- When and how should a coder query the physician? Review the physician query process, addressing related issues such as correcting errors and amending the medical record.

- What is the process for ensuring that codes assigned through the **chargemaster** are accurate? Review the developmental process for charges including the chargemaster description of the service, code assignment, and applicable dosage units and other units of service.

- Do policies address resources and instructions for ICD-9-CM, CPT-4, and HCPCS coding? Develop and frequently review facility-specific coding guidelines and policies, ensuring consistency with official guidelines and federal regulations.

- Are there specific coding areas that represent a compliance risk, and are instructions provided that address them?

- Does the policy emphasize that coding guidelines must be applied to all record types?

- Do policies address new-hire training and continuing education? Are coding resources adequate, and is there support and education for coding professionals?

- How are coding errors identified? The policy should address how internal coding audits are conducted, reported, and followed up. Discuss the process for addressing coding errors identified through prepayment or postpayment reviews.

- What documentation should be utilized to assign codes? How should documentation that is incomplete, unsigned, or missing be considered? The entire medical record should be reviewed to determine the specific reason for the encounter and the conditions treated.

- Are all staff educated on the importance of quality documentation, risk identification, and accurate coding and billing?

- How are issues related to denials or rejected claims relayed to coding?

- What is the process for making coding changes or corrections?

- Are issues such as upcoding, medical necessity, and DRG optimization addressed in policy?

- Does the policy address abstracting issues that may affect reimbursement such as admission and discharge status, present on admission (POA) criteria, and accurate demographic data?

- Are claims submitted to billing before coding review or before all appropriate codes have been added?

- Does the policy address the appropriate utilization of modifiers and variances in payer billing requirements? What is the process for addressing variances in official coding guidelines and coding advice from payers?

- Does the organization code directly off superbills and encounter forms? How does the facility ensure that the documentation supports the services billed?

As mentioned earlier in this chapter, within the corporate compliance program the code of conduct serves to guide employees in making ethical and compliant choices. Similarly, within a coding compliance program, a code of conduct should be developed that addresses compliance with coding guidelines and the responsibility to report coding compliance violations. The practice of upcoding or downcoding and the selection of codes that affect reimbursement such as complications and comorbidities should be addressed. For physician coding, guidelines should be established for selecting the appropriate evaluation and management code (for example, 1995 or 1997 CMS guidelines). For hospital coding, the importance of accurately reporting POA indicators should be included. The code of conduct can be incorporated with professional coding associations' codes of ethical behavior, such as the AHIMA's *Code of Ethics* and *Standards of Ethical Coding*, the American College of Medical Coding Specialists' (ACMCS) *Code of Ethics,* and the AAPC's *Medical Coding Code of Ethics*.

A coding compliance program may be an integral part of a broader health information management compliance program, which may include privacy and security issues of health records. As mentioned previously, the specific makeup of the coding compliance program will depend on the type and size of the organization. Regardless of whether an organization has a corporate compliance program or a health information management compliance program, a coding compliance program can be developed to address regulatory issues, coding policies, and coding integrity. Whether the health care organization consists of a single physician in private practice, a 25-bed critical access hospital, a 1000-bed teaching hospital, or a multiorganizational health care network, a coding compliance program can demonstrate the provider's commitment to compliant coding and billing.

Coding Compliance Education

Policies and procedures are only one part of the coding compliance program. **Coding compliance education** is a key element. Without it, the efforts of the coding compliance program are reduced to being only as good as the paper it is printed on. The purposes of an aggressive and thorough coding educational program include:

- Promoting an understanding of coding guidelines and federal regulations

- Implementing the policies and procedures developed and ensuring that employees understand their role in the compliance process

- Demonstrating the organization's commitment to compliance to employees, outside reviewers, and regulatory agencies.

Compliance education will vary based on the needs of the institution and will vary for new and existing employees. Educational needs should be assessed at least annually. In a large facility, regularly scheduled classes can be held on topics that are typically complex or areas of high risk. Smaller offices or facilities may wish to combine resources to bring educational opportunities to their coders. Offering convenient classes during work hours helps ensure that coders will obtain necessary education. Such classes can also provide opportunities for certified coders to obtain CEUs. Establishing regular educational classes also provides evidence of the organization's commitment to compliant coding. Some examples of fundamental coding classes that could be offered include:

- Evaluation and management coding

- Modifier usage

- CPT-4/ICD-9-CM coding

- Global period coding and billing (general or specific topics of interest)

- High-risk coding areas such as debridement (excisional and nonexcisional), interventional radiology, sepsis and urosepsis, preventive medicine

- Regulatory issues such as the proper use of the advance beneficiary notice (ABN) and local and national coverage decisions

- Payment methodologies including Medicare Severity Diagnosis-Related Groups (MS-DRGs), Ambulatory Payent Classifications (APCs), Ambulatory Patient Groups (APGs), and physician fee schedules

- Consultations and shared visits

- Midlevel provider coding

- Using the proper coding resources, including using the Internet to research regulatory or coding issues

The list and type of educational opportunities that can be offered are limitless. Offering opportunities for coders to gather in a coding "roundtable" format provides valuable opportunities for coders to discuss real-life coding examples with their peers. Educational sessions on clinical topics can be especially helpful for specialty coders who wish to gain insight into complex procedures. Anatomy classes can be especially helpful for coding orthopedics, obstetrics and gynecology, cardiac procedures, and interventional radiology. Topics should also include issues identified through coding reviews and audits.

Some organizations offer extended educational programs to coders designed to enhance coding education and to prepare individuals for coding certification exams. These programs bring the classroom to the workplace. Many offer semester-length courses in medical terminology, ICD-9-CM, CPT-4, pharmacotherapy, anatomy and physiology, and reimbursement methodologies. Numerous outside educational resources can be utilized for these classes, or the organization may choose to employ its own coding instructors.

Educational opportunities for employees should be flexible, allowing for *just in time* training for immediate educational needs. Just in time training can address the constantly changing regulatory requirements or coding errors that have been identified. Utilizing just in time training for new employees can help prevent unintentional coding errors. All education provided should be well documented, noting the date, topic, length, and names of attendees. Figure 5-1 shows a schedule of classes that could be ongoing. Figure 5-2 shows an organizational in-house coding curriculum. Offering on-site continuing education units to coding staff provides an opportunity for coding professionals to maintain coding certification conveniently and cost effectively.

Most professional coding associations that provide certification or accreditation to their members require continuing educational hours. The number of hours will vary with the association's requirements. The associations will also vary as to what they accept as an approved CEU. Some associations require a preapproval process before continuing educational hours can be accepted. Maintenance of certification should be required of coding staff to demonstrate that they are receiving updates on coding and regulatory changes.

Coding Accuracy

Along with providing coders continuing education and training updates, their accuracy rates should be periodically evaluated. Not only is coding accuracy critical for compliant claims submission, but it also affects the provider's complication rates, mortality rates, severity of illness computations, health care policy, and other administrative databases. Coding accuracy can also affect future rate setting figures and prospective payment system payment weights.

In some organizations coding accuracy is a goal measured in employee performance evaluations. Coding accuracy rates can also be used to determine salary and annual raises.

In determining coding accuracy it is important to distinguish coding errors that result from inaccurate code assignment verses errors that result from poor documentation. Documentation errors should not be counted as coding errors. Consider the following documentation errors that could result in coding errors:

- The physician documents that the patient has pneumonia. Documentation elsewhere in the medical record indicates that the patient may have a bacterial pneumonia. The physician fails to respond to repeated query attempts. The coder assigns ICD-9-CM code 486, "Unspecified pneumonia."

- The physician documents that the patient suffered "both bone fracture" in the right lower arm. An open reduction with internal fixation is performed. The coder is unable to assign an accurate code because the documentation does not indicate the specific site, for example, proximal end, distal end, or shaft.

- Under the "review of systems" in an evaluation and management (E/M) note, the physician documents, "Pertinent to headache addressed in HPI, others negative." The physician should indicate the specific systems reviewed and *all* others negative. The phrase "others negative" should not be used to indicate a complete review of systems.

General Hospital's Coding Compliance Course Offerings
USING THE TRICKS OF THE TRADE: This class will provide instruction on using the 3-M Encoder, Code-Correct and the CMS website, including finding the Medicare fee schedule. (1 CEU)
THE BASICS OF MEDICARE: This class will focus on the basics of Part A and Part B Medicare services, including beneficiary benefits, contractors, local and national coverage decisions and fee schedules. (2 CEUs)
EVALUATION AND MANAGEMENT (E/M) DOCUMENTATION AND CODING: This class will provide a review of documentation requirements for E/M services using the 1995 and 1997 guidelines. The use of E/M codes will be discussed, including definitions, E/M components and medical necessity. Participants will learn to apply codes from medical documentation. (2 CEUs)
THE OFFICE OF INSPECTOR GENERAL (OIG): Learn about the regulatory authority, regulations, audits, inspections and mission of the OIG in this class. A review of OIG targets for the current year will also be discussed. (1 CEU)
DOCUMENTATION GUIDELINES FOR TEACHING RULES AND MIDLEVEL PROVIDERS: This class will provide a review of documentation requirements, focusing on the teaching physician and midlevel provider requirements. Participants will discuss compliance issues and will review medical documentation. (2 CEUs)
The **PHYSICIAN QUALITY REPORTING INITIATIVE:** This class will provide a background on the Physician Quality Reporting Initiative (PQRI) measures and provide helpful information on appropriate coding and modifier usage. (1.5 CEUs)
THE CORRECT USE OF MODIFIERS FOR PHYSICIAN AND FACILITY: This class will provide an overview of the correct use of modifiers for physician and facility (hospital) services. Participants will discuss the use of modifiers and "CCI Edits" as they pertain to professional and facility services and will apply CPT/HCPCS modifiers in exercises. (2 CEUs)
CONSULTATIONS AND SHARED VISITS: This class will focus on the CMS guidelines for consultations and shared visits. Appropriate billing for these services will also be discussed. (1 CEU)
NEW! **RECOVERY AUDIT CONTRACTORS (RACs):** Learn what all the fuss is about with the RAC ATTACKS! This class will discuss CMS' efforts to identify improper payments to providers through the use of RACs, the experiences of providers who have had RAC audits and the scheduled roll-out for our State. (1.5 CEUs)
NEW! **PREGNANCY AND GYNECOLOGICAL CODING:** Chapter 11 of ICD-9-CM contains codes for normal pregnancy and delivery, miscarriage, abortion and various obstetrical complications. If you don't regularly code obstetrical cases, you may find this chapter a challenge. In this class, participants will review ICD-9-CM coding guidelines for pregnancy and gynecological conditions, along with pertinent HCPCS coding. A review of common payer payment guidelines will also be included. Send us your toughest coding questions before the class! (1.5 CEUs)
SKIN LESIONS AND LACERATION REPAIR: Don't get burned coding common skin procedures. These seemingly easy procedures can be some of the most complicated services to code. This class will guide the participant through the coding guidelines and present clinical examples. (1 CEU)
GI ENDOSCOPY CODING: This class will focus on gastrointestinal coding, specifically coding upper and lower endoscopies. Participants will discuss CPT and Medicare guidelines for coding colonoscopies, including reviewing screening versus diagnostic procedures. Correct use of modifiers and local coverage decisions (LCDs) will also be discussed. (2 CEUs)
WORKING DENIALS/THE APPEAL PROCESS – REVISED: One of the most important elements of accurate coding and billing is eliminating as many billing problems as possible *before* they occur. But working denials can be the coder's worst nightmare. This class will focus on methods to help you work denials and prevent them in the future. (1 CEU) **NEW ADDITION!** This class will also include a review of Medicare's denial and appeal process. (2 CEUs)
NEW! **PREVENTIVE MEDICINE:** This class will assist the participant in determining whether the visit is a preventive medicine visit or an office visit. Documentation requirements will be discussed, as well as the definitions of the comprehensive history and physical examination, anticipatory guidance, ordering of tests, and management of other medical problems. Medicare and commercial payment policies will also be discussed. (1.5 CEUs)
NEW! **RESEARCH CODING AND BILLING:** This class will guide participants in the proper assignment of V70.7, Examination of participant in clinical trial, and will discuss CMS' current requirements for coding and billing for patients involved in clinical trials/research. (1.0 CEU)

Figure 5-1 Coding Compliance Course Offerings. Example of listing of coding courses that could be offered regularly as part of a coding compliance program. Offering continuing education units to coding staff on site provides an opportunity for coding professionals to maintain coding certification conveniently and cost effectively. Coding courses may be tailored to address specific coding areas of concern.

General Hospital's Coding Curriculum			
Course	**Date/Time**	**Course Description**	**Notes**
Medical Terminology Start date: September 9 End date: December 5 Room: HIM Education Suite	Tuesday: 1:30–3:30 p.m. Friday: 8:30–10:30 a.m.	Students will learn medical terminology through a combination of anatomy and physiology and word building principles, focusing on the component parts of medical terms: prefixes, suffixes and word roots. Students practice formation, analysis and reconstruction of terms. Introduction to operative, diagnostic, therapeutic and symptomatic terminology of all body systems, as well as systemic and surgical terminology, is included.	24 class periods (Recommended before taking coding courses)
Pharmacotherapy December 9 and 12 Room: HIM Education Suite	Tuesday: 1:30–3:30 p.m. Friday: 8:30–10:30 a.m.	This course places an emphasis on the understanding of the action of drugs such as absorption, distribution, metabolism and excretion of drugs by the body. Included are drug classifications, most commonly prescribed drugs for each body system, and pharmacotherapy references including the formulary and PDR.	2 class periods
CPT Start date: September 8 End date: October 30 Room: HIM Education Suite	Monday: 2:00–4:00 p.m. Thursday: 2:00–4:00 p.m.	This class covers theories, concepts and applications of Current Procedural Terminology (CPT) coding. Included will be an introduction to basic coding principles, and conventions of CPT coding for each of the CPT manual sections.	16 class periods
ICD-9-CM Start date: January 12 End date: March 9 Room: HIM Education Suite	Monday: 10:00 a.m.–12 p.m. (no class 2/16) Thursday: 3:00–5:00 p.m.	This class discusses theories, concepts and applications in ICD-9-CM diagnostic coding. This in-depth advanced ICD-9-CM course includes practical exercises and discussion of official coding guidelines.	16 class periods
Certification Review September 15 Room: HIM Education Suite OR November 5 Room: HIM Education Suite OR March 12 Room: HIM Education Suite	September 15: 1:30–4:30 p.m. November 5: 9:00 a.m. to 12 p.m. March 12: 9:00 a.m.–12 p.m.	This class provides a review of certification exams, including a breakdown of exam sections, time allotments, as well as other important information. Class also includes study tips and a sample study schedule, and recommended resources. A brief review of coding competencies will also be discussed. Mock exam will be given and reviewed during class.	1 class period
Regulatory Issues March 18 Room: HIM Education Suite	March 18: 8:00 a.m.–12 p.m.	This class discusses various reimbursement methodologies including ambulatory surgical center payment rates (APCs), clinical laboratory fee schedule, hospital inpatient prospective payment system, hospital outpatient prospective payment system, inpatient psychiatric facility prospective payment system, Medicare physician fee schedule, the UB-04 and CMS 1500 claims. A review of the hospital and physician chargemaster development and maintenance will be presented.	

Figure 5-2 General Coding Curriculum. Example of an in-house coding curriculum offered as part of a coding compliance program. These classes may be eligible for continuing education units (CEUs).

- A patient has a diabetic ulcer of the left ankle that requires debridement. The documentation of the debridement does not indicate the deepest level debrided or the method of debridement (excisional or nonexcisional). The documentation does not indicate whether the patient has Type 1 or Type 2 diabetes. The coder is unable to correctly identify the type of diabetes, the extent of the debridement, and whether the debridement was excisional or nonexcisional.

- The physician documents the removal of a 2.0-cm benign lesion of the upper arm. The physician documents that "adequate margins" were taken to ensure complete removal. The coder assigns the code for a 2.0-cm lesion removal, as the physician failed to document the specific excised diameter.

As documentation errors should not be counted as coding errors, neither should billing errors or chargemaster errors be counted as coding errors. For example, codes that are entered into a coding or abstracting system but do not cross over accurately to the claim should not be counted as a coding error. An error in the chargemaster that incorrectly cross-walks a charge code to a CPT-4 or HCPCS code is not a coding error. When billing denials occur because payers do not follow coding guidelines, these are also not coding errors.

Accuracy standards should be consistent among all coding areas, such as hospital inpatient, outpatient, ancillary services, and physician coding. Nationally, the recognized best-practice standards indicate that a minimum of 95% accuracy is desirable. Some organizations may introduce incentive pay for accuracy rates that are higher. Coding reviews on individual accuracy rates should be performed at least biannually. An individual's accuracy rate can indicate the frequency of the review. For example, for a coder who is maintaining 95% accuracy, reviews can be performed only twice a year. For a coder failing to maintain the accuracy rate, reviews can be quarterly or even monthly. If coding accuracy is linked to salary and performance expectations, human resource policies should clearly outline the necessary disciplinary steps to assist the employee in achieving the performance goals. This may include additional training, a formal educational plan, or 100% coding review. Performance expectations in regard to coding accuracy should be clearly communicated to new staff at the time of hiring.

The Coding Compliance Manager and Coding Compliance Committee

Many health care organizations create a position of **coding compliance manager**, but this will vary depending on the individual needs of the facility. In smaller settings, the coding compliance manager may have other responsibilities such as coding manager or health information management (HIM) director. The coding compliance "department" may consist of one individual who has multiple responsibilities or an entirely separate department with multiple employees. The coding compliance department may be part of a facility's overall compliance area. The coding compliance manager may be responsible for monitoring and conducting audits as well as identifying risk areas. Other responsibilities include conducting educational and training programs, reporting issues, monitoring changes in federal and state guidelines, and ensuring that coding vendors (billing vendors, coding consultants) understand the institution's coding compliance guidelines. This individual will likely have an extensive coding background applicable to the organization's setting (e.g., hospital inpatient and outpatient, physician services, long-term care, teaching rules). An understanding of federal and state regulations is also important. Other desirable skills and knowledge sets include:

- Familiarity with fraud and abuse regulations

- Chargemaster or charge creation experience

- Claims and billing experience

Coding Compliance Manager Job Description
Purpose: To maintain the Corporate Compliance Program for ABC Hospital in accordance with ABC's Hospital Corporate Compliance Manual and the Office of Inspector General's Compliance Program Guidance.
Description: The Coding Compliance Manager manages, oversees, and monitors the audit process for the coding and billing operations. Responsible for: • Overseeing the Recovery Audit Contractors (RAC) audits and other outside payer audits, responding to denials, and ensuring timely responses. • Developing and implementing audit plans. • Preparing correspondence, reports, and presentation materials. • Serving as a subject matter expert in coding, billing, MS-DRG coordination, reimbursement, and compliance, as well as specific laws and regulations imposed on health care systems. • Managing and developing in-service educational programs and informational materials. • Assisting the VP, Health Information Manager, and Chief Compliance Officer in the development and implementation of RAC and other audit appeal strategies. • Managing and directing the operations of the compliance review program, including supervising Coding Compliance Analysts. • Keeping pace with the latest developments, advancements, and trends in coding, billing, reimbursement, laws, and regulations imposed on health care.
Minimum Qualifications: *Education*: Bachelor's degree in Health Information Management (HIM), Business Administration or related field or an equivalent combination of education and experience. *Experience*: 5–10 years experience in healthcare business practices relative to coding, billing, auditing, utilization, third-party payer regulations, risk assessment, reimbursement and contractual agreements, management and supervision. Expert knowledge of ICD-9-CM, CPT-4, and HCPCS classification systems, as well as MS-DRG, APC and other reimbursement methodologies. *Licensure/Certification*: RHIA, RHIT, CCS, or CPC-H *Other*: High moral and ethical character with a sense of honesty, integrity and caring. Independent, objective, detail-oriented, and analytical. Must possess excellent verbal presentation and education skills.
Contacts: *Reports to*: Executive Vice President, CFO, CRO. *Relationship with*: All levels of management and administration, department directors, physicians, nurses, ancillary staff, practice managers, coding and billing staff, registration staff. Reporting liaison with CRO, local board, ABC's Hospital Compliance Program Committee.

Figure 5-3 Coding Compliance Manager Job Description.

• An understanding of the relationship between coding and billing

• Familiarity with the local Medicare contractor

• Communication, management, and human relation skills

The coding compliance manager may report to the organization's compliance officer, HIM director, director of finance, or directly to the chief operating officer (COO). The coding compliance manager should have a current coding certification. See Figure 5-3 for a job description for a hospital coding compliance manager.

The coding compliance manager may be supported by staff that perform auditing, education, and other compliance activities. Titles of these individuals will vary but may include coding compliance auditors or reviewers, coding auditors, medical auditors, or compliance specialists. To gain the respect

Coding Compliance Analyst Job Description

Purpose: To perform audits in accordance with ABC's Health System's annual Compliance Work Plan and prepare written and oral communications to the Coding Compliance Manager and/or Corporate Compliance Officer.

Description: The Coding Compliance Analyst supports the organization's corporate integrity program through the identification and assessment of coding compliance risk and maintains a current understanding of regulatory trends and changes in coding policy and reimbursement methods.

- Serves as a resource for coding and clinical staff on issues related to compliant coding and billing
- Applies knowledge of medical terminology, abbreviations, anatomy and physiology, diseases, and procedures to accurately review coding assignments
- Applies knowledge of ICD-9-CM, CPT-4 and HCPCS nomenclature, coding rules, guidelines and proper sequencing to analyze medical record documentation and coding assignments
- Applies knowledge of ethical coding principles and revenue cycle activities to evaluate coding compliance through coding audits
- Works with departments and physicians to monitor compliance to coding standards and provide guidance to help them meet the requirements
- Assists departments and physicians in development of corrective action plans involving coding issues when areas of opportunity are identified
- Receives, develops, coordinates and/or oversees internal and external coding audits for the purpose of monitoring and detecting any misconduct or noncompliance to final resolution.
- Assist in the development of coding education plans, materials, and resources to educate employees with respect to overall objectives of the corporate compliance program
- Carries out all duties and responsibilities as assigned by the Coding Compliance Manager, Chief Compliance Officer and/or the Compliance Committee.

Minimum Qualifications:

Education: Associates Degree in Health Information Management or related field preferred.

Experience: Minimum three years of diagnostic and procedure coding. Experience with Microsoft Word and Excel, encoder products, auditing software preferred.

Licensure/Certification: RHIA, RHIT, CCS, CPC-H

Other: Detail-oriented and analytical. Strong customer service and communication skills. Ability to operate various computerized medical coding and information processing systems. Exceptional organization skills. Ability to analyze medical records and create audit reports that assist physicians, management and hospital staff in understanding coding compliance issues.

Contacts:

Reports to: Coding Compliance Manager.

Figure 5-4 Coding Compliance Analyst Job Description.

of the coding staff whose work is being reviewed, the auditors must be highly experienced in the area they are auditing. Utilizing individuals who are not responsible for the actual coding and billing processes within the organization will help demonstrate objectivity of the coding review and credibility of the auditing process. Figure 5-4 is a typical job description for the position of coding compliance analyst.

Many organizations utilize outside consultants or companies to perform coding audits. This can provide a valuable educational experience, as good consultants will be able to share best practices of several organizations. Consultants can also be utilized when the structure of the organization is small, and individual or independent reviews within the coding department are not possible. Prior to an outside audit, consultants should be provided with the coding policies and procedures that are used within the organization. Consultants should also be aware of local Medicare policies or state regulations that directly affect the organization's coding. Even if an organization has its own coding compliance department, consultants can be utilized periodically to assess the accuracy of the coding compliance auditing.

The coding compliance department and manager should be viewed as a valuable resource for other departments in the organization for answering coding and billing questions as well as for reporting potential compliance issues. The coding compliance program that runs like a police state will not provide a means for employees to seek advice or to report potential problems. Employees within the coding and billing areas, as well as other departments, should be encouraged to report potential compliance issues to the coding compliance manager.

A coding compliance committee should be part of the coding compliance program and have representatives from finance and accounting, administration, business office services, clinical staff, utilization management, and coding services. In some organizations, the coding compliance committee may function in cooperation with other committees, such as the chargemaster or medical record committee. The committee can discuss issues related to claims management, documentation, coding, duplicate billing, and issues relating to medical necessity. The committee can also share resources related to coding updates and regulatory changes.

The compliance committee structure should help foster communication among the various departments. The importance of communication among coding, billing, and patient accounts departments cannot be overstressed. In many organizations denial information is not shared with the individuals who are responsible for coding. As a result, coders may not be aware of coding errors that led to payment denials or delays. Communication among departments can result in immediate cost benefits owing to decreased denials, fewer delays in payment, and improved coding accuracy.

The activities of the coding compliance program must be carefully documented and may include:

- Summaries of compliance committee minutes, including approvals of the compliance plan or calendar and any policies/procedures

- Employee background, including résumés demonstrating coding qualifications, certifications, and ongoing continuing education

- Training and education agendas, handouts, and attendance rosters

- Hotline reports and investigations

- Corrective action including employee education, discipline, self-disclosures, rebilling, and policy/procedure revisions

- Monitoring and auditing activities

Staffing Coding Professionals and Coding Certification

Coding staff should be required to obtain the necessary training and education needed to accurately assign diagnosis and procedure codes. Hiring unqualified individuals to perform coding duties can lead to fraudulent coding and billing and be viewed as lack of commitment to compliant coding and billing. Along with a thorough understanding of coding systems, it is preferable that coders have course work in medical terminology, anatomy and physiology, pathology, and reimbursement systems.

When hiring certified coding individuals, it is important to recognize that there are several associations and organizations that provide **coding certification**, and the individual requirements for obtaining certification will vary. For example, the fact that a coder is "certified" may demonstrate that the individual has met only the minimum necessary standards of the professional association and has passed a certification exam. Other associations provide certification to individuals who pass an exam that reflect a "mastery" skill in a particular coding area.

It is important to understand the association's educational requirements, certification maintenance policy, and underlying philosophy. For example, some businesses and associations grant a coding certification after attendance at a day-long coding seminar. Others may provide coding seminars in a 40-hour "boot camp" format and then certify individuals after they have successfully passed an examination. Still other certifications are associated with approved programs in technical schools and universities. The educational requirements for coding certification vary from none required to high school diploma to associate and bachelor degrees. The phrase "truth in advertising" is important for both the organization that is hiring the certified coder and the coder who seeks certification. There are numerous examples of coders who spent hundreds of dollars on a coding certification course and exam only to learn later that the credential is not recognized by the majority of health care providers. There are an equal number of examples of employers who have hired individuals with letters after their name and a coding certificate in hand, but the individual could not perform entry-level coding. Certification alone does not indicate coding competence. The ideal candidate will likely have a combination of education, training, certification, and experience.

Several professional coding associations offer specialty coding certifications. For instance, there are coding certifications that emphasize hospital (facility) coding, professional (physician) coding, and specialty coding (e.g., dermatology, interventional radiology, emergency department). There are also certifications that represent apprenticeship or associate status, indicating that the individual has passed an entry-level coding exam but may be lacking in experience.

A coding exam should be administered to all potential employees. The exam should include questions replicating actual coding scenarios reflective of the facility and the specific position. Questions on regulatory requirements, coding guidelines, basic anatomy and physiology, and medical terminology can help gauge an individual's knowledge of the entire coding process. Including general compliance questions that assess how an individual might respond to a specific situation can provide valuable insight into the applicant's ethical behavior and understanding of compliance guidelines. Consider these examples of questions that appear on a hiring coding test:

1. The physician has marked the diagnoses and services performed for a patient on a superbill. You notice that the dictated documentation from that visit includes different diagnoses. You should:

   a. Select the code(s) noted by the physician on the superbill.

   b. Determine the code(s) yourself from the physician's documentation.

   c. Use a combination of both sets of codes.

   d. Query the physician.

2. You are the hospital coder responsible for coding ancillary visits, specifically, radiology and laboratory services. You notice that orders originating from a local physician's office always has the same diagnosis code noted, specifically "Pneumonia," ICD-9-CM diagnosis code 486. This occurs regardless of the specific tests that were ordered. You should:

   a. Assign the diagnosis listed on the order.

   b. Assign diagnosis codes based on the results of the tests.

   c. Inform the coding supervisor of the questionable diagnosis.

   d. Telephone the physician's office receptionist.

Questions such as these can help assess the employee's possible response to difficult problems and potential conflicts.

Coding Performed by Physicians

Sometimes, physicians may feel they should assign their own codes. Just as the coder should be skilled in correct coding assignment, the physician should be trained in ICD-9-CM and CPT-4 coding, the official coding guidelines, and state and federal regulations. But often, physicians are not able to spend the time necessary to be fully informed about the complex coding guidelines, frequent changes, payer billing requirements, and regulatory updates. Consequently, the physician's practice can be placed at risk for fraudulent coding and billing. Many coding auditors can attest that coding performed entirely by the physician who is not familiar with coding guidelines is often less accurate than coding performed by experienced coders.

The physician should not be entirely excluded from the coding process, however. The importance of their documentation and requirements needed to accurately assign codes should be stressed with physicians, and such discussion can close the communication gap that often exists between physicians and coders. As mentioned elsewhere in this book, the coding can be only as good as the documentation.

Coding Compliance Resources

Within the coding compliance program should be a commitment to utilizing the appropriate **coding resources**. Using outdated coding resources can result in coding and billing errors and pose a compliance risk for the organization. It is often surprising the number of denials that can be immediately traced back to using an outdated code book or superbill. Coding resources that must be kept up-to-date include:

- *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* code book

- *Current Procedural Terminology (CPT-4)* code book

- *Health Care Common Procedure Coding System (HCPCS) Level II Coding Procedures* code book

- National Correct Coding Initiative (NCCI) manual or electronic file

- Computerized encoding systems

- The most recent update to the *ICD-9-CM Official Guidelines for Coding and Reporting*

- AHA's *Coding Clinic for ICD-9-CM*

- AMA's *CPT Assistant*

- Encounter forms, billing sheets, superbills

Coders should also have access to the numerous online resources that can assist coding accuracy and reduce the possibility of future denials. These include access to local and national payer coverage decisions, local contractor Web sites, the CMS Web site, and regulations published in the *Federal Register.* Other valuable resources available online include medical terminology aids, medication and pharmacy information, resources on specific diseases, anatomy plates, and details on surgeries and procedures. A detailed listing of Web sites can be maintained and should be regularly updated.

The development of a coding compliance program does not need to be onerous. Many facilities already have policies on coding, billing, and documentation. The OIG Web site contains many publications helpful in developing compliance programs. Professional associations also have examples of coding compliance structure and policies that provide assistance in the development of a coding compliance program. It is important that the coding compliance program is not "left on the shelf." A program that is on paper only will not protect an organization from fraud and abuse risk and liability.

Chapter Review

1. List the seven components of a corporate compliance program and briefly describe each.

   _____

   _____

   _____

2. If a health care facility has an overall compliance program, why is it necessary that the facility also have a coding compliance program? How are the two programs different?

   _____

   _____

   _____

3. The OIG's Compliance Program Guidance for Hospitals states, "Because incorrect procedure coding may lead to overpayments and subject a hospital to liability for the submission of false claims, hospitals need to pay close attention to coder training and qualifications." What measures can health care facilities take to ensure that coders are properly trained and are qualified?

   _____

   _____

   _____

4. Review one of the areas that should be included within a coding compliance policy, for example, coding from incomplete records, making coding changes, or documentation that should be reviewed for coding purposes. Write the policy statement(s).

   _____

   _____

   _____

5. Define the purpose of the code of conduct, and identify some of the issues that should be addressed in the code.

   _____

   _____

   _____

6. Explain why documentation errors are not necessarily coding errors.

_____

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_____

7. Define the characteristics, responsibilities, and qualifications of the coding compliance manager.

_____

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8. Write a coding question for a hiring test that assesses the potential applicant's understanding of the official coding guidelines.

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9. What factors can demonstrate the trustworthiness of the health care provider?

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10. Structure, process, and outcome are components of effective assessment of a coding compliance program. If the *structure* question is: Are coding compliance policies reviewed regularly? what would be the *process* and the *outcome?*

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_____

_____

Case Studies

Case Study 1

The coding compliance manager has completed a review of inpatient hospital coding. In a few records she determines that the coder should have queried the physician to resolve conflicting information in the medical record. There is an organizational policy on physician queries that discusses the proper format of a query, but it does not address whether the physician should be queried as a result of findings on audits or postpayment.

1. What should a coding compliance program policy include regarding physician queries?

_____

_____

_____

Case Study 2

Within a surgical practice, a few physicians document the CPT-4 procedure code on their operative reports. Sometimes the coding is correct, but the surgeons are not generally considering coding guidelines and bundling rules. In a coding audit it is determined that some coders are assigning the codes as the surgeons have noted on their surgical reports, whereas others appear to be coding from the documentation within the operative note.

1. What should a coding compliance program policy state regarding codes within dictated reports and use of those codes by coders for billing?

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_____

Case Study 3

A patient is seen for multiple plantar warts. The physician states in the documentation that "multiple plantar warts were removed with laser." The coder assigns CPT-4 codes 17000 and 17003.

1. Has the coder assigned the codes accurately?

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_____

_____

2. What instruction, if any, should be given to the coder and/or the physician?

_____

_____

_____

Case Study 4

A local Medicare contractor's Part B policy states: "Codes V67.00, V67.09, V67.1, V67.2, and V71.1 are non-specific ICD-9-CM codes that require an additional ICD-9-CM code to specify the disease entity treated. When a metastasis of the primary neoplasm is suspected, report V71.1 with a secondary neoplasm ICD-9-CM code (e.g., 196.0–198.89) or personal history of neoplasm ICD-9-CM code (e.g., V10.00–V10.9)."

1. Determine the accuracy of the coding information provided by the contractor.

_____

_____

_____

2. Provide guidance in the form of a policy statement that would assist the coder in determining how to accurately assign codes in situations when a primary neoplasm is suspected.

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Case Study 5

An outside consulting firm has been hired to perform a coding audit of inpatient and outpatient records at a hospital. The audit shows the following:

- Inconsistent application of HCPCS modifiers. For example, some coders apply the modifier RT/LT only to Medicare claims, whereas other coders apply them to all payers.

- Inconsistent coding of excisional debridement for inpatients. Some coders are assigning ICD-9-CM procedure code 86.22 when the physician notes "the wound was sharply debrided." Other coders appear to be assigning 86.22 only when the physician notes "excisional debridement."

1. Create an educational plan that could be used to address the issues identified in the audit.

_____

_____

_____

2. Write coding compliance policy statements that could address each of the issues identified.

_____

_____

_____

3. Are the problems that were identified coding or documentation errors?

_____

_____

_____

References

American Health Information Management Association. (2008, July 24). *Benchmarking coding quality.* Audio seminar/webinar. Available for order at https://imis.ahima.org//orders/productDetail.cfm?pc=AU DMC072408&bURL=%2Forders%2FproductByCategory%5FAUD%2Ecfm%3Ft%3D7

American Hospital Association. (2008, July 16). Regulatory advisory; Medicare recovery audit contractors (RACS): Coding and documentation strategies. Retrieved from http://web.mhanet.com/ userdocs/articles/RAC/AHA_RAC_CodingAdvisory_071608.pdf

Department of Health and Human Services, Office of Inspector General. (2005, January 31). OIG supplemental compliance program guidance for hospitals. *Federal Register, 70*(19), 4858–4875.

Department of Health and Human Services, Office of Inspector General. Work plan for fiscal year 2009 Retrieved from http://oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf

Hapner, Peggy. (2001, May). Covering the bases of coding compliance [Electronic version]. *Journal of AHIMA, 72*(5), 69–71.

TMF Health Quality Institute, the Quality Improvement Organization Support Center for the Hospital Payment Monitoring Program. 2006, January; rev. 2008, March. *Hospital Payment Monitoring Program (HPMP) compliance workbook.* Retrieved from http://hpmp.tmfhqi.net/LinkClick.aspx?fileticket=nory3jyb h2U=&tabid=522&mid=1248

Wiggin and Dana, LLC. (2000, March 16). Compliance programs for nursing facilities: Ten steps towards making a "good faith & meaningful commitment" towards compliance. Retrieved from http://www .wiggin.com/pubs/alerts_template.asp?ID=737167212000