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Designing a coding compliance plan that protects!

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Auditing for coding compliance used to focus solely on the selection of accurate Diagnosis-Related Group (DRG) assignment; not anymore. Thanks in part to CMS Quality Reporting Programs and Quality Initiatives to reform healthcare payment models, the emphasis is reflected in value over volume and quality over quantity. Quality initiatives such as the Hospital-Acquired Condition (HAC) program, Hospital Readmission Reduction Program, and Hospital Value-Based Purchasing (VBP) program tie healthcare reimbursement to quality and value provided to the patient. Now is the time to rectify the coding compliance program to ensure it is aligned and fully compliant with state and federal rules and regulations.

OIG Work Plan

An effective coding compliance audit plan starts with reviewing the most trusted sources out there. The Office of Inspector General (OIG)'s Work Plan summarizes audits and evaluations that are in-progress or are in the pending stages. The Work Plan also identifies items that have been completed, revised, or removed and new items that have been added since April 2016. OIG used to update its Work Plan annually, but now it is updated monthly, and updated information can be found on OIG's webpage[1] under the Recently Added Items tab. These monthly updates help healthcare facilities evaluate their risks by vetting coding, billing, and reimbursement domains in hopes of catching problems early on to avoid costly and (sometimes) embarrassing fraud and investigative federal activities down the road.

Reviewing the audit items listed for Medicare Parts A and B under the Centers for Medicare & Medicaid Services (CMS) section makes it crystal clear that OIG is hard at work. Some topics currently under OIG's review are hyperbaric oxygen therapy services, intensity-modulated radiation therapy, Medicare's Two-Midnight Rule (medical necessity), Kwashiorkor malnutrition, severe malnutrition, ventilator support, and nationwide review of cardiac catheterizations and endomyocardial biopsies.

Periodically, the OIG also puts out its Medicare Compliance Review report performed on a particular hospital. The latest in the series came out in February 2018 and is titled, "Medicare Compliance Review of the University of Michigan Health System."[2] According to OIG's findings, the University hospital correctly submitted 108 claims, but 73 claims were incorrect and didn't comply with Medicare billing guidelines; a total of 181 inpatient (IP) and outpatient (OP) claims were reviewed for this report. OIG estimates that these errors resulted in an estimated $1,294,130 in overpayments that need to be refunded to Medicare. The report also highlighted the following as high-risk areas more prone to incorrect billing:

- Inpatient rehab;
- DRGs with major complications and comorbidities (MCC) or complications and comorbidities (CC);
- Incorrectly billed claims paid in excess of charges (outlier payments); and

- Manufacturer credits for replaced medical devices with condition codes 49 and 50, value code FD, and OP modifier 59.

These reports are available to the public at OIG's website, and coding compliance personnel should make a habit of visiting this website regularly.