DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy
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APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All personnel responsible for performing, supervising or monitoring of HCA Healthcare inpatient and outpatient coding services including but not limited to:

HCA Healthcare Facility/HIM Service Center (HSC) Leadership
Corporate Regulatory Compliance Support (Regs)
External Coding Contractors
Facility/SSC Ethics and Compliance Officer (ECO)
Internal Audit
Inpatient and Outpatient Coders
Coding Management/Supervisor/Coding Lead /Coding Oversight Designee
Parallon - HIM

This policy applies to diagnosis and procedure code assignment by facility and/or HSC Coders for all inpatient and outpatient services provided in HCA Healthcare-affiliated facilities such as Acute Care (including Critical Access facilities), freestanding Psychiatric (Psych), Skilled Nursing Facility/Units (SNF/SNU), Long Term Care (LTC) and Rehabilitation facilities (Rehab).

NOTE: For HCA Healthcare facilities that have not migrated into an HSC, a facility-specific monitoring and auditing plan will be established.

PURPOSE: Establishes a company-wide standardized coding compliance monitoring process to reduce variances in coding practices and ensure compliance with Official Coding Guidelines.

POLICY: This policy outlines the requirements for validating the coding accuracy (*e.g.*, ICD-10-CM, CPT, modifiers) and various types of inpatient reimbursement methodologies (*e.g.*, MSDRG, APRDRG, etc.) for hospitals inpatients and outpatients

For facilities that have not migrated into an HSC, including newly-acquired facilities, a facility-specific monitoring and auditing plan will be developed by Regs and facility leadership.

Definitions:

1. Newly Hired Coder
    a. A coder who has never worked for an HIM Service Center (HSC) or HCA Healthcare facility as a coder; or
    b. A coder who has previously worked for an HCA Healthcare facility/HSC performing coding but who has a 12-month or greater break in service; or
    c. A coder who is transitioning from one coding discipline to another (*i.e.*, outpatient coder transitioning to inpatient coding, an inpatient coder transitioning to outpatient coding, an outpatient coder transitioning from ED/Clinic coding to Same Day Surgery coding)
2. Established Coder - A person who has completed the initial coding training and prebill review requirements of a newly hired coder with acceptable accuracy rates being achieved.
3. Non-migrated facility – An HCA Healthcare facility in which the day-to-day coding is performed locally and under the management of the facility leadership. This is in contrast to the day-to-day coding function being managed and performed by an HSC.

4. Transactional DRG Accuracy Rate – The transactional DRG accuracy rate is calculated as the number of correct DRGs divided by the total DRGs reviewed. In calculating transactional DRG accuracy, the errors should be broken into overcoded and undercoded.
5. Transactional Outpatient Accuracy Rate –The transactional accuracy rate for outpatients shall be minimally reported by diagnosis code (ICD-10-CM), procedure code (CPT), E/M and infusion/injection codes (as applicable), and modifier. It is defined as the number of correct transactions divided by the number of correct codes plus the number of codes added, revised and deleted.
6. Financial Impact – Financial impact will only be reported for inpatient DRG reviews. It will be reported both as a rate (percentage) and in dollars over- and under-coded. The financial impact rate is calculated by taking the total dollars reviewed plus the net dollars in error and dividing by the total dollars reviewed. Financial impact for outpatients will not be reported because only a subset of outpatient line items are reviewed (*i.e.*, only codes assigned by HIM coders) compared to all line items that impact the financial outcome per visit.

PROCEDURE:

Performing Reviews

Reviews must be performed by HCA Healthcare facility and/or HSC Coding staff (*e.g.*, HIM/Coding Director/Manager, Coding Supervisor, Coding Lead) and/or a Parallon – HIM reviewer who has met all mandatory educational requirements as outlined in Company policies REGS.COD.005, REGS.COD.006, and/or by a Certified External Coding Vendor (refer to REGS.COD.017).

Reporting Accuracy and Financial Impact

Transactional accuracy rates will be reported for both inpatients and outpatients. Financial impact will only be reported for inpatients. As defined above, inpatient financial impact includes both a rate and the total dollars over- and under-billed. For outpatients, only a transactional accuracy rate will be reported. Results shall also be reported for both Medicare and non-Medicare accounts as requested. Medicare is defined as traditional fee for service Medicare.

Review Requirements

The number and types of reviews shall be identified by the Company, mutually agreed upon with Parallon, and reviewed annually or more frequently, if necessary. The number and types of reviews performed shall be reasonable, taking into consideration publicly-available data, industry trends and prior review results. Based on these considerations, the Company may periodically revise or set specific expectations as to the types and number of reviews performed. Reviews shall encompass the following categories:

1. Inpatient Reviews – DRG and/or or code validation review will be performed on inpatient records selected based on review type.
2. Outpatient Reviews – HIM-assigned diagnosis code (ICD-10-CM), procedure code (CPT), E/M and infusion/injection codes (as applicable), and modifier validation review will be performed on outpatient records selected based on review type.

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Review Types

1. Newly Hired Coder Pre-Bill Reviews
    a. The prebill review will consist of at least the first fifty records coded by the new coder or utilizing a new hire pre-bill assessment tool to determine DRG accuracy (inpatient)/code accuracy (outpatient).
    b. A prebill review shall be conducted until a 95.00% or greater transactional accuracy rate has been obtained for a 50 record batch.
        i. Coaching, education and/or corrective action will be immediately initiated if the transactional accuracy rate is less than 95% and will continue until the accuracy rate is equal to or higher than 95% transactional accuracy rate.
        ii. If a transactional accuracy rate of 95.00% or higher is not achieved within the initial 90-day employment period, formal disciplinary action may be initiated by the employee's supervisor.
2. Performance Improvement Pre-bill Reviews
    a. These reviews will be performed as warranted based on identified issues defined in a Coder Performance Improvement Plan (PIP).
    b. The review will continue as necessary until a minimum of 95% transactional accuracy has been achieved or as defined within the PIP.
3. Random Coding Reviews
    a. Inpatient/Outpatient coding reviews will be performed on a monthly basis for each HSC across all facilities and will be used to determine appropriate focused education and/or performance improvement requirements for the coder, HSC, and/or overall Company.
    b. The number and type of charts reviewed shall be sufficient to determine the quality of coding. The number and types of charts will be periodically re-assessed as noted in the Review Requirements section of this policy.
4. Focus Coding Reviews
    a. Monitoring may be performed on any of the following areas: DRGs, ICD-10-CM diagnosis codes, ICD-10-PCS procedure codes, modifiers and/or CPT procedure codes that tend to be deemed high risk based on high likelihood of errors, complexity of code assignment and/or with significant revenue variation.
    b. The list of focus areas will be determined by Regs based on code/MSDRG ratio benchmark reports, PEPPER reports, high risk areas identified by the Recovery Audit Contractors (RAC) or other review agencies, industry literature, high weighted MS-DRGs, percentage of CCs/MCCs and other mechanisms.
    c. Focus reviews will be performed on a monthly basis for each HSC across all determined focus areas and will be used to determine appropriate focused education and/or performance improvement requirements for the coder, HSC, and/or overall Company.
    d. The number of charts reviewed shall be sufficient to evaluate the coding accuracy in the particular focus area (*i.e.*, code, MS-DRG, modifier).
    e. The review scope and number of charts reviewed will be periodically re-assessed as noted in the Review Requirements section of this policy.

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Oversight

The Senior Vice President and Chief Ethics and Compliance Officer, in conjunction with Regs will serve as the principal liaison with Parallon to provide oversight of the Company's coding compliance. Group Operations will be consulted on compliance issues, as appropriate, and may also provide independent direction to Parallon regarding coding operations and reporting. Compliance oversight includes setting standards for accuracy, developing appropriate controls to mitigate risk and establishing routine reporting. In its monitoring role, Regs is also responsible for**:**

1. Assessing and following up on non-migrated facilities' coding reviews and action plans, and
2. Conducting routine quality checks and reviewing reports issued by the Company's certified external coding review vendors.

Internal Audit will conduct an independent audit of the coding reviews performed by Parallon Coding Quality Review team. At a minimum, the review population will include all random and focus reviewed performed by Parallon Coding Quality Review team.

Resolution of Individual Case Disagreements

1. In the event that there is a disagreement regarding the code, DRG or APC assignment between the HSC coder, the Parallon Coding Quality Reviewer, and/or Internal Audit that cannot be resolved, the case may be appealed. The account may be submitted to the Regs Helpline at http://trinisys.app.medcity.net/regshelpline for a final determination.
2. The account may not be appealed under the following situations:
    a. If the MSDRG/DRG change recommendation includes "needs query" and the coder created a query and/or obtained documentation related to the recommendation after the review but prior to appealing.
    b. Recommendations that resulted in no MSDRG/DRG or APC change, such as coding recommendations only with no impact to reimbursement.
    c. A change that is in accordance with the established Official or Internal Coding Guideline.

Remediation/Rebilling

1. For any identified coding discrepancy identified during the coding reviews, there must be remediation of potential claims in error and implementation of corrective action.
2. Corrective action may include, but is not limited to, education, training, initiation of prebill or retrospective review for identified areas, and, if applicable, disciplinary action.
3. All confirmed overpayments will be repaid according to company policy (REGS.BILL.005).
4. Underpayments will be rebilled according to the individual payer guidelines for underpayments.

Results Reporting

The results of the internal coding reviews, independent coding audit work, and corrective action plans must be compiled and reported on a routine and agreed upon basis to applicable stakeholders. The results and corrective action plans will be reviewed to determine if further education/training, root cause analysis or additional corrective action needs to be taken.

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REFERENCES:

1. Coding Orientation and Training Policy, REGS.COD.005
2. Coding Continuing Education Requirements Policy, REGS.COD.006
3. External Coding Vendors for Coding Services, Reviews and Related Education Policy, REGS.COD.017