

# Integrating Performance Excellence & Business Strategy

## Managing Coding, Audit & CDI

In the business of healthcare, it is vital that hospitals, health systems and physicians adhere to accurate coding and billing processes. That includes relevant documentation of medical records, precise application of billing codes, and proper charging of insurers for medical services rendered.

### CHALLENGES TODAY



#### Medical Billing Errors

Anywhere from 30 to 80% of medical bills from hospitals, outpatient facilities and physician offices are estimated to have errors.



#### Grace Period Over

Transition from ICD-9 code set to ICD-10 provided greater specificity about diagnoses and procedures, but also additional complexities. The year between Oct. 1, 2015, and Oct. 1, 2016, was designed as a grace period where CMS and commercial payers offered more latitude on claims details.



#### 2017 Changes to ICD-10 That Went Into Effect on October 1, 2016

- 6,000 new codes were released at once
- Coders are not trained
- Shortage of coders overall
- Lack of experienced coders could lead to errors and denials, negatively impacting revenue

### RISKS TO PROVIDERS

Submitting an inaccurate diagnosis, or a diagnosis resulting in a different hierarchical condition category (HCC), is a compliance risk. Any change in the HCC could result in the provider receiving too much or too little revenue.



The following is list of common medical billing mistakes:

<p>1 The record does not contain a legible signature with credential.</p>	<p>2 The electronic health record (EHR) was unauthenticated (not electronically signed).</p>
<p>3 The most precise ICD-10-CM code wasn't used to fully explain the narrative description of the symptom or diagnosis in the chart.</p>	<p>4 Discrepancy was found between the diagnosis codes being billed vs. the actual written description in the medical record.</p>
<p>5 Documentation doesn't indicate the diagnoses are being monitored, evaluated, assessed/ addressed, or treated.</p>	<p>6 Status of cancer is unclear. Treatment is not documented.</p>
<p>7 Chronic conditions are not documented as chronic, impacting Medicare Risk Adjustment Factor (RAF) scores.</p>	<p>8 Lack of specificity</p>
<p>9 Chronic conditions or status codes aren't documented in the medical record at least once per year.</p>	<p>10 A link is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.</p>

### REDUCING RISK



Clinical documentation integrity (CDI) is important—for hospitals and physician practices—coding is only as accurate as the documentation of the medical record. Patient care, data integrity, compliance and reimbursement are at risk when the severity of illness, treatment provided and mortality rates aren't detailed. That's why more providers rely on the CDI team to support medical necessity of the services provided, quality care and patient safety measures.

Auditing measures reimbursement accuracy, ensures compliance adherence and achieves quality assurance while reviewing procedures to ensure that the correct diagnosis related code (DRG) is assigned so the correct reimbursement is received.

Areas of focus for CDI:

- Clarify conflicting, incomplete and non-specific documentation
- Ensure documentation supports the clinical indications and treatment for diagnosis or procedure documented
- Ensure the SOI (severity of illness) and ROM (risk of mortality) are accurate
- Collaborate with others on healthcare team to support quality measures, patient safety and LOS (length of stay) management

#### Navigant's Coding, Audit and CDI Solutions Offer Measurable and Sustainable Results

- Wide array of services offers combined quality and compliance with savings
- CDI provides clean billing environment
- Proprietary and innovative technology accelerates task completion
- Audit reveals opportunities for accurate reimbursement
- Experienced professionals address complex issues