REVINT SOLUTIONS INSIGHTS

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DRG Validation - A New Approach to Combat Audits

To Our Healthcare Clients and Friends:

Recovery Audits (RAs) ordered by the Centers for Medicare and Medicaid Services (CMS) have increased over the last few years, with the goal of enforcing coding quality and compliance with payor requirements. Typically, the result of an external audit is revenue recoupment, as the RAs focus on cases at risk for overpayments. However, the opposite outcome is also possible and actually very common when internal audits are performed: underpayments. According to HFMA, there is a 3-5% average leakage rate for coding and charge capture, which correlates to millions of dollars of lost reimbursement for the average hospital facility on an annual basis. In this edition of *Revint Insights*, we will provide insight into the common challenges facing hospitals with proper coding and documentation, and highlight how technology can assist with the identification of lost revenue due to under coding claims.

BACKGROUND

While the industry standard set by AHIMA for coding and clinical documentation is 95% accuracy, many hospitals struggle to achieve this mark consistently. With the challenges of accurate coding practices, coding audits and reviews from both RAs and commercial plans have increased significantly over the last 5 years.

The increase of audit activity puts a strain on hospital resources and has put an increased focus on coding accuracy. This increased focus has transpired into added pressure on hospitals to protect themselves. As a result, coders may act overly conservative in their coding, which could lead to under-coding. In an effort to ensure coding accuracy, many hospitals have implemented internal coding quality audits in anticipation of external auditor scrutiny. Coders then receive individual feedback based on these audits and are asked to make the appropriate changes moving forward. This can lead to incentive or reinforcement to under-code as well.

In addition, the adoption of electronic health records (EMRs) and the progression to ICD-10 is another major trend that has an impact on these audits. With these technological advancements, the volume of information captured digitally surrounding hospital services has drastically increased. For example, the number of diagnosis and procedure codes exploded from 20,000 codes in ICD-9 to almost 160,000 codes in ICD-10. The question is though, does more information improve quality or accuracy of documentation and coding?

To proactively address these issues, most hospitals implement programs such as Clinical Documentation Improvement (CDI) initiatives, internal coding quality audits, and Computer Assisted Coding (CAC) tools to help manage the massive amounts of data and increase staff productivity. Some hospitals take it a step further and utilize technology to identify anomalies and gaps in quality and/or missing charges. However, inpatient services are not typically a focus in this arena due to the nature of DRG reimbursement. Simply put, the addition or capture of missing charges on an inpatient stay has historically had little or no impact on the net revenue reimbursed by the payer.

CHALLENGES

Given the shift in reimbursement structures and an increased dependence on the DRG in both government-based programs and commercial agreements for reimbursement purposes, coding and charging for all services and procedures performed is critical for fair reimbursement.

While there is increased focus within the revenue cycle on accuracy in coding and clinical documentation for inpatient stays, there are still a host of challenges that many hospitals face.

- Under-coding: The constant pressure from internal and external audits forces coders to be more conservative. This means that hospitals may be assigning the wrong DRG and not capturing the most accurate and comprehensive DRG reimbursement.
- DNFB/Suspense: Every hospital has goals to get bills out the door quickly and not hold claims up due to lack of coding or documentation. This pressure forces staff to work quickly and shoot for maximum efficiency, but not always quality.
- Resources: Most hospitals utilize CDI resources to assist with documentation but may have gaps in coverage on nights and weekends. In addition, every coding group deals with PTO, FMLA, new staff training and other changes that lead to inconsistent results.
- Productivity: Most hospitals enforce productivity standards for how many charts are coded per day or hour, which can be at odds with quality.
- Documentation: Hospitals are at the mercy of their physicians, nurses, and physician assistants to document accurately. CDI programs can provide guidance and spot one-off situations, but these programs can never cover 100% of cases.
- Industry Changes: Besides the shift from ICD-9 to ICD-10, there are always updates to documentation and coding guidelines. The industry continues to shift and it is difficult to keep up.
- Technology Challenges: Most technology solutions do not capture the detailed charge information that is not included on a payer claim and is more arduous to obtain. This can leave technology platforms blind to a large portion of information that is crucial to identifying DRG shifts.

INSIGHTS

CDI teams, documentation prioritization tools, CACs and other software tools can accomplish part of the overarching goal of improving accuracy, but how can we be sure there is nothing slipping through the cracks?

The answer lies in having a safety net that can review inpatient visits and find the one-off scenarios that are missed somewhere along the assembly line. This approach allows staff to perform their duties with a confidence that there is a ‘spell-check’ like functionality helping review their work.

From our experience, we’ve seen hospitals that have CDI initiatives and coding auditor processes in place still find millions of dollars of additional reimbursement from performing DRG validation audits. We’ve found that CDI programs cannot review 100% of all inpatient charts and coding audits are usually focused reviews into specific problem areas. These processes inevitably leave room for opportunities to fall through the cracks.

The safety net should review the coding and documentation after all upstream processes are complete and validate the appropriate DRG assignment. Hospitals may choose to use internal staff or contract with an outside vendor to perform DRG validation services. DRG validation can be done pre-bill (after coding is complete, but before the claim is billed) or post-bill (after the inpatient claim has been paid).

However, while there might be some clinical audit experts who could look at ICD-9 codes and intuitively know where to look to find opportunities, that is just not the case with ICD-10. The number of codes is too great for manual audits to keep up and scale across the organization. Technology is needed to sift through the massive amount of data and help identify issues beyond the standard CDI and coding audits.

INSIGHTS

For example, hospitals can create a report that compares coded, billed and paid DRGs. The report can be automated and continually identify exceptions when comparing the coder-assigned DRG with the claim and electronic remittance advice (ERA) data sets. Any discrepancies can then be audited to determine the cause and action can be taken to prevent future discrepancies.

Another option is to dive into the detailed charge data set to help pinpoint DRG shift opportunities. Charge level data has often been ignored in the inpatient realm, due to the DRG reimbursement methodology. However, charge data can provide small hints and suggestions that, when compared to the existing procedure and diagnosis codes, can lead to an opportunity to shift a DRG to a higher weight (i.e. complication or comorbidity (CC) or major complication or comorbidity (MCC)). No matter how the DRG validation is performed, the results should be compared over time and the root cause identified to prevent future errors. The additional effort spent up front to double check the DRG assignment and ensure accuracy will help proactively avoid penalties down the line from RA audits.

Opportunities for improvements identified may be tied to various root causes:

- Coding education (i.e., following coding guidelines)
- Physician documentation (i.e., opportunities to query the physician for more specificity)
- Process improvement (i.e., final coding without a discharge summary)
- EMR configuration (i.e., modifying templates)
- System related issues (i.e., the flow of data between the coding and billing systems)

Finally, it is important to remember that DRG validation audits may provide insight into what is working well. HIM leadership needs to recognize those achievements and ensure they are rewarded and repeated.

SUMMARY

When it comes to DRG and clinical validation, hospitals should not wait for an audit to penalize them for internal issues or broken processes. Hospitals should be proactive and build processes that ensure the accuracy of their coded data and supporting documentation. In fact, an increased focus on coding and documentation quality will better position and prepare for third party audits. Best practice is to have not only internal validation processes, but external reviews backed by advanced logic and rules to flag high risk cases. Furthermore, payors have invested in technology and creative contracting in order to challenge proper coding practices. It is important for our clients to establish a process of validating coding and address all potential issues prior to third party audits. Even the best practices can fall short and Revint Solutions is proud to assist our clients in achieving best practices with coding and compliance to ensure proper reimbursement.

We are pleased to provide this information to you, should you have any questions or require assistance, please contact me at 847.208.7926.

Truly Yours,
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Meet the Author | Ryan Feldt

Ryan is the General Manager of Operations at Revint Solutions and is responsible for managing operational performance and strategic partnerships. He has experience building and implementing technology-based applications at several large revenue cycle consulting and software companies driving operational and financial performance. Ryan's varied experience from product design, client implementation, account management, and go-to-market strategies provide the experience to drive efficient operations and innovative products. Ryan holds a Bachelor's degree in Accountancy from the University of Illinois at Urbana-Champaign.

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