The Importance of Internal Audits
By Marcia Vaqar, MPH, RHIA, CCS, CCS-P

The OIG (Office of Inspector General) states: “The best evidence that a provider’s compliance program is operating effectively occurs when the provider, through its compliance program, identifies problematic conduct, takes appropriate steps to remedy the conduct and prevent it from recurring, and makes a full and timely disclosure of the misconduct to appropriate authorities.” To identify the problem areas, utilization of internal and external audits is the key. A good compliance plan that utilizes both internal and external auditors shows your facility’s desire to operate within the guidelines.

If discrepancies are found, the penalties applied will be less severe because you are showing due diligence to be in compliance. If done correctly, internal audits done as part of a proactive overall compliance plan ensures enough effort is being made to uncover and fix potential coding problems, documentation issues, and any billing issues that may be found during the audits before they become major issues.

Most healthcare organizations understand the urgency of internal and third-party audits but the effort appears most often to have to take a backseat to the other day-to-day operations of the organization. Internal coding audits require labor time to conduct them appropriately. With over 10 audit and fraud prevention programs being conducted by the federal government and quality organizations along with private payer requests HIM (Health Information Management) departments are busier than ever. The fear is that internal coding data quality audits will halt or at the least be severely cut due to all the demands of these external audits.

Facilities will need to adopt a standardized method that will measure coding quality performance. A valuable industry resource is the American Health Information Management Association’s (AHIMA’s) Benchmarking to Improve Coding Accuracy and Productivity book. This tool provides guidelines for measuring coding quality. The primary internal coding audit should serve as a baseline indicator of coding accuracy. It will identify root causes for coding errors, which should in turn decrease variance and increase reliability. The audit will also identify strengths and weaknesses of coders which will help facilitate the establishment of education goals.

Coding audits are primarily a function of HIM and compliance but the best method is to involve other individuals’ especially upper management. A strong team might be comprised of the following participants: the compliance officer, the CFO, case management, IT, a physician advisor, and HIM. The physician advisor would be an important member of the team because clinical documentation and reporting is important in the overall goal of improving accuracy.

The results of all audits must be shared with the coding team members and clinical documentation specialists and used to define educational opportunities for the team members. In doing so this

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information may be used to build the next phase of the auditing program. Organizations should be looking to broaden their auditing goals to identify new areas that they may improve upon which may not have been included in the initial objective.

Facilities need to take an active approach in assuring compliance. Reimbursement Management Consultants, Inc. (RMC, Inc.) recommends regular staff audits. This may be done internally with auditing of 30 cases. If a coder codes more than one patient type it is important to audit the coder on 30 cases of each patient type they are responsible for coding. RMC, Inc. supports the dual (internal and external audits) approach to having a successful compliant audit program.

Best practice guidelines from AHIMA recommend facilities use a combination of internal and external coding audits for effective coding compliance. AHIMA recommends internal audits every quarter and external audits done at least once a year but if possible more often.

If you have any questions, concerns, or would like further information on this topic, please contact Marcia@rmcinc.org

For more information please visit www.ahima.org, www.aapc.com, or www.oig.hhs.gov


Marcia Vaqar, MPH, RHIA, CCS, CCS-P is a healthcare medical auditor and coding consultant who works with hospitals and healthcare organizations to help insure accurate and correct coding through education, auditing, and coding support. Before venturing out as a consultant and joining the staff of RMC, Inc. Marcia spent over twenty years as a coding manager, project manager/coordinaor of Health Information Management Operations, Inpatient/Outpatient Coder, Health Information Coordinator, and Medical Record Administrative Aide. Today Marcia offers her extensive knowledge background to healthcare systems in cooperation with RMC, Inc. which includes but is not limited to coding; severity of illness data collection and verification; clinical documentation improvement; and coding management skills.

THE 2011 OIG WORK PLAN FOR PHYSICIANS

On October 1, 2010, the Office of Inspector General (OIG), Department of Health and Human Services (HHS), released its 2011 Work Plan which provides an overview of priority areas on which the OIG intends to focus its audit and enforcement activities in the upcoming fiscal year. Physicians and other healthcare providers should use the Work Plan as a guide for prioritizing and updating their own compliance activities.

Many areas addressed in the 2011 Work Plan concern ongoing focus areas from previous years’ work plans. In fact, the 2011 Work Plan includes very few new initiatives. Areas of focus that are most relevant to physician practices include the following:

NEW INITIATIVES

Beneficiary Payments

The OIG will determine whether physicians and other suppliers are billing Medicare beneficiaries in excess of the copayment and deductible amounts allowed by Medicare.

Under the assignment rules, participating providers agree to accept the Medicare allowable charge as payment in full for the services or supplies provided.

Imaging Services

Medicare Part B pays for imaging services on the basis of physician professional cost, malpractice costs, and practice expenses. The OIG will review payments for Part B imaging services to determine whether Medicare payments accurately reflect the practice expenses incurred and whether the utilization rates reflect industry standards. The Work Plan also calls for a review of portable x-ray suppliers to identify unusual claim patterns.

Diagnostic Testing

The OIG will examine the types of laboratory tests and the number of laboratory tests ordered to ensure they were medically necessary and to identify how physician specialty, diagnosis, and geographic differences in the practice of medicine may impact laboratory test ordering.

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In particular, the OIG will review claims to determine the appropriateness of Medicare payments for **Glycated Hemoglobin A1C Tests**. The *Medicare National Coverage Determinations Manual*, Pub. 100-03, Ch. 1, pt. 3, § 190.21, states that it is not considered reasonable and necessary to perform a glycated hemoglobin test more often than every 3 months on a controlled diabetic patient unless documentation supports the medical necessity of testing in excess of national coverage determinations guidelines.

**RMC RECOMMENDS:** Medicare will pay for a hemoglobin A1c every three months for stable diabetic patients. Make sure you have an electronic or manual system, such as a diabetic flow sheet, in place to track this.

**Appropriateness of Medicare Payments for Polysomnography**

Per the CMS *Medicare Benefit Policy Manual*, Pub. No. 102, ch. 15, § 70, sleep studies are reimbursable for patients who have symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia. Medicare payments for polysomnography increased from $62 million in 2001 to $235 million in 2009, and coverage was also recently expanded. The OIG will examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

**RMC RECOMMENDS:** If your practice performs sleep studies, make sure the diagnosis and medical necessity is clearly documented to support the service billed.

**ONGOING FOCUS AREAS**

**Place-of-Service Errors**

The OIG will continue to review physician claims to determine whether physicians properly indicated the place of service on claims for services provided in ambulatory surgery centers and hospital outpatient departments.

**RMC RECOMMENDS:** Check place of service codes to make sure they are correct before submitting claims.

**Evaluation and Management (E&M) Services**

Medicare paid $25 billion for E&M services in 2009, representing 19 percent of all Medicare Part B payments. E&M codes represent the type, setting, and complexity of services provided and the patient status, such as new or established. Providers are responsible for ensuring that the codes they submit accurately reflect the services they provide. The OIG will continue its review of E&M claims to determine the extent of potentially inappropriate payments for E&M services.

Documentation is key to substantiating the level of E&M service provided and electronic medical records (EMR) can be a valuable tool for complete and efficient documentation of services provided. The Work Plan specifically notes, however, that Medicare contractors are seeing an increased frequency of records with identical documentation across services, especially among EMR users. The OIG will review multiple E&M services for the same providers and beneficiaries to identify EMR documentation practices, such as cloning, associated with potentially improper payments.

Medicare initiated the global surgery fee concept in 1992. Physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E&M services provided during the global surgery period. The OIG will continue to review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee.

**RMC RECOMMENDS:** Audit your documentation or hire a coding and compliance professional like RMC to audit for you. Make sure the documentation supports what was coded and billed. If you are using an EMR, beware of over-documentation with templates. Do not document to meet a level of service. Rather, provide the service and use the templates as a tool to facilitate coding and documentation of the service provided. If your practice performs surgery, be diligent about tracking global periods and make sure you understand when you may or may not bill an E&M code during the global period.

**Medicare Payments for Sleep Testing at Sleep Disorder Clinics**

A preliminary OIG review identified improper payments when certain modifiers are not reported with sleep test procedures. The OIG will examine Medicare payments to physicians and independent diagnostic testing facilities for sleep test procedures

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“2011 OIG Workplans for Physicians” Continued...

to determine whether they were in accordance with Medicare requirements as per the CMS Medicare Benefit Policy Manual, Pub. No. 102, ch. 15, § 70.

**RMC RECOMMENDS:** If your practice performs sleep studies, make sure the diagnosis and medical necessity is clearly documented to support the service billed.

**Modifiers**

The OIG will review modifier usage, specifically, the GA, GZ, and GY modifiers. For the GA or GZ modifiers, focus will be on whether the services were reasonable and medically necessary. For the GY modifier, focus will be on proper use. The -GY modifier signals to Medicare contractors that the claim should be denied because the item or service represented by the claim is not covered by Medicare either because coverage is excluded by statute or because the service does not meet the definition of a covered service.

This is just a brief overview of some of the areas relevant to physician practices. It would be wise for physicians to familiarize themselves with the 2011 OIG Work Plan focus areas and modify their practice compliance activities to address the issues of most concern to the OIG.


Ms. Eckenrodt is the Director of Physician Coding & Compliance at RMC. With over 15 years in the HIM field, Ms. Eckenrodt’s focus has been on professional fee coding and documentation improvement. Areas of expertise include: new provider coding orientations; individual and group coding education for providers and professional fee coders; pre-bill and retrospective coding audits; and risk assessment and focus review audits for internal compliance initiatives and compliance initiatives pursuant to federal investigations. Consulting has been provided in myriad settings, from small practices to large multi-specialty practice groups.

**Discharge Disposition Codes for Inpatient Coding**

Hospitals have been assigning the “Discharge Disposition” code for a very long time (with some modifications). Even though it appears straightforward, it can be very challenging. Below you will find the official list. RMC Recommends that hospitals do training/reminders to staff on a regular basis. And also do audits regularly to ensure compliance with these very important code assignments.

All facilities should have a mechanism in place to assure the patients intended discharge plans occurred. All too often patients are sent home with home health, but decline services. A facility is responsible for the discharge to be accurate within 3 days of discharge. Revenue can be affected, and for compliance purposes accuracy of the Discharge Disposition is of utmost importance.

The Inpatient Prospective Payment System for hospitals (IPPS) relies on correct discharge disposition codes for appropriate DRG assignment and reimbursement. Following is a brief review of each code.

01 - Discharge to Home or Self Care (Routine Discharge)

Jail or law enforcement, group home, foster care, assisted living facilities that are not state-designated.

02 - Discharged/Transferred to a Short-term General Hospital for Inpatient Care

Discharges or transfers to long-term care hospitals should be coded with discharge status Code 63.

03 - Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care.

This code should be used regardless of whether or not the patient has skilled benefit days and regardless of whether the transferring hospital anticipates that this SNF stay will be covered by Medicare. Code 03 should not be used if the patient is admitted to a non-Medicare certified area.

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“Discharge Dispositions” Continued...

04 - Discharged/Transferred to an Intermediate Care Facility (ICF)
This can be used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification, or for discharges/transfers to state designated Assisted Living Facilities.

Effective, per NUBC, on April 1, 2008

05 - Discharged/Transferred to a Designated Cancer Center or Children’s Hospital

05 - Discharged/Transferred to Another Type of Health Care Institution Not Defined Elsewhere in This Code List
Cancer hospitals excluded from Medicare PPS and children’s hospitals are examples of such other types of health care institutions.

Usage Note: Transfers to non-designated cancer hospitals should use Code 02.

06 - Discharged/Transferred to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care
Written plan of care for home care services, Discharged/transferred to a foster care facility with home care

07 - Left Against Medical Advice or Discontinued Care
Patient leaves against medical advice or the care is discontinued, patients who leave before triage, or are triaged and leave without being seen by a physician.

09 - Admitted as an Inpatient to this Hospital
Medicare outpatient claims only; applies only to those Medicare outpatient services that begin greater than three days prior to an admission.

20 - Expired

30 - Still Patient or Expected to Return for Outpatient Services
It is used for inpatient claims when billing for leave of absence days or interim billing (i.e., the length of stay is longer than 60 days).

43 - Discharged/Transferred to a Federal Hospital
Discharges and transfers to a government operated health care facility including: Department of Defense hospitals; VA hospitals; Psychiatric services at a VA Hospital, or VA nursing facilities.

50 - Hospice Home
Use if the patient went to his/her own home or an alternative setting that is the patient’s “home,” such as a nursing facility, and will receive in-home hospice services.

51 - Hospice medical facility
Use if the patient went to an inpatient facility that is qualified (or remains at same hospital under hospice care) and the patient is to receive the general inpatient hospice level of care.

61 - Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed
Patients discharged/transferred to a SNF level of care within the hospital’s approved swing bed arrangement.
When a patient is discharged from an acute hospital to a Critical Access Hospital (CAH) swing bed, use Patient discharge status Code 61. Swing beds are not part of the post acute care transfer policy

62 - Discharged/Transferred to an Inpatient Rehabilitation Facility Including Distinct Part Units of a Hospital
Inpatient rehabilitation facilities (or designated units) are those facilities that meet a specific requirement that 75% of their patients require intensive rehabilitative services for the treatment of certain medical conditions.

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63 - Discharged/Transferred to Long Term Care Hospitals
Facilities that provide acute inpatient care with an average length of stay of 25 days or greater.

64 - Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare
Nursing facility that has no Medicare certified beds. If any beds at the facility are Medicare certified, use either Patient discharge status Code 03 or 04.

65 - Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
Transferred to an inpatient psychiatric unit or inpatient psychiatric designated unit (except Federal hospital)

66 - Discharged/Transferred to a Critical Access Hospital (CAH)
Transfer to a critical access hospital (CAH) for inpatient care. Note: Discharges or transfers to a critical access hospital (CAH) swing bed should still be coded with Patient discharge status Code 61.

70 – Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List
If you have any questions, concerns, or would like further information on this topic, please visit the CMS website at: http://www.cms.hhs.gov/MLNMattersArticles or contact Judy at judyt@rmcinc.org

Judy Terry RHIA, CCS has more than 30 years of experience in the field of Health Information Management and is currently working as Director of Review Services for RMC. She earned her Bachelor’s Degree at Loma Linda University and since that time she has enjoyed working as an HIM Director and a consultant both to long term care facilities and hospitals. She lives in Vancouver, Washington and is currently pursuing a Master’s Degree in Public Health.
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12042 SE Sunnyside Rd #452 Clackamas, OR 97015

800.538.5007

www.rmcinc.org

Questions? Email Kristin Gibson: kristin@rmcinc.org

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