This article will provide some key points on how you can incorporate the current Office of Inspector General (OIG) items and future items into your organization’s auditing and monitoring functions. Paying attention to what the OIG for Health and Human Services (HHS) plans to audit and monitor during the upcoming year should be a one of the key drivers in developing your own annual audit plan.

As a reminder, auditing and monitoring is one of seven key elements of an effective compliance program. Auditing and monitoring program functions can help an organization identify risks to business, assists with preventing real or potential risks from escalating and shows a good faith effort that you are truly looking at your own processes and controls.

Although the OIG no longer publishes out an annual work plan, you can still prepare your organization’s compliance work plan as was done in the past. However, this year, as the pandemic has affected all of our operations and even our compliance work plan effectiveness you may approach it a bit differently. One approach is to go to the OIG work plan and look at the items that have been added since the public health emergency began. You can then sort through them for the applicable items related to your organization’s services. Although the plan is specific to what the OIG plans to audit in respect to HHS programs, it provides a plan of the audits that organizations may experience as well. The OIG items covers Medicare, Medicaid, FDA, Substance Abuse/Mental Health, Public Health, Indian Health Services and Other.

After reviewing the OIG items, you may consider some questions related to your 2021 compliance work plan including:

- Has the public health emergency (PHE) resulted in items to add to your plan?
- Due to the PHE, will you be narrowing the focus of you plan? Or expanding your plan?
- Were there items you deferred during 2020?

Some of the most notable recent and active OIG work plan items include:

Telehealth Services

- In October 2020, CMS announced the plan to begin auditing Medicare Telehealth Services. CMS has implemented a number of waivers and flexibilities that allowed Medicare beneficiaries to access telehealth services. Medicare Part B and C data will be reviewed for program integrity risks associated with telehealth services during the pandemic. OIG will analyze provider billing patterns. Although there isn’t a lot of detail, you should continue to watch for updates and review once the initial audit is published.

- OIG will also be reviewing Medicaid Telehealth for oversight of state agencies and waivers that occurred during the PHE.

- OIG will also focus on selected States use of telehealth in behavioral health services. It will analyze how these States and managed care organizations (MCOs) use telehealth to provide behavioral healthcare. It will also review selected States' monitoring and oversight of MCOs' behavioral health services provided via telehealth.

Laboratory Billing for Potential Fraud and Abuse with COVID-19 Add-on Testing

In June 2020, OIG added an item related to laboratory add-on tests to confirm or rule out a diagnosis other than COVID-19 as well as the ordering provider. These add-on tests in conjunction with COVID-19 testing – respiratory pathogen panel (RPP) tests, allergy tests or genetics tests will be reviewed for medical necessary and appropriateness.

Continued...
**Two-Midnight Rule for Inpatient Admissions**

In November 2020, the OIG announced a revised plan to begin auditing short stay claims in 2021 related to the implementation of the Two-Midnight Rule in Fiscal Year 2014. Under this rule, it is generally considered inappropriate to receive payment for stays not expected to span at least two midnights.

Other key items to look at for 2021 include waiving or reducing co-payments under telehealth policy, infection control items related to guidance in some areas, Medicaid provider enrollment, COVID inpatient discharges, cybersecurity review of HHS, review of CARES Act, Provider Relief Funds, emergency preparedness and other long-standing OIG audit areas.

No matter the time an organization reviews the OIG Work Plan, this resource is important in creating an annual audit plan and educating leadership on ongoing OIG activities.

**Encounter for General Examination- Is it with or without Abnormal Findings?**

*By Susan Morton, CPC, CPC-I, CEMC, CGSC, COBGC, COPC, Approved Instructor*

When a provider addresses additional conditions at a general examination visit, usually referred to as a Well-Child or Adult Physical encounter, coders are often left to decide whether to assign a “with” or “without” abnormal findings code. So, how can we easily decide which code to assign? Per Coding Clinic First Quarter 2016 “For the purpose of assigning codes from this category, an “abnormal finding” is a newly discovered condition, or a known/chronic condition that has increased in severity.” When documentation supports an additional condition is being addressed during a general examination encounter, it doesn’t automatically mean that a “with abnormal finding” code should be assigned.

Coders should carefully review the documentation to determine if the condition(s) being addressed are new or have increased in severity. If the documentation supports a new or exacerbated condition(s) were addressed, a “with abnormal finding” code should be reported. When a coder determines that a new or worsening chronic condition(s) was addressed and will be assigning a “with abnormal findings” code, an additional code(s) is required to identify the abnormal findings. If a stable, chronic condition(s) is addressed at the visit, an additional code may also be reported with the “without abnormal findings” code, if the documentation supports the condition(s) was addressed at the encounter.

Example: A 56-year-old man is seen for his yearly physical exam. During the visit, the provider addressed his chronic conditions which include hypertension, hyperlipidemia, and diabetes, all of which are documented as stable and no adjustments in treatment are documented. In this case, the coder should assign code Z00.00 (encounter for general adult medical examination without abnormal findings) along with the appropriate codes for hypertension, hyperlipidemia, and diabetes.

Example: A 3-year-old girl is seen for her well child exam. During the encounter, the patient’s mother mentions to the provider the patient has been coughing for the last couple of days and has a known diagnosis of asthma. During the examination, the provider notes wheezing with occasional cough. The child is diagnosed with an asthma exacerbation. The provider starts the patient on an oral steroid and increased her routine asthma medications. In this case, the coder should assign code Z00.121 (encounter for routine child health examination with abnormal findings) along with the appropriate code for asthma exacerbation.

It should be noted that this article is only addressing ICD-10-CM code assignment. Coders should remember that reporting additional findings/diagnoses ICD-10-CM codes during a preventive exam does not automatically mean that an additional Evaluation and Management Code should be reported. Coders should familiarize themselves with the rules for reporting preventive medicine visits with sick visits, as the E/M does require significant and separately identifiable services to be documented. Coding guidelines and rules should be understood before reporting services.

**Susan Morton, CPC, CPC-I, CEMC, CGSC, COBGC** is a Manager of Physician Coding Services at BMC. Susan has been working in the medical field since 1996, within physician offices. In addition being a Certified Professional Coder, she also holds specialty certifications in Evaluation and Management, General Surgery and OB/GYN. She is also a certified AAPC instructor. She has experience in professional fee coding, provider auditing (retrospective and prospective) and coder/provider education. Her experience ranges from small to large multispecialty groups and large teaching hospitals. Susan also has experience coding Ophthalmology (to include Ophto-plastics), Infusions for Chemotherapy, General Surgery (to include bariatric surgery), and Dialysis. Susan can be reached at smorton@rmcinc.org.
Like the Neverending Story – COVID-19 Coding Continues to Evolve

By Stacy Hartstine, RHIT, CCS

Coding for pneumonia continues to be problematic for most coders. There are many types of pneumonia and documentation is often insufficient for coding to the level of specificity available in our current ICD-10 structure. Some of the specific types of pneumonia codes available include aspiration, bacterial, lobar, pneumonia due to influenza, ventilator associated pneumonia, and viral pneumonia including COVID-19. Pneumonia can also be associated with other pulmonary conditions such as COPD. COVID-19 caused an outbreak of respiratory illness, and was first identified in 2019 in Wuhan, China. The first lab-confirmed case in the U.S. was reported to CDC on January 22, 2020. In February 2020 the CDC announced possible community spread. Since then COVID-19 has spread internationally and was declared a global pandemic by WHO in March 2020. Beginning April 1, 2020 there was a new code implemented for COVID-19 and the AHA published Interim Coding Guidelines. On October 1, 2020 the AHA released the first set of Complete Guidelines related to COVID-19.

Some important guidelines to be aware of:

- Code only confirmed cases as documented by the provider or documentation of a positive COVID-19 test result. "Confirmation" does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient.
- When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.
- When a provider has documented both aspiration pneumonia (J69.0) and pneumonia due to COVID-19 (J12.89), both codes may be assigned. (Assign code U07.1 as Pdx per COVID guidelines). Although there is an excludes 1 note at category J12, Viral pneumonia, not elsewhere classified, that excludes pneumonia not otherwise specified (J69.0), aspiration pneumonia and pneumonia due to COVID-19 are two separate unrelated conditions with different underlying causes which meets the exception to the excludes 1 guideline.
- When a patient is re-admitted for a complication of recent COVID-19 Infection, assign a code for the complication followed by B94.8 Sequela of other specified infectious and parasitic diseases.
- Screening – Assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. Do NOT assign code Z11.59 screening for other viral diseases. Per 2021 OCG, effective 10/1/20, During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e). Coding guidance will be updated as new information concerning any changes in the pandemic status becomes available.

Stacy Hartstine, RHIT, CCS is the Director of Coding Services at RMC. Stacy started in healthcare in 1994, working in various clinics and hospital settings. Holding positions as office manager, coder, Director of Health Information and Privacy Officer. In 2006 Stacy joined RMC as a Manager over the Texas Region. Stacy has proven herself to be an accomplished coder, auditor, manager, and now Director of Coding Services at RMC. In this position, Stacy is ultimately responsible for the overall success of the Hospital Division at RMC. Assuring exceptional client satisfaction with excellent services and exceptional customer service. Additionally, RMC staff engagement is a top priority.

Project Management for Risk Adjustment Coding Review - Part 1

By Dott Campo, RHIT, CCS & Dana Brown, MBA, RHIA, CHC, CCDS, CRC

Risk Adjustment coding reviews can take many different shapes and forms. When starting a new project/review, there are many things to consider. A “Project Management” approach is key to success. Project Management includes four phases: Project Planning Phase; Project Build-up Phase; Project Implementation Phase; and Project Completion & Closure Phase. In this article we will address the Risk Adjustment Review best practices using a Project Management approach.

Project Planning Phase: In this phase it’s important to lay out the why’s and how’s to the project. Why are we doing it and how are we going to get it done. Below is an outline:

- **Identify Stakeholders:** Stakeholders can be various depending on the size of the organization and the anticipated benefits or results from the review. They are the individuals in an organization that will be impacted by the outcome of this review, or whose resources are necessary to perform the review (staff, tools, information and money).
- **Define Objectives:** Simply why are we doing this review? For overall compliance? To find errors in codes that were submitted? To find diagnoses not previously submitted? To educate Providers in HCC code capture? To find missing revenue?
- **Define Project Scope:** The below items are typically needed to define the project scope:
  - Dates of service – What dates of service (or timeframe) for charts will be reviewed
  - Payors – Which payors (insurance type) will be reviewed
  - Volume – How many charts/patients will be reviewed
  - Review Approach – This part is very important and can vary immensely but is necessary to delineate. What specifically will be reviewed, what capture points or items will be gathered. Additionally, what other tasks that will be required of the team? It is important to know exactly what the project entails, as this will enable planning for staffing and training.
  - Staffing requirements – This can be calculated using an estimated charts per hour or patients per hour calculation. Knowing staffing requirements is important because if understaffed, the job will not get completed on schedule.
  - Completion due date – When is the project to be completed? After lining out the volume of work to be audited, and the productivity anticipated, it will be clear how many Auditors will be needed to complete the project on time.

Continued...
“Project Management for Risk Adjustment Continued…”

* Cost/Budget - Estimated cost for such review can be made based upon the volume to be reviewed, divided by the estimated productivity, multiplied by the average cost per hour of the auditors. In estimating cost, also include costs of individuals who run reports, perform quality reviews, organize and prepare final reports of findings, and presenting or education to staff.
* Scaling of Project – Depending on the budget, scaling of the project may be in order. Rescoping of volumes to review would be the initial area to analyze.

**Project Build-Up Phase:** In this phase, the Audit Team is assembled, approach and timelines are solidified.

- **Assemble Audit Team:** It is important that the Auditors are the right fit for the review. Having Coding Auditors that are experienced and credentialed will ensure they have top notch knowledge and skills to perform the review. Depending on the size of the Team, quality control must be considered, and who will perform these quality reviews. Additionally, Team oversight and management must be considered as well.
- **Audit Approach:** A thorough, and well thought out audit approach is also critical to the success of a review. Below are the steps to ensure a successful review:
  * Patient/Chart to Review: To identify patients/charts to be included in a review, a comprehensive report typically can be created by Information Technology. This report will show the entire universe of claims or patients enrolled in a given timeframe. From this report, patients/charts can be selected to be reviewed (or a sampling can be selected for the review).
  * Review Tools: Review tools or software are critical to the capture and storage of review results. Software or technology can be used to gather data, but also, a simple excel report can be utilized.
  * Anticipated Final reports: What does leadership or the stakeholders want to see in the final reports. Be sure the information wanted in final reports is extracted during the review process and in the capture of results.
  * Patient Records: To perform all coding related risk adjustment reviews, access to patient record is necessary. If within the organization – access to records can be done via electronic access (assuming the organization has an Electronic Health Record). If records are from entities outside of the organization, that is a bit more tricky as request for records will be required. Access for auditors will need to be performed, and/or copies of records requested.
  * Coding Review Instructions/Guidelines: Even if there are experienced and credential auditors, detailed written instructions are important to have in place. Also written coding guidelines, specific to the organization are critically important. There are many gray areas in coding – an organizations interpretation and stance on these issues is important for consistent coding review results.
- **Project Timelines:** Timelines, mid-point completion goals and completion goals are all important to have delineated. To know an end date or completion goal is key to staffing (you will hire more/less auditors depending on the timeline). The timeline ties in with the budget. Typically, a review with a shorter timeline (with large volume) will be a higher rate per chart than a longer timeline (due to potential of required overtime to hit goals).

Dott Campo, RHIT, CRC is an expert in Risk Adjustment Coding and currently holds a leadership position in the Risk Adjustment Division at Reimbursement Management Consultants, Inc. In this role, Ms. Campo performs Risk Adjustment/HCC coding, auditing and education of coders and providers. Ms. Campo expertise in the review of patient profiles, records, and Annual Wellness Visits to assure RMC clients compliance with reported HCC’s, RAF scores, and appropriate reimbursement. Prior to coming to RMC in 2017, Ms. Campo held various HIM positions. Most recently, she held a position at a large regional healthcare network in which she was Quality Data Coordinator, responsible for review and abstraction of data in conjunction with CMS and TJC core measures, reporting results and education of stakeholders. Ms. Campo is actively involved in the Oregon AHIMA CSA holding various positions. She is currently enrolled at Western Governors University, pursuing her B.S. in Healthcare Informatics.

Dana Brown, MBA RHIA, CHC, CCDS, CRC, President - Ms. Brown founded RMC in 1994, with the desire to assist healthcare facilities in obtaining correct reimbursement and minimizing lost revenue through complete and accurate coding, documentation improvement, and education. Prior to founding RMC, Ms. Brown performed DRG Validation, Admission, and Utilization Reviews for the Oregon PRO/QIO. She has extensive management, education and coding experience spanning her 30+years in HIM. Ms. Brown’s expertise in Compliance, Inpatient Coding, DRG’s/MSDRG’s, OIG & RAC Targets, Clinical Documentation Improvement, as well as an interest in HCC and Critical Access Hospitals round out her areas of focus at RMC. Ms. Brown’s vision for RMC is to continue to support our clients with exceptional services, delivered by exceptional staff.

For more information register to attend Dott & Dana’s presentation

“Compliant Coding Review Project Management: From Project Concept to Analyzing Review Results and Everything in Between!”

at HCCA’s Virtual Managed Care Compliance Conference

February 3rd @ 1:30pm CST

Project Management is Key in overall success of a Coding Review Project. This presentation will review the key steps one should take to ensure the review performed will garner useful information once completed.

Compliance is a necessity in performance of any coding review. Risk Adjustment poses compliance/privacy/security risks not seen in other reviews. This presentation will highlight common issues and best practices

Staff relent and Tools are critical to any project success. This presentation will address best advice and practices in these areas.

Register here: https://www.hcca-info.org/conferences/national/2021-managed-care-compliance-conference
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