TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER. EL PASO
Office of Institutional Compliance

Texas Tech University Health Sciences Center El Paso
Billing Compliance Policy

Policy: Coding Accuracy Audit	**Policy #:** BCP EP 3.2
Effective Date: January 11, 2018	**Last Revision Date:** October 23, 2024
References: N/A	
TTUHSC El Paso Billing Compliance Website: https://ttuhscep.edu/compliance/BillingCompliance/default.aspx	

Policy Statement

The reporting of codes for medical services is a critical element of clinical operations. Failure to accurately report codes based on documentation obtained from a patient's medical record can result in overpayment and underpayment fines, penalties, and a loss of reputation for the university. Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) is committed to practicing ethical, accurate, and consistent reporting of codes for other additional diagnoses.

This policy defines and describes the process for monitoring the coding accuracy associated with submitted and paid claims. The process will be a collaborative effort between the Office of Institutional Compliance and the Medical Coding School of Medicine coding leadership of each clinical area. The Office of Institutional Compliance staff is responsible for performing the audits and audit reconciliations with the coding leadership of each clinical area to determine the true accuracy level of each individual coding medical claim.

Scope

This policy applies to the auditing staff of the Office of Institutional Compliance and all the areas of the university that submit medical claims.

Policy

1. All TTUHSC El Paso coding staff, including full-time and part-time employees and contracted vendors, are responsible for performing, supervising, and monitoring the coding of inpatient and outpatient encounters at acceptable standards as defined by this policy and TTUHSC El Paso Billing Compliance Policies.

2. TTUHSC El Paso will follow the most current:
    a. Centers for Medicare and Medicaid Services (CMS) Official Guidelines for Coding and Reporting.
    b. Diagnosis and procedure coding will be governed by the official guidelines of the International Classification of Diseases (ICD) for coding and reporting. All codes mandated by these guidelines will be assigned and reported. Adherence to these guidelines promotes consistency and accuracy of coded data.

Coding Guidelines

1. ICD diagnosis, procedure codes, CPT procedure codes, and modifiers must be correctly submitted and will not be modified or mischaracterized in order to be covered and paid.

2. Diagnoses or procedures will not be misrepresented or mischaracterized by assigning codes for the purpose of obtaining inappropriate reimbursement.

3. Diagnosis codes reported will accurately reflect the medical necessity of service, as well as the individual requirements of a CPT code, in accordance with documentation entered by the provider.

4. Procedural codes reported will accurately reflect the procedures performed during the encounter, as documented by the provider.

5. The following items are required to be read and reviewed in order to obtain sufficient documentation:
    a. Transcribed Discharge Summary and the Multi-disciplinary Discharge Form
    b. ER Record
    c. History and Physical
    d. Admit Note
    e. All Progress Notes
    f. Diagnostic Test Results – these shall not be used for diagnostic coding purposes but for physician querying only.
    g. Procedures performed – this shall include the monitored anesthesia care (MAC) report, dictated operative (OP) report, pathology report, and all operative documents (HSM).
    h. Physician's Orders
    i. Physician Addendum submitted for additional supporting documentation.
    j. Medication Sheets (HED) – these shall not be used for diagnostic coding purposes but for physician querying only.
    k. Clinic notes
    l. Nursing Notes – these shall not be used for coding purposes but for physician querying only.
    m. Appropriate Advance Beneficiary Notice (ABN)

Coder/Departmental Accuracy Measurements

1. Compliance will perform regular coding reviews for each coding area (Clinic, Hospital, and Ancillary). The number and types of records sampled will be a homogenous sample of clinic billing, hospital billing, and procedural billing.
    a. The sample of claims will consist of a random selection of claims.

2. Prior to audit finalization, the coding leadership (Coding Director and/or, Coding Manager (s)) and coders will have an opportunity to reconcile the audit results. This also includes contracted vendors and their Leadership.

3. Any identified coding and billing errors that result in an overpayment to TTUHSC El Paso will be reported and addressed, as per policy.
    a. The completed audits will be emailed to the coding/vendor leadership.
    b. The coding leadership and coders will have a two-week window to challenge audit findings by meeting with the Compliance audit staff. Audits that are not challenged within this two-week period are final.

4. Final results will be provided to the individual coder, the coding leadership, and applicable administrator(s). Reports will be sent to the Billing Compliance Advisory Committee, as well as the Institutional Compliance Committee.

5. Consistent with industry standards, coders are expected to achieve an accuracy measurement of 95% or above.
    a. 95-100% - Coder is scheduled for re-audit annually.

6. The following will apply for Coders that do not achieve the 95% accuracy rate:
    a. 90-94% - The coder will be scheduled for post-audit education and the coding/vendor leadership will provide proof of Work Plan and Quality Checks on the coder in 2 weeks.
    b. 80-89% - The coder will be scheduled for post-audit education and re-audit in 90 days. The coding/vendor leadership will provide proof of Work Plan and Quality Checks on the coder.
    c. <80% - The coder will be scheduled for post-audit education and re-audit in 30 days. The coding/vendor leadership will provide proof of Work Plan and Quality Checks on the coder.
    d. Three consecutive scores below 80% - Claims are put on hold for 100 percent review with coding/vendor leadership.

7. Coders who fail to consistently perform at the 95% accuracy rate will be referred to the coding leadership for counseling and corrective actions.

8. Rebilling of Identified Underpayments and Charge Corrections: If the timely filing window is open, Compliance will submit it to Medical Practice Income Plan (MPIP).

9. Refund of Identified Overpayments: In all cases, refunds will be submitted within 60 days of completion of the audit reconciliation, and any identified overpayments. Compliance will submit to MPIP. See Billing Compliance El Paso 3.1 Report and Return of Overpayments and BAC 18 policy.

Administration and Interpretation, Revisions, or Termination
Questions regarding this policy may be addressed to the TTUHSC El Paso Institutional Compliance Officer or the Billing Compliance Unit Manager.

This policy may be amended or terminated at any time, subject to approval by the Billing Compliance Advisory Committee.

Frequency of Review

This policy shall be reviewed by November 1st of each year.

Review Date: 1/11/2018, 3/2019, 1/27/2021, 10/26/2022, 7/26/2023, 10/23/2024
Revision Date: 3/2019, 1/27/2021, 10/26/2022, 7/26/2024, 10/23/2024