Policy: BCP EP 3.2 Coding Accuracy Audit	
Approved Date: January 11, 2018	**Last Revision Date: January 27, 2021**
TTUHSC El Paso Billing Compliance Website: http://elpaso.ttuhsc.edu/compliance/BillingCompliance/	

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 practice 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 Institutional Compliance department and the coding leadership of each clinical area. The Institutional Compliance department 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 Institutional Compliance department 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 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 shall be governed by the International Classification of Diseases (ICD) official guidelines for coding and reporting. All codes mandated by these guidelines should be assigned and reported. Adherence to these guidelines promotes consistency and accuracy of coded data.

Coding Guidelines

1. ICD diagnosis and procedure codes, and 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 purpose of obtaining inappropriate reimbursement.

3. Diagnosis codes reported will accurately reflect the medical necessity of a 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 shall 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 reviews of the coding 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 (Unit Managers and/or Coding Director) and coders will have an opportunity to reconcile the audit results.

3. Any identified coding and billing errors which 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 leadership.
b. The coding leadership and coders will have a two week window to challenge audit findings by meeting with the compliance audit staff.
c. 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.

6. Coders that do not achieve the 95% accuracy rate will need to have remedial training provided by the coding leadership.

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

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

9. Rebilling of Identified Underpayments and Charge Corrections. If the timely filing window is open, Compliance will submit to MPIP.

Frequency of Review

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

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