



E-BRIEF SERIES



7 Steps

to the Perfect Coding &
Documentation Audit



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Introduction

Due to the recent changes in healthcare delivery during the COVID-19 public health emergency, the new ICD-10-CM codes released out of cycle, and the 2021 evaluation and management (E/M) guideline changes, coding accuracy is more critical than ever. And ensuring your compliance audit program is focused on the right type of audits is essential.

Coding and documentation audits safeguard your business. And when done correctly, you will have peace of mind knowing that your organization is taking the best steps to prevent fraud, waste, and abuse, while ensuring accurate and appropriate reimbursement.

Steps to Perform the Perfect Coding Audit

01 Step 1 Identify who will perform the audit

There are benefits to both internal and external audits, you must find what's best for your organization. Internal audits can ensure accuracy of an organization's regulations and compliance standards, which may lead to the discovery of workflow gaps. External audit performed by a third party can provide specialty experts with an outside perspective, resulting in new ideas and solutions to your pain points.



02 **Step 2** **Identify the audit scope**

Industry best practices tell us that focusing on high-risk areas is a good start. Defining the specific areas of risk depends on where you are with your compliance program. Reviewing the Medicare Recovery Audit Contractors (RAC) report, Office of Inspector General (OIG) work plan, and Comprehensive Error Rate Testing (CERT) reports can help guide you. Don't forget to review your revenue cycle key performance indicators (KPIs) and your highly utilized/highly compensated services. Areas of risk are often identified by looking at these billing patterns. Another approach to identify your risk areas is to use claim analytics software to look at your coding patterns. The software will streamline the labor intensive shifting through piles of data. If you don't have the benefit of software, don't fret! Start out small so you don't get overwhelmed. Finally, referring to previous audit results can also provide intel on what that perfect audit should be.

03 **Step 3** **Determine the audit type**

Audits may be performed prospectively, which takes place prior to claim submission, or retrospectively, which involves reviewing claims that have already been submitted. The advantage of prospective reviews is the prevention of incorrect claims going out, thereby reducing the chance of a denial or payback. The advantage of retrospective reviews is that you have more time to perform the audit, write up meaningful reports, and implement post-audit education. Retrospective reviews are not subject to the same short timeline as prospective audits.



04 **Step 4** **Plan for the audit frequency**

Audit frequency will depend on the occurrence of coding changes, regulatory changes, and compliance issues uncovered in your organization. Both the OIG and CMS recommend that all physicians and nonphysician providers have their coding reviewed annually. Best practice suggests that coders should be reviewed more frequently. When there are significant changes in the industry, like our current state, more frequent reviews are necessary to ensure providers and coders are up to speed and comfortable with the changes. Based on Healthicity's recent Compliance and Auditing survey, 51% of organizations perform coding audits monthly or quarterly, a 2% increase from previous years.

05 **Step 5** **Determine sample selection**

Sample size can be driven by many factors. Guidance published by the OIG recommends auditing a minimum of 10 patient encounters per provider. Larger samples are recommended for focused audits, such as with surgical specialties that perform services in the office and at the hospital or surgical center. Or when looking at the entire organization rather than an individual provider. In this instance, a sample size of 3% is common. Keep in mind, a larger sample size audit is recommended if your pass rate threshold is 95% or greater. The math just won't work with a sample size of 10. Lastly, let's review how to pull the sample. A random sample approach may be used for standard compliance audits. This can be done manually or by using technology. Obtaining a valid statistical sample using RAT STATS is typically used for focused audits in situations where money is due back to the payer.

06 **Step 6** **Perform the audit**

Performing a coding and documentation audit involves not only reading over the medical record documentation for coding accuracy, but also reviewing the claim form to ensure the entire claim was billed correctly. Audit findings should include coding errors as well as missed opportunities for improved clinical documentation and missed revenue. For example, including findings for missed opportunities to support a higher level of diagnosis specificity or including counseling time for discussing smoking cessation with patients.

07 **Step 7** **Present findings and recommendations**

Written reports containing findings, recommendations, and proposed corrective actions must be communicated to not only the providers and coders, but also to clinical staff and other stakeholders in your organization. This report should be meaningful and easy to follow. Avoid using 'coder speak' as this often does not resonate with a physician's clinical mindset. While no one likes getting graded, it's important to include a scorecard and that's the only way to monitor the effectiveness of your audit and training programs. Most importantly, encouraging open dialog is critical to ensuring desired behavior changes and will result in personal buy-in and accountability.

Ultimately, the perfect audit will differ by organization. The key is to know your organization's risk areas and create an audit program that will allow you to audit all physicians, non-physician providers, coders, all lines of business, and for all payers. Using your audit results will improve accuracy of documentation and coding, boost your revenue cycle, and improve the overall performance of your organization.



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AUTHOR BIO

Stephani Scott, RHIT, CPC, has over 25 years' experience in the healthcare industry, working closely with physicians and staff in health information management. She has worked in a variety of settings including hospital, long-term care, large multi-specialty physician practice, and electronic health record software design and development. Scott has extensive experience in inpatient and outpatient auditing and coding compliance and is responsible for overall project performance and client satisfaction. Scott was also a part-owner of a consulting company for many years, providing services in best practices for physician practice management services including coding, billing, and revenue cycle management audits.

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