Continuous Quality Monitoring to Maximize ICD-10 Proficiency and Organizational Benefits

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Welcome!

A common strategy to maintain coding accuracy, continuous quality reviews have taken on greater importance in recent years. Between the federally mandated transition to ICD-10 (now delayed until at least 2015) and a desire to maximize the impact of ICD-10 on outcomes, these reviews have become an important tool for mitigating post-transition productivity and financial dips.

Every care setting, from large academic medical centers and ambulatory surgery centers (ASCs) to physician practices, will benefit from implementing a continuous quality-monitoring program ahead of ICD-10. In fact, ICD-10 aside, most organizations will benefit from regular reviews because of the broad implications for quality coding across departments. For example, part of the review process confirms type of admission, present on admission (POA) indicators and discharge disposition, and admission and discharge dates, which impact finance and care management. Compliance and quality assurance departments also benefit from continuous monitoring, as do areas such as infection control and core abstraction, which do not normally receive spot-check reviews.

When a proper quality-monitoring program is implemented, the typical coding department will realize a 5 to 10 percent increase in coding accuracy in one year. In turn, these higher accuracy rates typically result in a much lower volume of cases subject to Medicare administrator contractor (MAC) and recovery audit contractor (RAC) review. That alone makes it worth a closer look.
The New Role of Quality Monitoring
Technological advances combined with a national agenda for healthcare reform are shifting health information processes and practices from paper records to electronic records as the dominant form. As this transformation takes place, the quality of patient records becomes a critical focus for patient safety and improved patient outcomes. Quality practices of both service providers and in-house medical transcription departments benefit from a more standardized approach to measuring, reporting and improving the quality of healthcare documentation to achieve consistent patient safety outcomes.\(^1\)

Central to these practices is the coder. An inpatient coder’s job is to make sure all the codes on the claim are captured in the correct order so the correct diagnosis-related group (DRG) is assigned and the hospital gets paid appropriately. It sounds easy. In reality, though, as more patients are treated on an outpatient basis, the acuity level of inpatients is higher than ever — and “sicker” means harder to code. For instance, when a patient presents with shortness of breath and the final diagnosis is acute exacerbation of chronic obstructive pulmonary disease, staphylococcal pneumonia and respiratory failure, how a coder codes and sequences the case will determine the appropriate DRG and reimbursement.\(^2\)

In the past, coding-quality reviews focused primarily on validating codes determining DRGs prior to claim submission. That is inadequate in today's environment. It tells only half the story, artificially limiting the usefulness of quality review coding and impacting the mortality and severity of illness profiles for the hospital and physicians. Missing information or unclear documentation impacts data integrity. It does not adequately hold up to compliance audits, nor does it provide the specificity or detail required for analysis and process improvement.

Done properly, coding-quality monitoring can serve multiple purposes, including measuring proficiency and closing gaps in coders’ ICD-10 knowledge. This impacts reimbursement and outcomes of RAC and other third-party audits and enables targeted education and training efforts to focus on shoring up specific areas of weakness.

Continuous quality monitoring will also help healthcare organizations comply with increasingly strict regulations to prevent fraud and abuse that mandate regular internal audits. Specifically, the Office of the Inspector General (OIG) has published compliance guidelines mandating that hospitals have a compliance officer on site, as well as a robust compliance plan that protects against billing fraud. What that means is the traditional approach to quality monitoring, which typically involved bringing in a consultant once every few years to review a handful of records and report on accuracy rates, is no longer sufficient. This is where an outsourced continuous quality-monitoring program provides yet another benefit. It doubles as the external monitor required by the OIG.

Drilling deeper, a properly framed quality-monitoring program arms clinical documentation improvement (CDI) specialists with the data needed to educate physicians on areas of weakness in documentation. This is important because the granularity of ICD-10 demands comprehensive documentation to support proper reimbursement and drive quality reporting. By approaching continuous quality monitoring as a clinical documentation gap analysis, CDI specialists can focus on key areas of risk for more efficient and effective physician education.

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A Well-Designed Program

- Clinician Documentation
- Coder
- Coding Quality Review
- Increased Revenue

Physician Query
More Documentation Needed
The best continuous monitoring programs take an “educate first” approach to coding audits, and they deliver the feedback that hospitals, ASCs, physician practices and other healthcare organizations need for accurate billing, clinical documentation improvement and targeted physician and coder education.

The best approach is two-pronged:
1. Conduct regular audits of coded charts to identify accuracy issues before they significantly impact revenues or slow the time to bill.
2. Provide coders with immediate, direct feedback supported by official coding guidelines to continuously improve proficiency and retention.

In particular, the educational aspect of coding-quality reviews takes on greater urgency in the shadow of ICD-10. Direct communication with individual coders ensures a complete understanding of errors and recommended corrections, helping to close knowledge gaps. This serves to fine-tune coder skills by ensuring each coder has a complete understanding of any errors they may make and increases coding productivity for procedure-based DRGs. It also pinpoints particular areas where coders would benefit from targeted training and coding practice, such as through e-learning modules and practice records.

Over time, the focus will shift from building proficiency to maintaining it by making sure coders retain guidelines and coding accuracy. To that end, ongoing access to lessons and practice records is particularly important to ensuring coders’ skills remain sharp between completion of training and their facility’s conversion to ICD-10. Giving staff the ability to code charts in a simulated production environment will help maintain core competencies training, so ICD-10 implementation, when it happens, is as seamless as possible.

Whether coding review is handled internally or outsourced to an experienced vendor, program design will determine how well the program can function as an educational channel. Reviews, preferably conducted by credentialed consultants with extensive ICD-10 training, should validate 100 percent of codes within sample charges, not just DRGs. While the latter is sufficient for billing accuracy, it falls short when coding review doubles as an educational opportunity.

When corrections or changes must be made, the coder should receive immediate, direct feedback in a way that ensures a complete understanding of errors and recommended corrections, helping to close knowledge gaps. Whenever possible, this feedback should be supported by official coding guidelines to continuously improve proficiency and retention.

Continuous quality monitoring will also identify patterns of inaccuracies that can be used to pinpoint particular areas where coders would benefit from targeted training and coding practice. Once identified, these knowledge gaps can often be filled through online programs offering individual training modules so coders can focus on their specific areas of weakness. Look for programs taught by instructors approved by the American Health Information Management Association (AHIMA), in addition to ongoing access to a library of practice records, codebooks, terminology manuals and reference sites to keep skills sharp. Some programs also provide pre- and post-training ICD-10 assessments to measure readiness and demonstrate proficiency.

Finally, the most important characteristic of any educationally focused coding-quality monitoring program is the relationship between the coders and reviewers. It cannot be adversarial if it is to be effective. This requires establishing channels for timely educational conversations and ensuring the coder is comfortable asking questions and seeking clarification.

Some training vendors also offer a simulated production coding environment, providing staff with the advantage of ongoing, interactive practice on inpatient and outpatient records for each chapter of clinical modification (CM) and operative procedures covering each root operation of the procedural coding system (PCS). Developed by seasoned coding professionals, Amphion Medical Solutions’ The Minnette Expert Coding Library™, for example, was created to provide coders with a continual learning environment.

Coders who can pause and resume courses as often as necessary and who have full access to a library of practice records, codebooks, terminology manuals and reference sites even after training has been completed will be well on their way to maximizing ICD-10 comprehension. There are also pre- and post-training ICD-10 assessments to measure readiness and demonstrate proficiency.

Ultimately, properly trained coders help ensure facilities are not leaving money on the table by failing to recoup higher associated reimbursements — or being forced to repay monies when audit appeals are denied.
Optimizing Results

Coder Quality

60% 70% 80% 90% 100%
It is no secret: Accurate documentation is the number-one key to coding and billing appropriately, particularly in an ICD-10 world. An organization’s ability to quickly and efficiently identify, define, design, build, train and deploy changes to the clinical and physician documentation processes will be the definitive course of action critical to their long-term success.iii

The bottom line is coding in ICD-10 will initially be very complex. Even facilities with encoders will experience a sharp uptick in coding errors, especially if they rely too heavily on the software without some sort of validation process. A robust coding-quality program will help streamline the transition by ensuring coders are — and remain — proficient. It will improve CDI programs for clinicians and even identify areas within encoder software that the vendor must upgrade.

Ultimately, a continuous quality-monitoring program helps healthcare organizations prepare for the complex ICD-10 coding environment and comply with increasingly strict regulations to prevent fraud and abuse that mandate regular internal audits. When approached from an educational perspective, it can also provide the knowledge and tools coders need to achieve proficiency and CDI specialists need to continuously educate physicians on documentation practices.