Insights to Coding and Data Quality

Increased error rate for Medicare Part B shows need for APC audits

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A couple of months ago, in another CHIA Journal article [June-July 2011], we spoke of the Palmetto GBA's November 2010 Medicare fee-for service (FFS) claims error of 22% in California, Nevada, and Hawaii, for Medicare Part B. Palmetto GBA is the Medicare Fiscal Intermediary for the regions covering California, Nevada, and Hawaii. Since Medicare Part B consists mainly of outpatient claims, providers are forced to look closely at their Ambulatory Payment Classifications (APCs), coding accuracy. This article will share some additional information and offer ways to improve outpatient coding accuracy.

Many health information management professionals across the nation use 95% as the coding industry accuracy benchmark. The Palmetto coding audit accuracy rate was found to be 88%. The errors included: administrative type errors however, medically unnecessary services largely attributed to the J1 claims paid error. Medically unnecessary services were determined to be due to the lack of adequate documentation to support services billed.

To reduce the error rate, providers may want to take a proactive approach to ensure that the codes provided on the claims are correct. The codes assigned must be supported by documentation in the medical record. In addition to the documentation of the test or service performed, the need for the test or service, (medical necessity), must also be documented. Physician education is a key element in ensuring that medical necessity is documented. Routine review of the documentation and physician feedback is vital.

For hospital outpatient claims, the best method to ensure accuracy is to conduct routine APC audits. These audits are two-fold; consisting of both a review of the codes assigned by the health information management (HIM) coding staff and those codes that are assigned through the chart entry process. All line items listed on the uniform bill are assigned an APC code which has a fee associated with it under the Outpatient Prospective Payment System (OPPS) payment methodology. The items are listed as Current Procedure Terminology and/or Healthcare Common Procedure Coding System (CPT/HCPCS) codes and designate the procedures, tests, drugs, and supplies provided to a patient. An APC audit verifies these procedures codes, along with the diagnosis codes assigned against the information documented in the medical record.

Providers typically have APC audits in place that check the validity of the codes assigned by the HIM coding staff, but do not have audits that look at what populates the actual claim from the charge entry process. The Office of the Inspector General, (OIG), recommends that providers conduct at least one outside audit per year.

Common problems found in the codes listed on the claim are:

- Missing revenue codes fail to capture all CPT4/HCPCs codes reported by the HIM coder, so these codes are missing from the bill.
- Chart entry reports one code and the HIM coder reports the same code; both codes are submitted on the bill.
- Charge Description Master, (CDM), is not updated with new codes to report current procedures.

- Physicians fail to document the reason for test or services.
- Inappropriate use of modifiers 59 and 25.
- Unbundling of procedure codes.

Any compliance plan should include a review of the codes submitted on the uniform bill, as well as a quarterly APC audit that looks at all procedure codes submitted. The uniform bill is a recommended industry standard. The Palmetto finding of a 22% error rate (88% accuracy), is a far cry from the national benchmark of 95% accuracy.

Where does your facility stand?

For more information on physician documentation, see the CMS Web site, at <www.cms.gov/MLNEdWebGuide/25_EMDOC.asp>.

See also Palmetto GBAblog at <www.palmettogba.com/gbdbloglaunch>.

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