Auditing: Inpatient Coding Microcredential

Content Outline

A. Practice (38-41% of questions)

1. Describe the impact of coding (including POA) on hospital quality scores and value-based reimbursement (e.g., HAC/PSI, mortality reviews, etc.)
2. Understand, interpret, and apply ICD-10-CM and ICD-10-PCS conventions, guidelines, and regulatory guidance to audit the accuracy of diagnosis and procedure codes to the highest level of specificity.
3. Thorough knowledge of Inpatient Prospective Payment System (IPPS) and related reimbursement requirements.
4. Consistently maintain a minimum auditing accuracy rate of 95% and meet an entity's production standards
5. Ability to accurately determine the principal diagnosis occasioning the admission with attention to key concepts of reason for admission, focus of care, treatment, co-equal scenarios, and all applicable coding guidelines.
6. Review health records to validate the assignment of diagnosis and procedure codes for inpatient admissions.
7. Ensure compliance with privacy, security, and confidentiality requirements and regulations (e.g., HIPAA guidelines).
8. Ensure adherence to the AHIMA Standards of Ethical Coding and the AHIMA Code of Ethics.
9. Identify key performance indicators for coding, audit, and compliance.
10. Compare an institution with external institutional benchmarks (e.g., AHRQ, PEPPER, Leapfrog, US News, CMS Star ratings, and other health data comparison sites).
11. Knowledge of current coding guidance including American Hospital Association (AHA) Coding Clinic (TM) guidance, state and federal regulations.
12. Extensive knowledge of the legal health record (LHR) and electronic health records (EHR) structure/functionality.

B. Clinical Documentation (18-21% of questions)

1. Identify and address health record discrepancies (e.g., clear, concise, consistent, complete, legible).
2. Describe the clinical documentation workflows and key documentation requirements needed to clinically support the coding of a diagnosis or procedure.
3. Identify query opportunities for documentation clarification with prior experience writing queries.
4. Describe disease pathophysiology and drug utilization.
5. Define and describe medical terminology, anatomy, and disease processes.

C. Abstracting Data Elements (15-17% of questions)

1. Review and validate abstracted data elements (e.g., present on admission indicators, discharge disposition, admission and discharge dates, etc.).
2. Understand and apply MS-DRG and APR-DRG classifications and reimbursement structures.
3. Understand case mix index (CMI) and describe what it means for reimbursement and hospital statistical reporting.
4. Audit hospital transactions/charges against provider documentation to ensure complete coding and full revenue capture.
5. Apply the criteria for the new technology add-on payments (NTAP) and medical devices for appropriate reporting and reimbursement.

D. Communication (14-16% of questions)

1. Effectively communicates (verbally and in written reports or summaries) opportunities for documentation improvement related to coding issues.
2. Communicates job expectations by planning, assigning, and monitoring.
3. Develop a training program utilizing the findings and trends from the audit and performance score cards.
4. Contribute to the information provided for staff performance reviews.
5. Present audit findings to the stakeholders in a way that allows the stakeholder to understand and implement the findings for improvement.
6. Describe change management techniques that allow for the implementation of audit results to impact improvement efforts.

E. Reporting (9-11% of questions)

1. Ability to create clear and concise audit reports and maintain productivity standards.
2. Generate a representative statistical sample report.
3. Create the audit summary report for the coder scorecard and reporting of audit findings.

https://www.rasmussen.edu/degrees/health-sciences/blog/what-does-a-medical-coding-auditor-do/