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The Importance of Implementing Clinically Intelligent Compliance Programs

Creating and maintaining a clinically intelligent compliance program must be an operational priority for hospitals. Eliminating healthcare fraud and abuse is a top priority for the government regulators and is a significant concern for healthcare organizations. The number of regulatory investigations continues to increase, as does media attention. To avoid becoming the next investigative target, hospitals must maintain strict adherence to the regulatory requirements that govern healthcare operations.

What Does Medical Compliance Mean for Hospitals?

Simply put, medical compliance ensures that hospitals protect state and federal funding from being misused[1]. However, medical compliance continues to evolve as additional regulatory requirements are established for healthcare organizations. Increasing compliance requirements place healthcare organizations at significant reputational and financial risk. Failure to devote adequate resources to compliance programs can be detrimental, with worst-case scenarios including costly penalties, sanctions, and lawsuits.

Establishing Compliant Coding Practices

Healthcare organizations must diligently maintain coding standards and compliance. Billing errors account for 14% of the annual Medicare fee-for-service payments[2] (47% for insufficient documentation, 37% for no medical necessity, and the remaining 16% for other coding errors). These billing errors can easily snowball into government investigations and penalties.

To avoid these issues, healthcare organizations must establish defined coding practices. Coding risks should be well-defined, with a designated course of action if a negative coding scenario is encountered. Coding practices must reference official coding guidelines. Documentation should be standardized across the organization so that all records have the same level of detail and specificity regarding a patient's treatment. Consistently detailed records ensure that each coding episode accurately reflects the physician's documentation of the visit. Additionally, enlisting a physician advisor can help the coding staff resolve coding issues and communicate with the medical team.

Hospitals can also improve coding by ensuring that all coding staff members are appropriately trained. This may include requiring staff to obtain certifications and continuing education so that each staff member has the most relevant and current knowledge of best practices. Training and educational requirements should be well-documented so that they are maintained and followed by the staff. Conducting regular skills assessments to identify areas of weakness and areas to improve coding integrity are well-advised.

Beyond ensuring that hospitals bill payers for the appropriate level of treatment, maintaining medical records for compliance is critical. For example, accurate records are essential to the patient, as procedures and treatments often have implications for future care, and a complete medical history may be useful in the diagnosis or prevention of diseases.[3] Additionally, when managing medical records, healthcare organizations must establish policies and procedures that safeguard protected health information (PHI). Organizational policies prevent legitimate users from accidentally misusing or disclosing PHI in addition to reducing the risk of hackers accessing sensitive information.[4]

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Improving Coding Integrity

Through efforts to improve coding and maintain compliance, hospitals and other healthcare organizations can vastly improve medical records and coding integrity. Processes around coding and quality assurance can be automated to not only strengthen revenue cycle management, but redirect coders to perform tasks that align with their level of expertise and require critical thinking, such as reviewing complex cases. AHIMA considers the benefits of automated coding to include streamlined coder productivity, improved coding consistency, reduced errors, and fewer missed codes.[5]

Just as automated coding can improve the efficiency of coding, developing a strong data security program supports the requirement to safeguard medical records per HIPAA, HITECH and other regulatory mandates for detailed medical records required for accurate coding. Ensuring compliance with data security standards for a hospital and its vendors is not just a professional and ethical responsibility, but a legal one. As medical records grow more complex and detailed, the need to ensure the information stored within them is safe from unauthorized access is even more critical.

> **Hospitals and their vendor partners should implement auditing procedures, both internal and third-party, which are essential for identifying areas of lost revenue and under documented services. For example, it is common to miss billable procedures such as immunizations and ECGs in outpatient visits.[6]**
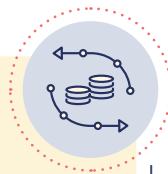
Audits also help to identify areas that require improvements within coding practices and record-keeping to develop comprehensive employee training procedures. Auditing helps prevent fraudulent claims and billing, identifying mistakes so that an organization can rectify them before payers can challenge inaccurate claims. Additionally, organizations should have third-party audits conducted by an independent party for an objective look at the organization's coding. Third-party audits have capabilities that extend beyond that of the hospital's internal resources. It should be emphasized that hospitals and health systems should look at their service providers in this respect to ensure that coding and clinical documentation vendors also undergo third-party audits to validate their work.

Healthcare organizations must seek to establish defined communication procedures for changes to regulatory requirements, so that their staff members are following the most recent rules and regulations. Regulatory updates must be communicated quickly to the staff so they can implement the newest practices in a timely manner.

Another option is seeking the help of an outside coding consultant. Such a partner can help improve coding accuracy but requires careful consideration by the hospital to ensure it chooses an ethical, compliant partner.

A Solution that Lessens Compliance Risk

Accuity is a tech-enabled, physician-led platform that provides accurate, higher-quality clinical documentation and compliant coding so hospitals can thrive in a complex value-driven environment. The advantage of Accuity's service for a hospital's data integrity and clinical documentation excellence is that a trained physician leads the medical record review.

Accuity's solution ensures that the final coded DRG matches the level of treatment given to the patient and the hospital receives full reimbursement for the care provided. Accuity combines the power of experienced physicians, coding professionals and CDI specialists with proprietary technology to deliver the most effective and efficient medical record review in the market. Utilizing physicians well-versed in the coding system is a winning strategy for DRG reconciliation and improves the level of scrutiny for each record.

It is important to note that physician education in the finer details of the DRG coding system is necessary. According to a 2014 study: "Many clinicians are not well versed in the system by which acuity of patient care and inpatient technical billing (that is, nonprofessional services) are determined."[7] The process that Accuity establishes for clients includes peer-to-peer, data-driven physician education. Over time, with Accuity's assistance, the hospital's internal staff become more versed in coding and clinical documentation to increase overall data integrity.

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Accuity works in collaboration with a hospital's coding, CDI, and revenue cycle management team, complementing its existing technologies and processes. Accuity's solution ensures an experienced partner is giving each chart an added clinical review from trained medical and HIM professionals. Multiple touchpoints throughout the record process are the best way to safeguard coding and compliance for patient health and revenue integrity. Accuity's physician-led team of expert HIM professionals can help clients to be compliant within the system and recover lost revenue.

1   https://www.aapc.com/healthcare-compliance/healthcare-compliance.aspx

2   https://library.ahima.org/doc?oid=58837#.YVM7K2Zuf0o

3   https://www.ama-assn.org/delivering-care/ethics/management-medical-records

4   https://www.ncbi.nlm.nih.gov/books/NBK233430/

5   https://bok.ahima.org/doc?oid=106663#.YWUC7kbMJAc

6   ama-assn.org/practice-management/cpt/13-reasons-your-practice-should-have-medical-record-audit

7   https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142511/

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