

Warmest thoughts and best wishes for a wonderful holiday and a very Happy New Year.

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CODE OF THE MONTH...

*"The price of success is hard work, dedication to the job at hand, and the determination that whether we win or lose, we have applied the best of ourselves to the task at hand."*

Vince Lombardi

MONITORING AND AUDITING

Every facility should provide monitoring and auditing of its activities by conducting routine reviews, medical chart auditing, coding audits, risk-based reviews, and audits of physician relationships and payments made to potential referral sources. Based on the type of review, audits and reviews may be conducted monthly, quarterly, annually, or may be conducted in response to regulatory changes or identified risk areas.

**I. Medical Chart Auditing:** The Medical Auditor (Nurse Auditor) should perform monthly concurrent account audits to identify charges issues not normally found during the course of defense audits. A concurrent audit is defined as a complete audit on a non-disputed account, completed within 30-days of patient discharge. Concurrent audits should include all Payor Types. Financial Classes and Patient Types. The audits samples for concurrent review must include no less than 10 patient accounts. The sample must be random for both the inpatient and outpatient and should equal one-third of single day's hospital revenue. The scope of a billing audit is limited to verifying the charges on the detailed hospital bill are accurate and that charges represent services rendered to the patient and are ordered by physician. The Medical Auditor should assist the appropriate Department Managers, Nursing, Ancillary Departments with maintaining and/or developing Charging Protocols and Policies in all

revenue producing departments.

**II. Coding Audits:** Coding managers should perform quarterly or semi-annual coding accuracy reviews at each facility. Reviews include correct assignment of ICD-9 and CPT-4 codes as well as DRG assignment. Billing errors identified during the course of the review are included on the corrective action plan, and overpayments are refunded. The results of all reviews are reported to facility senior management, and a corrective action plan is implemented, if necessary.

**III. Risk Based Reviews and Other Specialized Reviews:** In each facility, Compliance Department should conduct a variety of risk-based audits and reviews. The audit results and findings should be forwarded to facility senior management and work with the facilities to develop, implement, and monitor corrective action

plans. In addition, education, policy changes and disciplinary action are implemented as appropriate.

**Corrective Action:**

Based on the summarized audit findings presented by various departments a Corrective Action must be implemented in order to identify and resolve any issues. Elements of each corrective action plan include: (1) identification of the issue; (2) revisions to policies and procedures, if necessary; (3) training on those policies and procedures, or retraining on established policies and procedures; (4) monitoring to ensure compliance; and (5) appropriate disciplinary action in the event of non-compliance.

**Julie Doumad RN, BSN, CMAS**

**Director of Audit Services**

*(American Healthcare Audit Professionals, Inc.)*



## CMS LEAVES PRG OUT OF RAC...

Though the CMS didn't necessarily address all provider concerns with its Recovery Audit Contractor program rollout, one change that brought relief to California providers was the exclusion of PRG-Schultz International as an auditor.

PRG-Schultz was one of the most controversial RAC auditors in the demonstration project. The Atlanta-based company was the designated RAC for California during the demonstration and had a reputation for denying a large portion of the Medicare inpatient rehabilitation claims it reviewed in the state.

The California Hospital Association welcomed the CMS' choice of Las Vegas-based HealthDataInsights to oversee the Western states in the permanent program and not PRG-Schultz.

California also will be part of the second phase of the RAC

program's rollout, in March 2009. "It is well-known that hospitals in California had challenges during the demonstration stage of the program with the previous program contractor, PRG-Schultz," CHA said in a written statement. "We are gratified that CMS took our concerns into consideration and selected HealthDataInsights to work with California providers during the permanent, national RAC program," CHA said.

In a statement, James McCurry, chairman, president and chief executive officer of PRG-Schultz, said the company was "obviously disappointed in CMS' decision and believes our proposal offered the best value to suit CMS' recovery audit program needs."

The CMS' criteria had been to award contracts in the four RAC regions to the lowest



contingency-fee bidder that satisfied minimum technical requirements, with no single bidder being eligible for a contract award in more than one region. "The company understands from CMS that it received one of the highest technical scores, but was not awarded a contract because it ultimately did not have the lowest contingency fee bid in any region," McCurry said in the statement.

The company's next step is to receive a debriefing from the CMS. "Once we have reviewed the details behind the selections, we will evaluate all of our options related to the RAC procurement," McCurry said. The company was unavailable for further comment.

The three other contractors chosen for the official RAC program were: the Fairfax, Va., office of CGI Technologies and Solutions; the Wilton, Conn., office of Connolly Consulting Associates; and Diversified Collection Services, Livermore, Calif.

HealthDataInsights and Connolly Consulting were both a part of the original RAC demo.

Rep. Lois Capps (D-Calif.), a harsh critic of RACs and of PRG-Schultz in particular, wrote in an e-mail she wasn't particularly surprised to see the recovery audit firm hadn't been selected "given its huge problems during the demonstration program."

## IS THE ECONOMY STRESSING YOU OUT?

Business owners and employees alike are feeling anxious and losing sleep – and all that concern about layoffs, rising costs, and a tumbling stock market is taking a toll. A look at how you can cope. "Looking at things long term, you worry about how you're going to come up with your numbers at the end of the month, it's a stressful time."

While New York area cardiologists have reported a

rise in hospital visits by Wall Street executives complaining of chest pains, Main Street business owners aren't doing much better. According to the American Psychological Association, eight out of 10 Americans are feeling anxious about the economy, with many getting increasingly angry, irritable, and fatigued.

All that built-up anxiety is taking a toll on workplace productivity. According to Workplace Options, a work-life services firm based in Raleigh, N.C., roughly half of 711 adults surveyed said recent financial stress was making it hard for them to perform well on the job,



**Continued on pg. 3— The Economy**

## THE ECONOMY...CONTINUED FROM PAGE 2

citing rising anxieties over everything from personal day-to-day expenses to retirement savings.

"Financial problems affect emotional and physical health, and ultimately trickle down to the workplace, where employees must juggle these worries with hectic schedules,"

Yet, with so many forces at play, what's an employer to do? According to Kathleen Hall, the founder of the

Atlanta-based Stress Institute and a former Wall Street broker, everyone needs to step back and take a breather, for starters.

"Stress is like battery acid on the brain," says Hall, "But there are some amazingly simple low-cost things employers can do to relief stress at the office," she says.

Among other approaches, Hall recommends taking the time to listen to quiet music, which studies have shown directly affects brain waves and gives your immune

system an immediate boost. Just memorizing and repeating a positive affirmation can also lower cortisol levels that cause stress. She also prescribes healthy eating and regular activity, like walking around your office building or climbing a fleet of stairs, rather than taking the elevator. Texting or emailing friends, or just sharing lunch with a co-worker, can raise oxytocin and endorphins levels, Hall says.

"Responsible CEOs and business owners need to accept that these pressures are going to affect their bottom line. They've got to be aware of how their staff is coping and what they can do to help," she says. "Sometimes you just need to sneak away and get a panoramic view of things," she says. "Even just seeing a busy restaurant let's you know that people are still spending out there, and that's reassuring."

## 2009 CODING CHANGES

For CPT 2009, there are 291 new codes, 375 revised codes, and 95 deleted codes. Significant additions, deletions, and revisions have occurred in the sections relating to pediatric and neonatal critical care services, administration of vaccines and toxoids, cardiac monitoring, infusion, chemotherapy

administration, diagnostic injection, and the treatment of end-stage renal disease.

In addition, there have been numerous clarifications of "commonly used definitions," "cross-referencing," and "section guidelines" to eliminate or reduce misinterpretation. For instance, added to "definitions of commonly used terms" under evaluation and

management is the phrase "other qualified health-care professionals." Make certain to read the instructions carefully at the beginning of each section, even if the section contains codes that have not changed. In addition to added, deleted, or revised codes, there are numerous grammatical revisions without cross-referencing.



## RUNNING A SUCCESSFUL CDIP

Clinical documentation improvement programs can enhance the clinical record and capture lost reimbursement. But they can be a challenge. Getting physician buy-in, avoiding turf wars between documentation specialists, coders, and nurses, and measuring program success are just a few of the challenges many facilities face with their programs. Below are a few tricks of the trade on running

a successful CDIP, lent by experienced clinical documentation specialists.

**Physician Cooperation**

- Find a physician champion, since physicians will usually listen to other physicians. Approach those physicians with excellent documentation practices and an interest in coding issues.
- Start off the program slow, gradually integrating different departments and

groups of physicians, says Linda Haynes, RHIT, documentation specialist with Legacy Health Systems, located in Portland, OR. Assure physicians you are not trying to change the way they practice medicine. Be persistent and patient. Some physicians will follow the CDIP for a while, then slack off answering queries, says Lori Schmitz, RHIA, the DRG coordinator with Mississippi Baptist Health System, based in Jackson, MI.

- Physician education is key. Attend their staff meetings; put up flyers and posters in the physician's lounge and dictation areas. Create pocket cards with documentation reminders by specialty, Schmitz suggests.

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- *Worker's Compensation Reviews*

**MAKING A DIFFERENCE WHERE IT COUNTS...**

**CDIP...CONTINUED FROM PAGE 3**

- Illustrate how better documentation more accurately reflects risk of mortality and severity of illness, says Joan Enloe, RHIT, director of medical information, documentation integrity and utilization management at Greenville Memorial Hospital, in Greenville, SC. This shows that the CDIP is about more than reimbursement—it results in better care and a clearer physician report card.

**Avoiding Turf Wars**

- Getting clinical documentation specialists and coders to get along can be tricky. This may happen most frequently when the CDSs are nurses. Try using a facility's coding auditor or coding specialist as the go-between. This has worked great at Legacy Health Systems, Haynes says, as the coding auditor is seen as an expert in both coding and clinical information.
- Hold a "meet and greet" session in neutral territory (perhaps off-site) so

that coders and CDSs can get to know each other, recommends Joyce Leppo, CCS, inpatient coder with Gettysburg Hospital, in Gettysburg, PA.

- Show respect. Acknowledge that each side has something to learn from the other, says Betty Bean, RHIA, consultant with HealthPort, based in Clarksville, AR. Include both CDSs and coders in the program planning process. This builds teamwork from the start, says Colleen Lunski, RN, clinical documentation specialist at Altru Health System in Grand Folks, ND.

**Measuring Success**

- Track as much information as you can about your program, using statistics to mark improvements and downtrends, says Joan Enloe, RHIT, director of medical information, documentation integrity and utilization

management at Greenville Memorial Hospital, in Greenville, SC.

- Track physician response rates and present those to the medical staff advisory board, Enloe says.
- Don't measure productivity solely on the number of queries submitted. Fewer queries could mean physician acceptance of the program. More queries could mean less acceptance.
- Do a post-discharge review of the chart to ensure that all documentation obtained by query was considered for coding, Haynes says.

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