**Application (30 points):**

The health information management team at Anywhere University Hospital (AUH) contracted with an auditing firm to perform full assessment coding review. The results from this baseline assessment are provided in four tables:

* Variation Log by Type of Error
* Variation Log by Coder
* Variation Log by MS-DRG
* MS-DRG Relationship Assessment

You are the inpatient coding manager at AUH. Your director has asked you to **develop an ongoing review and monitoring schedule for the next year based on the results from the outside review.**

Include internal and external reviews, coding in-services, physician workshops, and external seminars/educational sessions that will be performed and or provided for your staff. The schedule should be specific (include volumes and/or percentages of charts to be reviewed). Keep in mind that on average it takes 18 minutes to review one inpatient chart. Budget provides for $15,000 for external reviews. The average cost for reviewing one inpatient record by an external review team is $55.00 (fully loaded).

**There are 3 primary components I'm looking for in your response.**

1. Review the results of the external audit (coder error rate, high volume/high error MS-DRGs, MS-DRG sets with greatest deviations, areas of concern identified in the audit), identify the risk areas, and determine an audit and training plan for the year. Include details on the frequency of charts to be audited by the external auditor, Coding Manager and Data Quality Auditor taking the $15,000 budget into consideration. Describe the frequency and type of education to be provided for the coders & physicians (i.e., monthly, annually, etc.).

**(20 points)**

* 1. Considerations:
		1. Will the entire budget be used for external audits, split between education and audits, etc.?
		2. How is the work to be divided between the external & internal auditors?
		3. What MS-DRGs or focus areas are to be reviewed (refer to the external audit findings)? Possibly those identified by the external audit with greater error rates?
		4. Will specific attention be given to the coders with higher error rates and/or new coders?
		5. What is the plan for physician education?
1. What coding quality statistics (i.e., coder error rate, MS-DRG sets, etc.) should be monitored and reported to the HIM Director and Compliance? **(6 points)**
	1. The data quality auditor could maintain coding quality logs similar to the ones produced by the external auditor. Monitor the same stats including coder error rate, error rate by DRG, reasons for DRG changes (Omission CC, etc.). This would make for easy comparison from month to month, quarter to quarter, and such.
	2. The statistics should be easy for the data quality manager to maintain, perhaps in a database or spreadsheet format. The time it takes to maintain statistics should not be a significant amount of time per day.
2. What reward & incentive plan should be used for the coders who improve and/or consistently meet or exceed the standard of 95% compliance? **(4 points)**
	1. There is not a right or wrong answer on this so be creative. Think of incentives you appreciate at current or previous positions.
	2. Example: A coding team worked very hard to lower the “days from discharge to coding”. As a reward, the CEO/President of the hospital came to the department, shook each coder’s hand, and thanked them all for their hard work. He also expressed how important their position was to the hospital and to the patients.
	3. Perhaps the coding manager could request that some of the budget be set aside for incentives. If the entire $15,000 is not used for external reviews, then could some of that be used for the employees?

**Your Coding Team consists of:**

 Coding Manager (you)

 Data Quality Auditor (1 FTE)

 8 – Inpatient Coders (8 FTE)

 2-RHIA, CCS

 3-CCS

 3-RHIT

**Results of the full assessment coding review for AUH**

Two audits were performed:

1. Coding quality review by MS-DRG

2. MS-DRG Relationship Analysis

|  |  |
| --- | --- |
| **Variation Log by Type of Error** | **% of errors** |
| Inaccurate sequencing or specificity principal diagnosis, affect MS-DRG | **17%** |
| Inaccurate sequencing or specificity principal diagnosis, non affect MS-DRG | **16%** |
| Omission CC, affect MS-DRG | **33%** |
| Omission CC, non affect MS-DRG | 2% |
| Inaccurate principal procedure, affect MS-DRG | 3% |
| Omission procedure, affect MS-DRG | 4% |
| More specific coding of diagnosis or procedure, non affect MS-DRG | **12%** |
| Inaccurate coding | 5% |
| Missed diagnosis or procedure code | 8% |

|  |
| --- |
| **Variation Log by Coder** |
| **Coder** | **Error Rate** | **Standard** |
| Coder 1 | 3% | 5% |
| Coder 2 | **9%** | 5% |
| Coder 3 | **8%** | 5% |
| Coder 4 | 2% | 5% |
| Coder 5 | 4% | 5% |
| Coder 6 | **16%** | 5% |
| Coder 7 | **12%** | 5% |
| Coder 8 | 3% | 5% |

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| **Variation Log by MS-DRG\*** |
| **MS-DRG** |  **Volume**  | **Error Rate** |
| 470 | 420 | 2% |
| 313 | 233 | 14% |
| 392 | 232 | 1% |
| 291 | 232 | 17% |
| 247 | 220 | 3% |
| 292 | 216 | 5% |
| 871 | 213 | 12% |
| 641 | 209 | 0% |
| 194 | 195 | 3% |
| 293 | 193 | 1% |
| 885 | 188 | 3% |
| 312 | 177 | 0% |
| 191 | 175 | 7% |
| 287 | 173 | 2% |
| 310 | 171 | 15% |
| 689 | 157 | 11% |
| 603 | 143 | 2% |
| 379 | 137 | 3% |
| 192 | 131 | 9% |
| 683 | 116 | 11% |
| 189 | 114 | 1% |
| 069 | 110 | 2% |
| 190 | 92 | 12% |
| 193 | 87 | 10% |
| 690 | 76 | 4% |
| 065 | 76 | 5% |
| 195 | 72 | 2% |
| 066 | 52 | 2% |
| 064 | 41 | 5% |
| 906 | 35 | 2% |

\*MS-DRG descriptions provided below

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| **Variation Log by MS-DRG\* Set** |
| MS-DRG Set | Hospital % | Nation % |
| 064 | 24.3% | 21.4% |
| 065 | 45.0% | 43.8% |
| 066 | 30.8% | 34.8% |
|  |
| 190 | 23.1% | 15.2% |
| 191 | 44.0% | 33.5% |
| 192 | 32.9% | 51.3% |
|  |
| 193 | 24.6% | 17.5% |
| 194 | 55.1% | 54.2% |
| 195 | 20.3% | 28.3% |
|  |
| 291 | 34.6% | 29.2% |
| 292 | 36.7% | 38.8% |
| 293 | 28.8% | 31.9% |
|  |
| 689 | 67.4% | 21.7% |
| 690 | 32.6% | 78.3% |

\*MS-DRG descriptions provided below

|  |  |
| --- | --- |
| **MS-DRG** | **MS-DRG Title (FY 2008)** |
| 064 | Intracranial hemorrhage or cerebral infarction w MCC |
| 065 | Intracranial hemorrhage or cerebral infarction w CC |
| 066 | Intracranial hemorrhage or cerebral infarction w/o CC/MCC |
| 069 | Transient ischemia |
| 189 | Pulmonary edema & respiratory failure |
| 190 | Chronic obstructive pulmonary disease w MCC |
| 191 | Chronic obstructive pulmonary disease w CC |
| 192 | Chronic obstructive pulmonary disease w/o CC/MCC |
| 193 | Simple pneumonia & pleurisy w MCC |
| 194 | Simple pneumonia & pleurisy w CC |
| 195 | Simple pneumonia & pleurisy w/o CC/MCC |
| 247 | Perc cardiovasc proc w drug-eluting stent w/o MCC |
| 287 | Circulatory disorders except AMI, w card cath w/o MCC |
| 291 | Heart failure & shock w MCC |
| 292 | Heart failure & shock w CC |
| 293 | Heart failure & shock w/o CC/MCC |
| 310 | Cardiac arrhythmia & conduction disorders w/o CC/MCC |
| 312 | Syncope & collapse |
| 313 | Chest pain |
| 379 | G.I. hemorrhage w/o CC/MCC |
| 392 | Esophagitis, gastroent & misc digest disorders w/o MCC |
| 470 | Major joint replacement or reattachment of lower extremity w/o MCC |
| 603 | Cellulitis w/o MCC |
| 641 | Nutritional & misc metabolic disorders w/o MCC |
| 683 | Renal failure w CC |
| 689 | Kidney & urinary tract infections w/ MCC |
| 690 | Kidney & urinary tract infections w/o MCC |
| 871 | Septicemia w/o MV 96+ hours w MCC |
| 885 | Psychoses |
| 906 | Hand procedures for injuries |