Integrating Performance **Excellence & Business Strategy**

Managing Coding, Audit & CDI

In the business of healthcare, it is vital that hospitals, health systems and physicians adhere to accurate coding and billing processes. That includes relevant documentation of medical records, precise application of billing codes, and proper charging of insurers for medical services rendered.

////////CHALLENGES TODAY



Medical Billing Errors

Grace Period Over

on October 1, 2016

Anywhere from 30 to 80% of medical bills from hospitals, outpatient facilities and physician offices are estimated to have errors.

greater specificity about diagnoses and procedures, but

where CMS and commercial payers offered more latitude

also additional complexities. The year between Oct. 1,

2015, and Oct. 1, 2016, was designed as a grace period



on claims details.

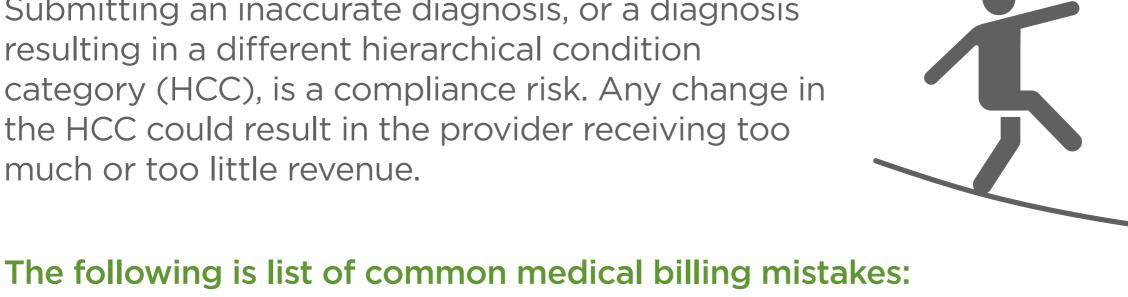
2017 Changes to ICD-10 That Went Into Effect

Transition from ICD-9 code set to ICD-10 provided

• 6,000 new codes were released at once Coders are not trained

- Shortage of coders overall
- Lack of experienced coders could lead to errors and denials, negatively impacting revenue

Submitting an inaccurate diagnosis, or a diagnosis resulting in a different hierarchical condition category (HCC), is a compliance risk. Any change in the HCC could result in the provider receiving too much or too little revenue.





a legible signature with credential.

The most precise

ICD-10-CM code

wasn't used to fully

description of the

explain the narrative

symptom or diagnosis

The record does

not contain



(not electronically signed). Discrepancy was

the diagnosis codes

found between

being billed vs.

health record (EHR)

was unauthenticated

The electronic



in the chart. **Documentation** doesn't indicate the diagnoses are being monitored,

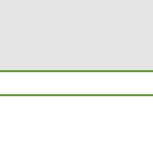
evaluated, assessed/

Chronic conditions

are not documented

as chronic, impacting

addressed, or treated.



the actual written description in the medical record. Status of cancer is

unclear. Treatment

is not documented.



Medicare Risk Adjustment Factor (RAF) scores. 9 **Chronic conditions**

or status codes aren't

documented in the

least once per year.

medical record at



A link is missing for a diabetic

there is a failure to

report a mandatory

manifestation code.

complication, or

10

Lack of specificity





Clinical documentation integrity (CDI) is important—

for hospitals and physician practices—coding is only

as accurate as the documentation of the medical

record. Patient care, data integrity, compliance and

detailed. That's why more providers rely on the CDI

//////// REDUCING RISK

reimbursement are at risk when the severity of illness, treatment provided and mortality rates aren't



strategic vision.

team to support medical necessity of the services provided, quality care and patient safety measures. Auditing measures reimbursement accuracy, ensures compliance adherence and achieves quality assurance while reviewing procedures to ensure that the correct diagnosis related code (DRG) is assigned so the correct reimbursement is received. Areas of focus for CDI: Clarify conflicting, incomplete and non-specific documentation

- and treatment for diagnosis or procedure documented Ensure the SOI (severity of illness) and ROM (risk of mortality)
- are accurate Collaborate with others on healthcare team to support quality
- measures, patient safety and LOS (length of stay) management

Ensure documentation supports the clinical indications

Navigant's Coding, Audit and CDI Solutions Offer Measurable and Sustainable Results

Wide array of services offers combined quality and compliance

Proprietary and innovative technology accelerates task completion

- with savings CDI provides clean billing environment
- Audit reveals opportunities for accurate reimbursement Experienced professionals address complex issues