



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6150.38A CH-1
BUMED-M3
27 Sep 2016

BUMED INSTRUCTION 6150.38A CHANGE TRANSMITTAL 1

From: Chief, Bureau of Medicine and Surgery

Subj: CODING PROGRAM STANDARD BUSINESS PRACTICES, PROCESSES, AND REPORTING GUIDELINES

Encl: (1) Revised pages 5 and 6 of the basic instruction
(2) Revised page 1 of enclosure (1)
(3) Revised page 4 of enclosure (1)
(4) Revised page 1 of enclosure (2)
(5) Revised page 2 of enclosure (3)
(6) Revised page 6 of enclosure (3)
(7) Revised page 15 of enclosure (3)
(8) Revised pages 19 and 20 of enclosure (3)
(9) Revised pages 29 and 30 of enclosure (3)
(10) Revised pages 35 and 36 of enclosure (3)
(11) Revised page 1 of enclosure (4)

1. Purpose. To update the language in anticipation of the implementation of the new electronic health record (EHR) and to reflect recent changes of the International Classification of Diseases, Ninth Revision (ICD-9) to the International Classification of Diseases, Tenth Revision (ICD-10) code set.

2. Action

- a. Remove pages 5 and 6 of the basic instruction and replace with enclosure (1) of this change transmittal.
- b. Remove page 1 of enclosure (1) and replace with enclosure (2) of this change transmittal.
- c. Remove page 4 of enclosure (1) and replace with enclosure (3) of this change transmittal.
- d. Remove page 1 of enclosure (2) and replace with enclosure (4) of this change transmittal.
- e. Remove page 2 of enclosure (3) and replace with enclosure (5) of this change transmittal.
- f. Remove page 6 of enclosure (3) and replace with enclosure (6) of this change transmittal.
- g. Remove page 15 of enclosure (3) and replace with enclosure (7) of this change transmittal.

h. Remove pages 19 and 20 of enclosure (3) and replace with enclosure (8) of this change transmittal.

i. Remove pages 29 and 30 of enclosure (3) and replace with enclosure (9) of this change transmittal.

j. Remove pages 35 and 36 of enclosure (3) and replace with enclosure (10) of this change transmittal.

k. Remove page 1 of enclosure (4) and replace with enclosure (11) of this change transmittal.

3. Review and Effective Date. Per OPNAVINST 5215.17A, this instruction will be reviewed annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, SECNAV, and Navy policy and statutory authority using OPNAV 5215/40, Review of Instruction. This instruction will automatically expire 5 years after effective date unless reissued or canceled prior to the 5-year anniversary date, or an extension has been granted.

4. Retain. For record purposes, keep this change transmittal in front of the basic instruction.


TERRY J. MOULTON
Acting

Releasability and distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site:

<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>

(2) Monitor MTF compliance with policy and procedures identified in this instruction and per references (d) through (i) and enclosures (1) and (2). Assist MTFs with the implementation of requirements associated with this instruction.

(3) Ensure MTF under their cognizance follow coding hotline business rules so that all coding issues are posted to the coding hotline. Ensure the NAVMED Regions MRA provides a response to all coding questions within 5 working days of receipt.

(4) Provide MTFs with guidance and support in utilizing the current DoD electronic health record (EHR) or applicable system to support optimal performance and productivity outcomes for the MTFs.

(5) Coordinate with Navy Medicine Education and Training Command (NMETC) to ensure the current version of the International Classification of Diseases (ICD), CPT, and HCPCS code table updates have been synchronized and installed in the MTF's information systems. Provide BUMED with a completed status report for MTFs under their AOR by 31 January and 31 October each year.

d. NMETC

(1) NMETC will support BUMED with the policies and procedures set forth in this instruction. NMETC will ensure the availability of technological support for a Web-based informational exchange platform including, but not limited to, the clinical coding section of the NAVMED DQMC Web site, serving providers, coders, data quality managers, and NAVMED Regions.

(2) NMETC will work with NAVMED Regions and the MTFs to ensure that notification of system updates is provided in a timely fashion to ensure that data completion can be accomplished prior to installation of updates or change packages.

(3) NMETC will work with BUMED-M3B13 to ensure applicable curricula are updated to reflect the policies and procedures in this instruction.

e. MTFs

(1) Enforcement of a closed medical record system, references (g) and (j), will ensure documentation availability when it is necessary for patient care and administrative purposes. Patient care will be documented at all Navy MTFs accurately, completely, and timely. Reference (i) is available at: <http://www.med.navy.mil/directives/Pages/NAVMEDP-MANMED.aspx>.

(2) Review all third party claims prior to being submitted to a third party payer. This 100-percent review, to resolve discrepancies between clinical documentation and actual coding of the encounter, will include Other Health Insurance (OHI) for the Third Party Outpatient Collections System (TPOCS)/Medical Services Account (MSA) and Medical Affirmative Claims Program (MACP) claims.

(3) Train all personnel involved in record management activities including handling, storage, and retrieval of health care documentation, as stated in reference (j).

(4) Ensure auditors/trainers and coders have the most up-to-date materials, to include but not limited to DoD Coding Guidelines, tables, and files, ICD manual, CPT manual, HCPCS manual, Diagnosis Related Group (DRG) manual, inpatient encoder grouper software, medical dictionary, book of common medical abbreviations, Physician Desk Reference and The CPT Assistant, American Hospital Association (AHA) Coding Clinic, and HCPCS Coding Clinic.

(5) Ensure that coding and billing functions are not completed by the same person or by personnel reporting to the same supervisor.

9. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per reference (l).

10. Reports

a. The reports in paragraph 7b(3) and paragraph 8b(5) are exempt from reports control per reference (k), Part IV, Paragraph 7n.

b. The report in paragraph 8b(1) is authorized by reference (k).

11. Forms. The following forms are available electronically on the Navy Medicine Web site at: <http://www.med.navy.mil/directives/Pages/NAVMEForms.aspx>:

a. NAVMED 6150/44 (01-2010), Inpatient Coding Audit Worksheet.

b. NAVMED 6150/45 (03-2013), Outpatient/APV Coding Audit Worksheet.

c. NAVMED 6150/47 (01-2010), IPS RNDS Coding Audit Worksheet.

d. NAVMED 6150/48 (01-2010), Inpatient Coding Audit Summary.

e. NAVMED 6150/49 (03-2013), Outpatient/APV/IPS RNDS Coding Audit Summary.

/S/

M. L. NATHAN

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<http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>

PROVIDER QUERY GUIDELINES OVERVIEW

In today's changing health care environment, Health Information Management (HIM) professionals face increased demands to produce accurate coded data. Therefore, establishing and managing an effective provider *query* process is an integral component of ensuring data integrity. A provider *query* is defined as a question posed to a provider to obtain additional, clarifying documentation to improve the specificity and completeness of the data used to assign diagnosis and procedure codes in the patient's health record. Documentation can be greatly improved by a properly functioning provider query process.

Querying providers is a standard process in the private sector. Implementing a similar practice in NAVMED should not impact the timely completion of the patient record and is expected to generate more complete and accurate documentation. Accurate coding and the fullest workload capture is a direct result of complete, accurate, and timely clinical documentation. This guidance offers NAVMED HIM professionals important factors to consider in the development and management of an effective provider query process. It is intended to offer guiding principles and best practices in implementing a provider query process.

American Health Information Management Association (AHIMA) *Standards for Ethical Coding* indicates:

Query provider (physician or other qualified health care practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g., present on admission indicator).

Additionally, the current version of the International Classification of Diseases includes commentary regarding the provider query process. ICD Official Guidelines for Coding and Reporting document is approved by the four organizations that make up the ICD Cooperating Parties: The American Hospital Association, the American Health Information Management Association, the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics.). The Guidelines may be used as a companion document to the official current version of the ICD coding conventions and instructions.

MTF medical record departments use the following references to assign diagnoses and procedure codes:

- Facility Services Coding: *Military Health System Inpatient Coding Guidelines*
- Professional Services Coding: *Military Health System Professional Services and Specialty Coding Guidelines*
- Current version of ICD Official Guidelines for Coding and Reporting
- Principles of CPT Coding, American Medical Association
- Coding Clinic for the current version of the ICD, American Hospital Association
- *Coding Clinic for HCPCS*, American Hospital Association
- *CPT Assistant*, American Medical Association
- *CPT*, Fourth Edition–Edition in effect for Dates of Service being audited
- Medical Dictionary
- Healthcare Common Procedure Coding System (HCPCS)
- CCE Coding Reference Library
- *AHIMA Code of Ethics*
- The Joint Commission Standards (IM 7.2, 7.6, and 7.10)
- Medicare Conditions of Participation

Expectations for Documentation

The primary purpose of health record documentation is continuity of patient care, serving as a means of communication among all health care providers. Documentation is also used to evaluate the adequacy and appropriateness of quality care, provide clinical data for research and education, and support reimbursement, medical necessity, quality of care measures, resource and workload utilization, reporting for services rendered by an MTF.

General Principles for Provider Queries

- Concurrent vs. Retrospective. Determine if providers must be queried during the patient's hospital stay (concurrently) or after discharge (retrospectively). A concurrent provider query has the advantage of allowing the information to be incorporated directly into the medical record before the patient is discharged. *Concurrent* provider queries are initiated "real time," during the course of the patient encounter or hospitalization, at the time the documentation is naturally done. They thus encourage more timely, accurate, and reliable responses. *Retrospective* provider queries are effective in cases where additional information is available in the health record, in short stays where concurrent review was not completed, or whenever a concurrent provider query process is not feasible.
- Standardized Tool. If deemed appropriate, use a generic provider query tool approved by the local Medical Records Committee and Forms Committee, to request more information from the provider. (Facilities might determine that they need condition-specific provider query tools in addition to a generic provider query tool.) Do not use "sticky notes," scrap paper, or other miscellaneous tools for a provider query.

INPATIENT AND OUTPATIENT CODING PROTOCOL PLAN

1. Coding Protocol Plan. Each MTF must develop a coding protocol plan and submit to the respective Navy Medicine (NAVMED) Region Command for annual review by 31 December. The purpose of the inpatient and outpatient coding protocol plan is to establish guidelines for daily business practices at all levels of responsibility for documenting patient care and ensuring BUMED policies are effectively executed. The MTF coding protocol plan should ensure the patient care documentation process is efficient and accurate and should include the elements defined below:

- a. Policy. A general policy statement about the commitment of the facility to correctly assign and report codes.
- b. Ethics. A statement clarifying that codes will not be assigned, modified, or excluded solely for the purpose of maximizing reimbursement. Clinical codes will not be changed or amended due to provider or patient requests to have particular services covered by insurance. If the initial code assignment does not reflect the actual services documented in the medical record, codes may be revised based on supporting documentation. The coding supervisor will handle disputes regarding coding with either providers or patients. The coding supervisor will determine the appropriate code to be used or action to be taken. If necessary the issue should be logged and presented for review by the Medical Record Review Committee (MRRC).
- c. References or Resources. Source of the official coding guidelines used to direct code selection. (List MTF's ICD, CPT, and HCPCS Level II Code publications; MHS Guidelines for Inpatient Coding.) Resources may include additional references such as a medical dictionary, anatomy or physiology textbook, Physician's Desk Reference, etc..
- d. Training and Education. MTF's initial and annual clinical coding training plan as well as the process to determine clinic specific training. The training should include acceptable documentation practices, coding practices, and regulatory requirements pertaining to coding and clinical documentation.
- e. Responsible Personnel. Ultimate responsibility for code assignment lies with the physician or privileged provider. However, policies and procedures may indicate instances where codes may be selected or modified by other authorized individuals. Ensure these individuals are identified as follows:

(1) Personnel within the MTFs (e.g., PAD and management information departments) who ensure updates of ICD and CPT code tables in the current DoD EHR or applicable coding system.

(2) Personnel who maintain current coding and documentation references.

2. Overview of Medical Coding Audit Requirements and Guidelines

These *Navy Medicine Standard Coding Audit Requirements and Guidelines* provide guidance for conducting coding audits and medical record reviews. Coding audits are conducted to determine whether the medical record documentation reasonably supports the diagnostic and procedural codes assigned. Coding audits are currently required by two separate Department of Defense instructions to determine coding accuracy, completeness, and timeliness. Those two Department of Defense instructions are:

DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," November 26, 2002

DoD Instruction 6040.42, "Management Standards for Medical Coding of DoD Health Records," June 8, 2016

These DoD-mandated audits offer visibility into departmental operations and coding processes. After completion of the audits, feedback meetings are necessary to review the findings and discuss corrective actions to improve coding and documentation based on any issues identified. If coding shows improvement from one quarter to the next, the facility can be relatively confident it is getting the most from its audits.

2.1. Audit Reference Materials. Navy Medicine medical treatment facilities (MTFs) will conduct monthly documentation and coding audits for inpatient, outpatient, APV, and inpatient professional service (IPS) records to determine coding accuracy.

a. Coder/auditors must follow the coding guidelines established by the MHS as follows:

- Facility Services Coding: *Military Health System Inpatient Coding Guidelines*
- Professional Services Coding: *Military Health System Professional Services and Specialty Coding Guidelines*

b. Supplemental Auditing Guidelines. If there are no guidelines specific to the MHS outlined in the references above, the coder/auditor will refer to the following publications as definitive references:

- The current version of the ICD Official Coding Guidelines
- *Principles of CPT Coding*, American Medical Association
- Coding Clinic for the current version of the ICD, American Hospital Association
- *Coding Clinic for HCPCS*, American Hospital Association
- *CPT Assistant*, American Medical Association
- *CPT*, Fourth Edition – Edition in effect for Dates of Service being audited
- Medical Dictionary
- Healthcare Common Procedure Coding System (HCPCS)
- Coding Compliance Editor (CCE) Coding Reference Library

2.3.1. Calculations and Formulas

Calculations and formulas (and some practical examples on how to apply them in specific audit situations) are supplied in order to develop uniformity and consistency in audit data. (For example, when calculating *CPT* accuracy, some MTFs audit only the first-listed *CPT* for an encounter, while other MTFs review all the *CPT* codes assigned to an encounter. Having a clear set of calculations and formulas will make it easier to compare data between MTFs.)

Calculations and formulas are provided to determine the accuracy of one individual chart in an audit sample. “Roll-up” calculations and formulas are also provided to aggregate the accuracy figures when reporting the collective cross-sample level of accuracy for a particular audited element.

Because past reporting has indicated both over reporting and under reporting of services, standard audit calculations need to quantify any over coding errors and under coding errors.

Accuracy calculations must use a denominator that is the *sum* of the number of codes that were reported originally by the coder *plus* the number of codes that were found to be missing by the coder/auditor. For example:

Thirty charts were audited and there were 75 CPT codes reported of which 70 were found to be correctly linked to all appropriate ICD codes. Seventy is divided by the combined total of 75 original CPT codes plus 8 additional CPT codes that were found by the coder/auditor but which were missed by the original coder (75 + 8 = 83). 70 divided by 83 equals 84.3 percent accuracy.

2.3. Targeted Audits

Targeted audits are usually triggered by an actual or perceived problem area or to monitor compliance with new coding guidance or standards. These audits identify individual or focused training needs such as The Joint Commission ORYX measures, present on admission indicators, “high volume” and “high RVU” records. For the purpose of targeted audits, providers that fall into categories other than Skill Type 1 or Skill Type 2 may be included as necessary. A minimum of one targeted audit must be performed at each MTF annually.

2.4.1. Elements of Targeted Audits. Below are some recommended data elements for a targeted audit. A random audit may identify that there is a problem, but a targeted audit provides greater audit granularity to identify the scope or specific root cause of the problem. Because targeted audits are based on issues identified by the MTF as needing assessment or quantification, the number of records needed to investigate the issues will be highly variable. It is therefore left to the discretion of the MTF to determine a statistically valid sample size and audit sample timeframes for targeted audits and to obtain a sample size during a timeframe that delivers a comfort level that any identified issues of concern are indeed being adequately measured.

4. Outpatient Audit Methodology. It is desirable to have an otherwise random sample of charts within the targeted sample selected for review.

a. Develop Audit Selection Criteria. Determine what type of audit will be conducted based on what item(s) you want to study.

b. Request Supporting Documentation. Provide the list of charts to the medical records department for them to pull. The medical records department will either send them to the coder/auditor or the coder/auditor will retrieve the encounters/charts from the medical record department. Because outpatient documentation involves a hybrid of paper and electronic documentation, the audit can be done in the current DoD EHR or applicable system.

c. Reconcile the Requested Sample to the Sample Received. The coder/auditor checks off the chart against the list of charts provided to the medical records department.

d. Conduct Audit. The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. Patient sex, age, and disposition type for each chart must be verified for accuracy.

e. Record Audit Findings. The coder/auditor will record the audit findings in NAVMED 6150/45 (03-2013), Outpatient/APV Coding Audit Worksheet; available from Naval Forms Online at: <https://navalforms.documentservices.dla.mil/>. Discrepancies identified with patient sex, age, and disposition type must be recorded in the comment field of the worksheet.

f. Record Coder/auditor Comments. If there is any disagreement between submitted and audited codes, the coder/auditor will provide a detailed explanation of why the audited code was selected in comparison to the submitted code. Auditor explanation must cite the referenced coding source(s).

g. Record Audit Statistics. The coder/auditor records the difference (+/-) between audited RVU/RWP and original RVU/RWP from CCE. The difference will be entered in the change field of the worksheet.

h. Write Audit Report. The coder/auditor will write a report summarizing the purpose, methodology, findings, and recommendations of the audit.

i. Feedback Meeting. The coder/auditor will prepare an audit report with an Executive Summary to list identified trends in documentation and error rates and recommendations for improvement. The Executive Summary must be provided to the MTF designee(s) and must include NAVMED 6150/49 (03-2013), Outpatient/APV/IPS RNDS Coding Audit Summary; available from Naval Forms Online at: <https://navalforms.documentservices.dla.mil/>. The audited record and audit sheets must be retained by the MTF designee(s) for a period of 2 years.

4.3.2 Units of Service Accuracy

The coder/auditor will recode the outpatient encounter and will assign units of service as appropriate. An accuracy rate will be determined by dividing the number of *correct* units of service by the sum total of units of service contained in the union of the set of units of service reported by the original coder and the set of units of service reported by the coder/auditor.

Example: The original coding showed 6 units of service assigned; while the audit showed 7 units of service should have been reported. Dividing the number of correctly coded units of service (6) by the combined total of modifiers reported by coder and the coder/auditor ($7 + 0 = 7$). 6 divided by 7 equals 85.7 percent accuracy.

Roll-up Example: Thirty charts were audited and there were 75 units of service reported of which 70 were found to be correct. seventy is divided by the combined total of 75 original units of service plus 8 additional units of service that were found by the coder/auditor but which were missed by the original coder ($75 + 8 = 83$). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

4.3.3 CPT Code “Linkage” Accuracy

Coders are required to “link” each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate ICD diagnosis codes. An accuracy rate will be determined by dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

Example: The original coding showed 10 CPT codes assigned while an audit determined only 8 of the CPT codes to be correctly linked to all the appropriate ICD diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor ($10 + 0 = 10$). 8 divided by 10 equals 80.0 percent accuracy.

Roll-up Example: Thirty charts were audited and there were 75 CPT codes reported of which 70 were found to be correctly linked to all appropriate ICD codes. Seventy is divided by the combined total of 75 original CPT codes plus 8 additional CPT codes that were found by the coder/auditor but which were missed by the original coder (75 + 8 = 83). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

4.3.4 RVU Changes

Outpatient workload is measured by RVUs. RVUs are directly related to the CPT and E/M codes. The coder/auditor will recode the outpatient service and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU--for a net gain of +0.5936 RVU.

This is a unique metric which does not currently exist in the DQMC standard.

4.4. E/M Calculation (1995) Worksheet. *Use the Evaluation and Management Services Audit Scoresheet Tools as developed by the Marshfield Clinic for use with the CMS 1995 or 1997 Documentation Guidelines for Evaluation and Management Services (depending upon the Outpatient Coding Protocol Plan) as outlined in Section 2.6c of this document.*

Roll-up Example: Thirty charts were audited and there were 75 modifiers reported of which 70 were found to be correct. Seventy is divided by the combined total of 75 original modifiers plus 8 additional modifiers that were found by the coder/auditor but which were missed by the original coder ($75 + 8 = 83$). 70 divided by 83 equals 84.3 percent accuracy.

Modifiers are an important part of coding. It would be appropriate to measure not only that all necessary modifiers are captured and reported but that stray, inappropriate modifiers are not reported.

This is a unique metric which does not currently exist in the DQMC standard.

5.2.2 Units of Service Accuracy

The coder/auditor will recode the outpatient encounter and will assign units of service as appropriate. An accuracy rate will be determined by dividing the number of *correct* units of service by the sum total of units of service contained in the union of the set of units of service reported by the original coder and the set of units of service reported by the coder/auditor.

Example: The original coding showed 6 units of service assigned; while the audit showed 7 units of service should have been reported. Dividing the number of correctly coded units of service (6) by the combined total of modifiers reported by coder and the coder/auditor ($7 + 0 = 7$). 6 divided by 7 equals 85.7 percent accuracy.

Roll-up Example: Thirty charts were audited and there were 75 units of service reported of which 70 were found to be correct. Seventy is divided by the combined total of 75 original units of service plus 8 additional units of service that were found by the coder/auditor but which were missed by the original coder ($75 + 8 = 83$). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

5.2.3 CPT Code “Linkage” Accuracy

Coders are required to “link” each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate ICD diagnosis codes. An accuracy rate will be determined by

dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

Example: The original coding showed 10 CPT codes assigned while an audit determined only 8 of the CPT codes to be correctly linked to all the appropriate ICD diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor (10 + 0 = 10). 8 divided by 10 equals 80.0 percent accuracy.

Roll-up Example: Thirty charts were audited and there were 75 CPT codes reported of which 70 were found to be correctly linked to all appropriate ICD codes. Seventy is divided by the combined total of 75 original CPT codes plus 8 additional CPT codes that were found by the coder/auditor but which were missed by the original coder (75 + 8 = 83). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

5.2.4 RVU Changes

Outpatient workload is measured by RVUs. RVUs are directly related to the *CPT* and E/M codes. The coder/auditor will recode the IPS Round and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU--for a net gain of +0.5936 RVU.

This is a unique metric which does not currently exist in the DQMC standard.

6. Inpatient Professional Services Audit Methodology

a. One calendar day of the attending professional services during each audited hospitalization will be audited from the randomly selected sample. For hospitalizations which begin and terminate the same calendar day, that calendar day will be audited. For all other hospitalizations, the registration number will determine if services for the first or second calendar

Roll-up Example: Thirty charts were audited and there were 75 units of service reported of which 70 were found to be correct. Seventy is divided by the combined total of 75 original units of service plus 8 additional units of service that were found by the coder/auditor but which were missed by the original coder ($75 + 8 = 83$). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.3 CPT Code “Linkage” Accuracy

Coders are required to “link” each *CPT* code assigned to a corresponding diagnosis code(s).

The coder/auditor will recode the outpatient encounter and will link the *CPT* codes to all appropriate ICD diagnosis codes. An accuracy rate will be determined by dividing the number of *correctly-linked CPT* codes by the sum total of *CPT* codes contained in the union of the set of *CPT* codes reported by the original coder and the set of *CPT* codes reported by the coder/auditor.

Example: The original coding showed 10 CPT codes assigned while an audit determined only 8 of the CPT codes to be correctly linked to all the appropriate ICD diagnosis codes. Divide the number of correctly linked CPT codes (8) by the combined total of CPT codes reported by the coder and the coder/auditor ($10 + 0 = 10$). 8 divided by 10 equals 80.0 percent accuracy.

Roll-up Example: Thirty charts were audited and there were 75 CPT codes reported of which 70 were found to be correctly linked to all appropriate ICD codes. Seventy is divided by the combined total of 75 original CPT codes plus 8 additional CPT codes that were found by the coder/auditor but which were missed by the original coder ($75 + 8 = 83$). 70 divided by 83 equals 84.3 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.4 RVU Changes

Outpatient workload is measured by RVUs. RVUs are directly related to the *CPT* and E/M codes. The coder/auditor will recode the IPS Round and compare the audit RVUs to the original RVUs. The coder/auditor will note a gain (+) or loss (-) for each encounter.

Example: Thirty rounds were audited and there were four CPT/E/M code changes. The first change resulted in a gain of +0.7654 RVU; the second resulted in a gain of +0.0476 RVU; the third change resulted in a gain of +0.2568 RVU; and the fourth change resulted in a loss of -0.4762 RVU--for a net gain of +0.5936 RVU.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.5 Rounds Applied to the Correct Service (A MEPRS Code)

For inpatients, a round is coded for the attending physician's services rendered during each 24-hour period (midnight to midnight). Coders review all inpatient documentation for that 24-hour period and determine the attending physician and service (A MEPRS Code). The coder is then responsible for validating the service in ADM for that round. The accuracy of service designation is measured by dividing the number of rounds with the correct service by the total number of rounds audited. The coder/auditor will need MTF MID support to correct any identified errors.

Roll-up Example: Thirty charts were audited and there were 3 that had the round applied to the incorrect MEPRS code. (27 were correct.) Twenty-seven is divided by the combined total of thirty original rounds plus zero additional rounds that were found by the coder/auditor but which were missed by the original coder (30 + 0 = 30). 27 divided by 30 equals 90.0 percent accuracy.

This is a unique metric which does not currently exist in the DQMC standard.

6.3.6 Rounds Applied to the Correct Attending Physician

A round is coded for the attending physician's services rendered during each 24-hour period (midnight to midnight). Coders review all inpatient documentation for that 24-hour period and determine the attending physician. The coder is then responsible for validating the attending physician in ADM for that round. The accuracy of the attending physician designation is measured by dividing the number of rounds with the correct attending by the total number of rounds audited. The coder/auditor will need MTF MID support to correct any identified errors.

Roll-up Example: Thirty charts were reviewed by the coder/auditor and there were 3 that had the round applied to the incorrect attending physician. (Twenty-seven were correct.) Twenty-seven is divided by the combined total of thirty original

ACRONYMS

ADM	Ambulatory Data Module
AHA	American Health Association
AHIMA	American Health Information Management Association
AOR	Area of Responsibility
APV	Ambulatory Procedural Visits
BUMED	Bureau of Medicine and Surgery
CC	Complication and Co-Morbidity
CCE	Coding Compliance Editor
CCS	Certified Coding Specialist
CCS-P	Certified Coding Specialist – Professional
CDI	Clinical Documentation Improvement
CMS	Centers for Medicare and Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer’s Representative
CPC	Certified Professional Coder
CPC-H	Certified Professional Coder – Hospital
CPT	Current Procedural Terminology
DOD	Department of Defense
DQ	Data Quality
DQMC	Data Quality Management Control
DRG	Diagnosis Related Group
EKG	Electrocardiogram
E/M	Evaluation and Management
FHCC	Federal Health Care Center
HAC	Hospital Acquired Condition
H&P	History and Physical
HCO	Health Care Operations
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act
ICD	International Classification of Diseases
IPS	Inpatient Professional Services
MACP	Medical Affirmative Claims Program
MATO	Multiple Award Task Order
MCC	Major Complication and Co-Morbidity
MEPRS	Medical Expense Performance Reporting System
MHS	Military Health System