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

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

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Ref: (a) Health Insurance Portability and Accountability Act (HIPAA) of 1996, (P.L. 104-191)
       (b) BUMED memo 6000 M00 of 1 Oct 2012, Effective Documentation and Coding of Medical Services in Navy Medicine (NOTAL)
       (c) DoD Directive 6040.41 of April 13, 2004
       (d) MHS Professional Services and Specialty Coding Guidelines
       (e) Joint Commission Information Management Standards
       (f) The Office of Inspector General's Compliance Program Guidance for Hospitals, Feb 1998
       (g) DoD Instruction 6040.43 of June 10, 2004
       (h) DoD Instruction 6040.40 of November 26, 2002
       (i) NAVMED P-117, Manual of the Medical Department, Chapter 16
       (j) SECNAV Manual 5214.1 of December 2005
       (k) SECNAV Manual 5210.1 of January 2012

Encl: (1) Physician Query Guidelines
       (2) Inpatient and Outpatient Coding Protocol Plan
       (3) Navy Medicine Standard Coding Audit Requirements and Guidelines
       (4) Acronyms

1. <u>Purpose</u>. The purpose of this instruction is to provide inpatient and outpatient coding program standard business practices, processes, and reporting guidelines. This instruction designates roles and responsibilities for inpatient and outpatient coding and provider query practices. References (a) through (i) and enclosures (1) through (3) are to be used by medical treatment facilities (MTFs) to establish management controls that support management of medical records, reporting responsibilities, and sustainment of accurate health information. Enclosure (3) includes a list of acronyms used in this instruction.

2. <u>Cancellation</u>. BUMEDINST 6150.38 and NAVMED Policy Memo 10-001, NAVMED 6150/46 (01-2010), APV Coding Audit Worksheet; NAVMED 6150/50 (01-2010), Outpatient Coding Audit Summary; and NAVMED 6150/51 (01-2010), APV Coding Audit Summary.

3. <u>Scope</u>. This instruction applies to all MTFs. It is expected that each MTF will design processes that comply with standard business practices, processes, and reporting requirements set forth in this instruction and enclosures (1) through (3). These processes include implementation and oversight of a coding program that incorporates training, auditing, and accurate submission of data.

4. <u>Background</u>. Coding for services rendered within the MTF is critical to providing a detailed and accurate clinical picture of patient population, overseeing population health, assessing quality outcomes and standards of care, managing business activities, and receiving reimbursement for services. Complete and accurate coding requires two critical inputs: that of the clinician who conducts and records the clinical episode, and that of the coder thoroughly versed in coding regulations and standards. The Military Health System (MHS) must meet the same high standards of integrity, compliance, and accuracy regarding health care data required of its civilian counterparts. Implementation of the collection from third party payors for health care services and changes mandated by reference (a) requires extensive inpatient and outpatient change management actions. Reference (a) is available at: http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf.

5. <u>Discussion</u>. Documentation is the key to accurate coding and is critical to Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)) programs such as third party reimbursement, itemized billing, the Data Quality Management Control (DQMC) program and the Health Insurance Portability and Accountability Act (HIPAA). As indicated in reference (b), accurate capture of data that clearly documents the outpatient health care services provided by the MTF is essential. In addition, inpatient and outpatient coding is important for the MTF's ability to manage issues related to population health and financial reimbursement from third party payors. The importance of full compliance with inpatient and outpatient coding standards cannot be overstated. Significant penalties for fraudulent coding and billing practices exist even if the error is unintentional. MTF focus on the auditing of inpatient and outpatient medical records is vital and leads to significant improvements in clinical documentation, health information, and cost recovery.

6. <u>Policy</u>. Clinical episodes throughout Navy Medicine (NAVMED) must be accurately and promptly documented and coded, adhering to legal and medical coding classification standards, as prescribed by references (c) through (e). Reference (c) is available at: http://www.dtic.mil/whs/directives/corres/pdf/604041p.pdf. Reference (d) is available at: http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm. Reference (e) is available in print and electronic formats and can be purchased from The Joint Commission (TJC). MTF managerial controls must be put into place to ensure standard business practices and processes outlined in the applicable enclosures are implemented. The Coding Compliance Editor (CCE) is a tool developed to provide coding edits and references for professional coders. Inpatient records are directly coded into CCE. At this time, Ambulatory Procedural Visits (APV) and inpatient professional services must be directly coded into the Ambulatory Data Module (ADM) and then audited in CCE. All billable encounters must be completed in CCE prior to release for claims processing. While this instruction focuses on some specific components of a compliance plan, it does not meet the complete spectrum of compliance as defined under reference (f). Reference (f) is included to assist MTFs in evaluating their inpatient and outpatient coding programs and is available at: https://www.oig.hhs.gov/compliance/compliance-guidance/index.asp.

7. <u>Responsibilities</u>. The roles and responsibilities of the Bureau of Medicine and Surgery (BUMED), NAVMED Regions, and the MTFs under their cognizance are outlined below.

a. BUMED

(1) Director, Records Management (BUMED-M3B13) develops and provides policy oversight of coding standard business practices, processes, table updates (Provider Specialty, International Classification of Diseases, Current Edition and Current Revision, Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) code table Department of Defense (DoD) Extender Code), system change packages, and reporting requirements through BUMED Health Care Operations (HCO) Directorate, BUMED-M3B13 and TRICARE Management Activity (TMA).

(2) Provides support to MHS through BUMED's representatives to the Uniformed Biostatistical Utility (UBU) on matters related to Health Information Management (HIM) processes, including but not limited to MHS Coding Guidelines, file and table updates, and system changes.

(3) Develops and manages policy for custody, control, and retention of the medical records, reference (g). Reference (g) is available at: http://www.dtic.mil/whs/directives/corres/pdf/604043p.pdf.

(4) Evaluates metrics outlined in reference (h) to assess overall data quality and the requirement to refine medical records documentation to facilitate accurate coding and is available at: http://www.dtic.mil/whs/directives/corres/pdf/604040p.pdf. BUMED-M3B13 provides ongoing analysis of external audit results, coding contract performance reports and other data outputs used to assess documentation and coding outputs.

(5) Provides oversight of all coding training conducted throughout NAVMED.

b. NAVMED Region Commands

(1) Assist BUMED with development of policies and procedures governing implementation and management of coding standard business practices, development of metrics, and interpretation of data as indicated in references (g) through (i) and enclosure (3).

(2) Oversee and assist MTFs with implementation of the policies and procedures defined in this instruction.

(3) NAVMED Regions will summarize issues reported on the Data Quality (DQ) statement by the MTFs within their area of responsibility (AOR) on the DQMC, and develop a corrective plan of action. Copies of all plans of action and quarterly progress reports shall be provided to BUMED-M3B13.

(4) Forward deficiencies and findings to BUMED as directed in reference (f).

(5) Appoint a Coding Program Manager to ensure compliance with this instruction and provide functional oversight over the MTF's inpatient and outpatient coding processes-including Multiple Award Task Order (MATO) contract coding, auditing, and training program guidance.

(a) Monitor coding practices and audit processes within the respective region.

(b) Provide functional and technical coding support to MTFs.

c. MTFs

(1) The MTF commander, commanding officer, or officer in charge will ensure that all clinical documentation, coding, and administrative procedures surrounding patient admissions and encounters are conducted per the requirements of this instruction, applicable State and Federal laws, and TJC standards.

(2) The Patient Administration Department (PAD) officer will ensure compliance with this instruction. The PAD officer is also responsible for maintenance of a closed medical record process within the MTFs AOR and functional oversight over the inpatient and outpatient coding processes, and implementation of the coding practices and audit processes outlined in enclosures (1) and (2). Functional oversight of the coding processes includes program management of the MATO contract for coding, auditing, and training.

(3) The MTF Medical Record Administrator (MRA), preferably a Registered Health Information Administrator (RHIA), or a Registered Health Information Technician (RHIT), credentialed by the American Health Information Management Association (AHIMA) will manage the coding process and assist with the management of a closed medical records system. The MRA or designee shall conduct random and focused audits per enclosure (3). Deficiencies must have corrective action taken when identified.

8. Action. The following programs and processes shall be implemented immediately if not already in place:

a. BUMED-M3B13

(1) Is responsible for development and oversight of policy and training concerning medical record documentation, coding processes, and audit processes.

(2) Will schedule quarterly NAVMED Region Command meetings to address compliance with the implementation of this instruction.

(3) Will have oversight of content for the clinical coding section of the NAVMED DQMC Web site, including, but not limited to, the coding hotline.

b. NAVMED Regions

(1) Provide BUMED with status reports on MTF compliance with coding and auditing plans per enclosure (3).

(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(l) 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/NAVMEDForms.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/
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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.

Especially in light of official coding rules that have been implemented regarding identifying conditions that are present on admission (POA) and conditions that are acquired during the course of the admission, coders, now more than ever, need to clarify clinical information with providers. This means that coders and HIM staff tasked with Clinical Documentation Improvement (CDI) responsibilities need to have a formal, standardized process of querying providers if important information needed to code a chart properly is illegible, incomplete, unclear, inconsistent, or imprecise.

Since reimbursement, workload capture, and clinical data mining all can be driven by how precise diagnostic information is, an opportunity exists to make sure medical treatment facilities (MTFs) are making good use of a provider querying process and are asking the necessary questions to optimize clinical data capture.

Querying a provider is generally limited to situations regarding:

- Legibility. This might include an illegible handwritten entry in the provider's progress notes, and the reader cannot determine the provider's assessment.

- Completeness. This might include a report indicating abnormal test results without notation of the clinical significance of these results (e.g., an x-ray shows a compression fracture of lumbar vertebrae in a patient with osteoporosis and no evidence of injury).

- Clarity. This might include patient diagnosis noted without statement of a cause or suspected cause (e.g., the patient is admitted with abdominal pain, fever, and chest pain and no underlying cause or suspected cause is documented).

- Consistency. This might include a disagreement between two or more treating providers with respect to a diagnosis (e.g., the patient presents with shortness of breath. The pulmonologist documents pneumonia as the cause and the attending documents congestive heart failure as the cause).

- Precision. This might include an instance where clinical reports and clinical conditions suggest a more specific diagnosis than is documented (e.g., congestive heart failure is documented even though an echocardiogram is performed and the results of that procedure provides a more specific clinical diagnosis of chronic diastolic congestive heart failure).

Who to Query

An MTF's provider query policy shall address the question of who to query. The provider query is directed to the provider who originated the progress note or other report in question. This could include the attending physician, consulting physician, or the surgeon. In most cases, a provider query for abnormal test results would be directed to the attending physician. Documentation from providers involved in the care and treatment of the patient is appropriate for code

Enclosure (1)

assignment; however, a provider query might be necessary if the documentation conflicts with that of another provider. If such a conflict exists, the attending physician is queried for clarification, as that provider is ultimately responsible for the final diagnosis.

When to Query

Providers shall be queried whenever there is conflicting, ambiguous, or incomplete information in the health record regarding any *significant* reportable condition or procedure.

Query the 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).

When Not to Query

Codes assigned to clinical data shall be clearly and consistently supported by provider documentation. Providers often make clinical diagnoses that might not appear to be consistent with test results. For example, the provider might make a clinical determination that the patient has pneumonia when the results of the chest x-ray might be negative. Provider queries shall not be used to question a provider's clinical judgment, but rather to clarify documentation when it fails to meet any of the five criteria listed above—legibility, completeness, clarity, consistency, or precision.

A provider query might not be appropriate simply because the clinical information or clinical picture does not appear to support the documentation of a condition or procedure (e.g., documentation of acute respiratory failure in a patient whose laboratory findings do not appear to support this diagnosis). In situations where the provider's documented diagnosis does not appear to be supported by clinical findings, an MTF's policies can provide guidance on a process for addressing the issue without querying the attending physician.

> Example:
>
> *Dr. Harvey: According to the patient's emergency room record from last week, the patient was placed on antibiotics for cellulitis of her leg. If the patient is still taking antibiotics, please document the cellulitis.*

In this case, if this diagnosis was not documented in the current admission and is not affecting the patient's care, it does not meet the definition of a secondary diagnosis. Querying the provider for this *new* information, which does not meet coding and reporting requirements, is inappropriate.

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.

Concurrent **Provider Queries**

HIM coders shall query the patient's providers if opportunities to improve documentation are noted during concurrent review of the patient's record. The query shall be documented on the appropriate approved MTF's query tools.

Providers shall be queried by coders or coding supervisors for:

1. Specificity in documentation.
2. Evaluation of lab data/radiology and other reports such as pathology as to the significance of any abnormalities or findings (and the name of the suspected/treated condition).
3. Agreement and documentation of diagnoses documented by other members of the health care team [i.e., Nutrition, Substance abuse team (if not completed by a physician member of team), Wound Care Team].
4. Co-signature of notes where a co-signature is necessary.
5. Differential diagnoses ruled in/out by discharge.
6. Conditions/procedure names which do not use approved hospital abbreviations.
7. Clarification if there are conflicts of diagnoses between consultant and the attending physician.

Providers shall review and respond to queries within 3 business days

1. If the provider *agrees* with the query, he or she is to document the applicable condition/ procedure on a late entry/addendum documentation.
2. If the provider does *not* agree with the query (i.e. there is no clinical significance for an abnormal lab test), they are to indicate that they "disagree with the query."

Retrospective **Provider Queries**

HIM coders shall query the patient's provider if opportunities to improve documentation are noted during retrospective review of the patient's record. Queries of the attending physician after discharge shall be made only when there is sufficient supporting documentation within the body of the medical record to warrant a provider query. Questions about documentation in the record might arise during the coding process or as a result of a focused audit.

The provider shall be queried in the following situations:

1. Documentation is inconsistent and/or ambiguous, unclear, incomplete, or unspecified or general in nature [AHIMA *Standards of Ethical Coding and Compliance Guidance for Third Party Billing Companies*, 1999].
2. Principal diagnosis (reason for admission, after study) is not clearly identified.
3. Significant case manager queries not answered prior to discharge (e.g., those which would impact severity level).

Enclosure (1)

4. Abnormal diagnostic test results indicate the possible addition of a secondary diagnosis or increased specificity of an already documented condition.
5. Lack of clarity as to whether a condition has been ruled out.
6. Patient is receiving treatment for a condition that has not been documented.
7. The clinical significance of abnormal operative/procedural/pathologic findings is not documented.
8. Pre-determined and agreed upon (with medical staff) clinical criteria are met.
9. Agreement and documentation of diagnoses documented by other members of the health care team [i.e., Nutrition, Substance abuse team (if not completed by a physician member of team), Wound Care Team].

Providers will need to review and respond to retrospective queries within 3 business days.

Provider Query Tool Format

The formats for capturing the provider query include MTF-approved provider query tool, facsimile transmission, electronic communication on secure e-mail, or secure information technology messaging system. A provider query generally includes the following information:

- Patient name
- Admission date and/or Date of service
- Medical record number
- Registration number
- Date provider query initiated
- Name and contact information of the individual initiating the provider query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart (e.g., history and physical states urosepsis, lab reports white blood count (WBC) of 14,400. Emergency department report fever of 102 degrees).
- Directions regarding how to provide the requested documentation clarification.

It is not advisable to record provider queries on handwritten sticky notes, scratch paper, or other notes that can be removed and discarded.

It is recommended that provider queries use precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case. Provider queries that appear to lead the provider to document a particular response could result in allegations of inappropriate "upcoding." The provider query format shall not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption.

A single provider query tool can be used to address multiple questions. If there are multiple questions for one case, the provider is to be alerted that there is more than one provider query requiring a response. A distinct question shall be asked for each issue (e.g., if three questions exist based on clinical indications in the health record, there shall be three distinct questions clearly identified on the provider query tool).

Enclosure (1)

Example: Insulin-dependent diabetes with high blood sugars on admission is documented in a patient with renal failure. The three questions identified on the provider query might be related to type of diabetes (type I or II, or secondary); relationship of diabetes to renal failure; and whether the diabetes is controlled or uncontrolled.

Guidelines in developing provider query language are as follows:

1. In completing the reason for the query on the provider query tool, the coder shall use open-ended questions and allow the provider to render and document his or her clinical interpretation of the diagnosis, condition, procedure, etc. based on the facts of the case. Closed-ended "yes/no" or "leading" questions shall be avoided (See below for Examples of "Leading" Provider Queries).

2. Exceptions to the open ended provider query, when it is appropriate to query for a specific diagnosis include the following:

   a. Positive lab or radiology findings clinically supporting the diagnosis (*Coding Clinic for ICD-9-CM*, 2nd quarter 1998).

   b. Medication is prescribed that supports the specific diagnosis (*Coding Clinic for ICD-9-CM*, 1st quarter 1993 and 2nd quarter 1998).

3. Provide query tools shall not be designed to ask questions about a diagnosis or procedure that can be responded to in a yes/no fashion. The exception is present on admission (POA) provider queries when the diagnosis has already been documented.

4. Finally, the provider query shall never indicate that a particular response would favorably or unfavorably affect reimbursement or quality reporting.

Examples of "Leading" Provider Queries:

In these examples the provider is not given any documentation option other than the specific diagnosis requested. The statements are directive in nature, indicating what the provider shall document, rather than querying the provider for his or her professional determination of the clinical facts.

> **Example 1:**
>
> *Dr. Smith: Based on your documentation, this patient has anemia and was transfused 2 units of blood. Also, there was a 10-point drop in hematocrit following surgery. Please document "Acute Blood Loss Anemia," as this patient clearly meets the clinical criteria for this diagnosis.*

Enclosure (1)

This could be corrected as follows:

Dr. Smith: In your progress note on 6/20, you documented anemia and ordered transfusion of 2 units of blood. Also, according to the lab work done on xx/xx, the patient had a 10-point drop in hematocrit following surgery. Based on these indications, please document, in the discharge summary, the type of anemia you were treating.

Example 2:

Dr. Jones: This patient has Chronic Obstructive Pulmonary Disease (COPD) and is on oxygen every night at home and has been on continuous oxygen since admission. Please document "Chronic Respiratory Failure."

This could be corrected as follows:

Dr. Jones: This patient has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Based on these indications, please indicate if you were treating one of the following diagnoses:

- *Chronic Respiratory Failure*
- *Acute Respiratory Failure*
- *Acute or Chronic Respiratory Failure*
- *Hypoxia*
- *Unable to determine*
- *Other:_____*

To achieve consistency in the coding of diagnoses, procedures, and/or POA indicators, coders must:

1. Follow procedures that result in complete, accurate, and consistent coding and accurately represent the patient's diagnoses, procedures, and/or POA indicators for the relevant episode of care.

2. Adhere to all official coding guidelines as stated in this policy.

3. Assess physician documentation to ensure that it supports the diagnoses, procedures, and/or POA indicators selected.

4. Consult physician for clarification and additional documentation prior to final code assignment when there is conflicting, ambiguous, or incomplete data in the medical record.

    a. Do not use the word "possible" in a query unless specified in the physician documentation.

b. Assist and educate physicians and other clinicians by advocating proper documentation practices to accurately reflect the patient's episode of care.

c. Follow the procedures as outlined in this policy to document an appropriate query.

d. Query the physician if the physician has substantially described a clinical condition but has not made a diagnosis.

Procedure for the Query Process

Any chart awaiting a response to a query should not be finalized until the provider's response is documented on the query tool and/or in the body of the traditional medical record or the physician has responded that no addition to or clarification to the medical record is necessary. Any chart awaiting a response to a query must be held according to the MTF's delinquency timeframe or at a minimum The Joint Commission's (TJC) delinquency timeframe of 30 days post discharge.

> *At a minimum, MTFs should ensure the Provider Query Process is implemented and maintained as it relates to high-volume clinical specialty areas. The Appendix of this document contains a series of tables that can be used to identify the highest volume clinical specialty areas for each MTF.*

Initiating a Provider Query

1. The coder will initiate the query process. All queries will be screened by the coding supervisor, physician subject matter expert, or lead coder before being placed on the medical record.

2. If e-mail encryption capability is "lacking" due to certificates, then the Management Information Department (MID) must be notified and the provider will need to be contacted using another mechanism.

3. An entry will be made in the deficiency/delinquency tracking system by the HIM designee to track timeliness of completion.

Tracking and Resolving a Provider Query

1. Once the query has been initiated, HIM must notify the provider and perform routine follow-up. The clerical staff, coding supervisor, medical records administrator, or appropriate designees must assist with contacting and following up with the provider. At a minimum, the designee will be responsible for follow-up (e.g., telephone, e-mail, office visit) and documentation to keep track of the follow-up.

2. Outstanding provider queries must be included in the incomplete and, as necessary, the delinquent record count. The Department Head, then Director must be engaged at the 7- and 14- day mark respectively, if the encounter is not closed out.

Tracking and Resolving a Provider Query (Continued)

3. The provider will be notified regarding their delinquent queries per the MTF's Medical Staff Bylaws. As applicable, it is encouraged that facilities also enlist such bodies as the Executive Committee of the Medical Staff, Medical Record Committee, Chairman of the Medical Staff and/or Department Chairpersons, or the respective Director to provide assistance in following up with physicians who are not responding to queries.

4. If a chart awaiting a provider response to a query has not been resolved based on the above required steps and within the MTF's delinquency timeframe or at a minimum TJC's delinquency timeframe of 30 days post-discharge, one of the following two options must be conducted in collaboration with the facility's Leadership:

- The facility may choose to continue to wait for a provider response to the query (e.g., awaiting essential documents for accurate code assignment such as pathology reports, operative reports, etc.).
- The facility may choose to code to the appropriate Medicare Severity-Diagnosis Related Group (MS-DRG) supported by provider documentation contained in the medical record. Leadership and the MRA or Coding Supervisor must approve final abstracting (final billing) of all records without a physician response to the query.

a. The MRA or Coding Supervisor must report to Leadership the dates and number of attempts (including the methods used) made to contact the physician regarding the outstanding query.

b. The MRA or Coding Supervisor in collaboration with Leadership must evaluate relevant factors regarding why a provider might not be responding, and organizational impact, etc.

c. The query deficiency must be removed from the incomplete/delinquent process and the response not further pursued.

d. In the rare occurrence that a provider responds after a record has been coded and finalized, the record must be reviewed to determine next steps for any potential data integrity impact and implications.

5   If the physician has responded that no additional or clarifying information is necessary, the deficiency may be removed from the incomplete and, as necessary, the delinquent record count.

Trending Provider Queries

Patterns of queries identified (i.e., are there repeated queries on the same topic, such as anemia or pneumonia) will be monitored for education and training focus areas. The volume, average delinquency age, and total relative value units (RVUs)/relative weighted products (RWPs) associated with outstanding provider queries will be reported to the NAVMED Regions and

BUMED on a monthly basis per the attached *Physician Query Log*. This information will be summarized at the MTF and forwarded to the NAVMED Regions to consolidate and submit by the third Monday of each month to BUMED-M3B13.

BUMED Responsibilities

1.   BUMED-M3B13 is responsible for development and oversight of policies concerning inpatient and outpatient coding standard business practices, processes, and reporting requirements. BUMED-M3B13 will answer questions and clarify requests escalated up from the NAVMED Regions and create policy clarification, as appropriate.

2.   BUMED-M3B13 will use a standard Execution Process to assist with annual performance metrics and monitoring compliance with the Provider Query Process.

NAVMED Regions Responsibilities

1.   The NAVMED Regions are responsible for assisting MTFs within their respective AOR in implementation of the policies and procedures defined in these Provider Query Guidelines. NAVMED Regions will ensure queries generated are tracked and trended in order to facilitate improved documentation.

2.   The NAVMED Regions will follow an Execution Process to ensure the Provider Query Guidance is implemented and executed correctly at all levels. The Execution Process will help the NAVMED Regions identify the key activities needed for successful implementation of the Provider Query Guidelines.

3.   In addition to assisting MTFs with the implementation of the Provider Query Guidelines, the NAVMED Regions are responsible for addressing any questions or clarification requests that are escalated up from the MTFs.

MTF Responsibilities

1.   The MTF commander, commanding officer, or officer in charge has the ultimate responsibility to ensure that all clinical documentation, clinical coding, and administrative procedures surrounding patient encounters are conducted following the requirements of these Provider Query Guidelines, applicable State and Federal laws, and TJC-formerly the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) standards. MTFs and MTF designee(s) will generate Performance Reports and will ensure training is in place to correct noted deficiencies, including (but not limited to) individual and group education, feedback, and ensuring bilateral communication between providers and coders.

2.   The MTF commander, commanding officer, or officer in charge will communicate to the medical staff that coding staff will query providers when there are questions regarding documentation for code assignment.

3. The PAD is responsible to the commander, commanding officer, or officer in charge for ensuring compliance with these guidelines and has functional oversight of the administrative coding process supporting both inpatient and outpatient encounters.

4. The MRA reports to the PAD or appropriate designee. The MRA is responsible for oversight of the inpatient and outpatient coding staff and coding processes and practices, including queries. The MRA is further responsible for ensuring that clinical documentation in the patient record supports and justifies the coding assigned for the episode of care.

5. It is the responsibility of the MTF to identify, track, and ensure the resolution of any questions or clarification requests regarding the Provider Query Guidelines. Any questions or clarification requests that cannot be addressed at the MTF level should be escalated up to the NAVMED Region.

Enclosure (1)

APPENDIX A

Top Medical Expense Performance Reporting System (MEPRs) per MTF by Volume
(Minimum 50 Encounters/Dispositions; FY2011)

Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
**NAVAL MEDICAL CENTER PORTSMOUTH**		
1	BHA	Primary Care Clinics	246,146
2	BHZ	Primary Medical Care Clinics Not Elsewhere Classified	184,663
3	BGZ	Family Practice Not Elsewhere Classified	100,402
4	BCB	Gynecology Clinic	91,277
5	BEA	Orthopedic Clinic	73,454
6	BIA	Emergency Medical Clinic	72,877
7	BFA	Psychiatry Clinic	59,700
8	BLA	Physical Therapy Clinic	57,577
9	FBN	Hearing Conservation	46,706
10	BFF	Substance Abuse Clinic	46,665
11	ACB	Obstetrics	3,537
12	ADB	Newborn Nursery	3,011
13	AAA	Internal Medicine	1,988
14	AFA	Psychiatry	1,370
15	AEA	Orthopedics	1,256
16	ABA	General Surgery	1,232
17	ADA	Pediatrics	1,042
18	AAB	Cardiology	973
19	ACA	Gynecology	854
20	ABD	Neurosurgery	345
		Total	995,074

NAVAL MEDICAL CENTER SAN DIEGO			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	328,546
2	BLA	Physical Therapy Clinic	90,461
3	BGZ	Family Practice Not Elsewhere Classified	84,949
4	BCB	Gynecology Clinic	83,644
5	BGA	Family Practice Clinic	77,445
6	BDA	Pediatric Clinic	71,965
7	BIA	Emergency Medical Clinic	64,484
8	FBN	Hearing Conservation	57,244
9	BFD	Mental Health Clinic	56,002
10	BFF	Substance Abuse Clinic	49,784
11	AAA	Internal Medicine	3,733
12	ACB	Obstetrics	3,665
13	ADB	Newborn Nursery	3,017
14	ABA	General Surgery	1,615
15	AFA	Psychiatry	1,541
16	ADA	Pediatrics	1,436
17	AAB	Cardiology	1,236
18	AEA	Orthopedics	699
19	ADE	Pediatric Intensive Care Unit (Refer to the DJ accounts)	664
20	ACA	Gynecology	465
		Total	982,595

FEDERAL HEALTH CARE CENTER (FHCC) (FORMERLY NAVAL HEALTH CLINIC GREAT LAKES)			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	237,991
2	BHZ	Primary Medical Care Clinics Not Elsewhere Classified	123,828
3	BHC	Optometry Clinic	43,765
4	BHD	Audiology Clinic	37,056
5	BEA	Orthopedic Clinic	30,754
6	BAA	Internal Medicine Clinic	21,516
7	BGA	Family Practice Clinic	21,457
8	BFD	Mental Health Clinic	17,894
9	BCB	Gynecology Clinic	17,287
10	BDA	Pediatric Clinic	14,495
		Total	566,043

	MEPRS3		Total Encounters/
Rank	Code	MEPRS Name	Dispositions
1	BHA	Primary Care Clinics	155,104
2	BGZ	Family Practice Not Elsewhere Classified	75,606
3	BFD	Mental Health Clinic	75,236
4	BLA	Physical Therapy Clinic	56,341
5	BGA	Family Practice Clinic	41,267
6	BIA	Emergency Medical Clinic	38,139
7	BCB	Gynecology Clinic	32,292
8	BFF	Substance Abuse Clinic	30,017
9	FBN	Hearing Conservation	29,374
10	BDA	Pediatric Clinic	21,213
11	ACB	Obstetrics	1,629
12	ADB	Newborn Nursery	1,409
13	AAA	Internal Medicine	718
14	ABA	General Surgery	473
15	AGA	Family Practice Medicine	398
16	ADA	Pediatrics	203
17	AGH	Family Practice Newborn Nursery	134
18	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	102
19	ACA	Gynecology	89
20	AEA	Orthopedics	56
		Total	559,799

NAVAL HOSPITAL CAMP PENDLETON

Appendix A to
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		NAVAL HOSPITAL CAMP LEJEUNE	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	117,269
2	BGA	Family Practice Clinic	78,540
3	BAR	Physical Medicine Clinic	49,978
4	BGZ	Family Practice Not Elsewhere Classified	48,375
5	BCB	Gynecology Clinic	47,418
6	BIA	Emergency Medical Clinic	42,634
7	BFD	Mental Health Clinic	36,989
8	BLA	Physical Therapy Clinic	27,996
9	FBN	Hearing Conservation	27,353
10	BDA	Pediatric Clinic	25,446
11	ADB	Newborn Nursery	2,040
12	ACB	Obstetrics	1,861
13	AGA	Family Practice Medicine	1,156
14	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	453
15	AFA	Psychiatry	374
16	ABA	General Surgery	303
17	AEA	Orthopedics	250
18	ADA	Pediatrics	176
19	ACA	Gynecology	130
20	ABF	Oral Surgery	81
		Total	508,824

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NAVAL HOSPITAL JACKSONVILLE			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	134,354
2	BGZ	Family Practice Not Elsewhere Classified	128,957
3	BGA	Family Practice Clinic	34,997
4	BIA	Emergency Medical Clinic	31,897
5	BLA	Physical Therapy Clinic	30,949
6	BDZ	Pediatric Care Not Elsewhere Classified	30,086
7	BAA	Internal Medicine Clinic	24,193
8	FBN	Hearing Conservation	21,051
9	BCB	Gynecology Clinic	19,900
10	BHG	Occupational Health Clinic	16,482
11	AGA	Family Practice Medicine	824
12	ACB	Obstetrics	788
13	ADB	Newborn Nursery	656
14	AAA	Internal Medicine	639
15	ABA	General Surgery	330
16	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	248
17	AGH	Family Practice Newborn Nursery	220
18	ADA	Pediatrics	128
19	AEA	Orthopedics	81
20	ACA	Gynecology	61
		Total	476,842

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WALTER REED NATIONAL MILITARY MEDICAL CENTER			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BAA	Internal Medicine Clinic	56,781
2	BHA	Primary Care Clinics	47,909
3	BCB	Gynecology Clinic	47,620
4	BAZ	Medical Care Not Elsewhere Classified	44,737
5	BDA	Pediatric Clinic	44,427
6	BFD	Mental Health Clinic	37,462
7	BHZ	Primary Medical Care Clinics Not Elsewhere Classified	35,879
8	BAC	Cardiology Clinic	35,628
9	BAG	Gastroenterology Clinic	34,078
10	BLA	Physical Therapy Clinic	32,885
11	ACB	Obstetrics	2,251
12	AAA	Internal Medicine	1,819
13	ADB	Newborn Nursery	1,743
14	ABA	General Surgery	752
15	AAB	Cardiology	694
16	AAK	Oncology	287
17	AFA	Psychiatry	256
18	ABD	Neurosurgery	246
19	ADC	Neonatal Intensive Care Unit (Refer to the DJ accounts)	216
20	ABB	Cardiovascular And Thoracic Surgery	156
		Total	425,827

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NAVAL HOSPITAL PENSACOLA			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	125,866
2	BGZ	Family Practice Not Elsewhere Classified	112,593
3	BAZ	Medical Care Not Elsewhere Classified	39,164
4	BLA	Physical Therapy Clinic	31,278
5	BJA	Flight Medicine Clinic	26,937
6	BIA	Emergency Medical Clinic	21,175
7	BDZ	Pediatric Care Not Elsewhere Classified	17,521
8	FBN	Hearing Conservation	13,948
9	BHC	Optometry Clinic	13,271
10	BHA	Primary Care Clinics	12,334
11	ADB	Newborn Nursery	535
12	AAA	Internal Medicine	524
13	ACB	Obstetrics	503
14	AGA	Family Practice Medicine	426
15	ABA	General Surgery	326
16	ACA	Gynecology	138
17	AEA	Orthopedics	124
18	ADA	Pediatrics	53
		Total	416,718

NAVAL HOSPITAL BREMERTON			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	74,214
2	BGZ	Family Practice Not Elsewhere Classified	63,570
3	BHG	Occupational Health Clinic	38,969
4	BIA	Emergency Medical Clinic	21,608
5	BLA	Physical Therapy Clinic	17,884
6	BCB	Gynecology Clinic	16,311
7	BAA	Internal Medicine Clinic	13,880
8	BDA	Pediatric Clinic	12,593
9	FBN	Hearing Conservation	12,412
10	FCA	Med Care In Non-Uniformed Facilities	12,129
11	AAA	Internal Medicine	718
12	ADB	Newborn Nursery	628
13	ACB	Obstetrics	555
14	ABA	General Surgery	292
15	AGA	Family Practice Medicine	258
16	AGH	Family Practice Newborn Nursery	169
17	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	113
		Total	286,304

		NAVAL HOSPITAL BEAUFORT	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	121,915
2	BLA	Physical Therapy Clinic	25,758
3	BHC	Optometry Clinic	23,791
4	BGA	Family Practice Clinic	20,779
5	BHD	Audiology Clinic	19,235
6	BIA	Emergency Medical Clinic	10,944
7	BCB	Gynecology Clinic	10,768
8	BGZ	Family Practice Not Elsewhere Classified	10,379
9	BFD	Mental Health Clinic	7,605
10	BAA	Internal Medicine Clinic	7,585
11	AAA	Internal Medicine	288
12	AGA	Family Practice Medicine	88
13	ABA	General Surgery	80
14	AEA	Orthopedics	64
		Total	259,278

		NAVAL HEALTH CLINIC HAWAII – JOINT BASE PEARL HARBOR-HICKAM	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	79,269
2	BDA	Pediatric Clinic	44,667
3	BLA	Physical Therapy Clinic	25,064
4	BGZ	Family Practice Not Elsewhere Classified	18,708
5	BGA	Family Practice Clinic	16,545
6	BHG	Occupational Health Clinic	14,009
7	BHC	Optometry Clinic	13,568
8	FBF	Epidemiology Program	12,096
9	FBN	Hearing Conservation	10,902
10	BDZ	Pediatric Care Not Elsewhere Classified	6,033
		Total	240,861

		NAVAL HOSPITAL OKINAWA	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	59,982
2	BLA	Physical Therapy Clinic	35,497
3	BHA	Primary Care Clinics	27,457
4	BDA	Pediatric Clinic	23,901
5	BIA	Emergency Medical Clinic	23,850
6	BCB	Gynecology Clinic	18,624
7	BGZ	Family Practice Not Elsewhere Classified	14,443
8	BHG	Occupational Health Clinic	11,681
9	BHC	Optometry Clinic	10,317
10	FBN	Hearing Conservation	9,976
11	ACB	Obstetrics	1,056
12	ADB	Newborn Nursery	922
13	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	390
14	ABA	General Surgery	309
15	AFA	Psychiatry	288
16	AGA	Family Practice Medicine	247
17	AAA	Internal Medicine	229
18	AGH	Family Practice Newborn Nursery	216
19	ADA	Pediatrics	135
20	ABD	Neurosurgery	124
		Total	239,644

		NAVAL HEALTH CLINIC NEW ENGLAND	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	101,982
2	BHA	Primary Care Clinics	33,657
3	BDA	Pediatric Clinic	18,427
4	BLA	Physical Therapy Clinic	16,452
5	BFD	Mental Health Clinic	14,895
6	FBN	Hearing Conservation	13,304
7	BHG	Occupational Health Clinic	10,911
8	BAA	Internal Medicine Clinic	10,747
9	BHC	Optometry Clinic	10,470
10	BKA	Undersea Medicine Clinic	8,109
		Total	238,954

NAVAL HEALTH CLINIC QUANTICO			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	74,413
2	BGZ	Family Practice Not Elsewhere Classified	45,128
3	BLA	Physical Therapy Clinic	20,641
4	BDZ	Pediatric Care Not Elsewhere Classified	14,111
5	BFD	Mental Health Clinic	7,103
6	BHC	Optometry Clinic	7,073
7	ELA	TRICARE/Managed Care Administration	5,688
8	BAR	Physical Medicine Clinic	5,437
9	BED	Chiropractic Clinic	5,407
10	FBN	Hearing Conservation	5,282
		Total	190,283

NAVAL HOSPITAL YOKOSUKA			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	44,093
2	BHG	Occupational Health Clinic	35,201
3	BGA	Family Practice Clinic	23,376
4	BGZ	Family Practice Not Elsewhere Classified	12,532
5	BLA	Physical Therapy Clinic	12,067
6	BJA	Flight Medicine Clinic	10,710
7	BIA	Emergency Medical Clinic	9,236
8	BHC	Optometry Clinic	7,899
9	BFD	Mental Health Clinic	7,418
10	BCB	Gynecology Clinic	7,254
11	ACB	Obstetrics	445
12	ADB	Newborn Nursery	415
13	AAA	Internal Medicine	153
14	ABA	General Surgery	118
15	ADA	Pediatrics	91
16	ACA	Gynecology	52
		Total	171,060

NAVAL HOSPITAL OAK HARBOR			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHG	Occupational Health Clinic	23,357
2	BGA	Family Practice Clinic	20,281
3	BGZ	Family Practice Not Elsewhere Classified	18,250
4	FCA	Med Care In Non-Uniformed Facilities	16,870
5	BHI	Immediate Care Clinic	15,353
6	BCB	Gynecology Clinic	13,163
7	BJA	Flight Medicine Clinic	12,737
8	BLA	Physical Therapy Clinic	9,340
9	BFD	Mental Health Clinic	9,204
10	BHA	Primary Care Clinics	6,943
11	ACB	Obstetrics	334
12	ADB	Newborn Nursery	331
		Total	146,163

NAVAL HOSPITAL TWENTY-NINE PALMS			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	33,610
2	BGA	Family Practice Clinic	18,213
3	BGZ	Family Practice Not Elsewhere Classified	15,199
4	BCB	Gynecology Clinic	14,353
5	BLA	Physical Therapy Clinic	14,193
6	BIA	Emergency Medical Clinic	13,973
7	BDA	Pediatric Clinic	13,818
8	BHC	Optometry Clinic	7,655
9	FBN	Hearing Conservation	7,358
10	BFD	Mental Health Clinic	5,621
11	ADB	Newborn Nursery	543
12	ACB	Obstetrics	539
13	AGA	Family Practice Medicine	115
14	ABA	General Surgery	90
		Total	145,279

	NAVAL HEALTH CLINIC CHERRY POINT		
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGZ	Family Practice Not Elsewhere Classified	28,642
2	BLA	Physical Therapy Clinic	23,216
3	ELA	TRICARE/Managed Care Administration	21,606
4	BHA	Primary Care Clinics	13,105
5	BCB	Gynecology Clinic	12,943
6	BDZ	Pediatric Care Not Elsewhere Classified	10,515
7	BHF	Community Health Clinic	8,512
8	BBA	General Surgery Clinic	7,182
9	BHG	Occupational Health Clinic	7,090
10	FBN	Hearing Conservation	6,540
		Total	139,351

	NAVAL HEALTH CLINIC ANNAPOLIS		
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	72,026
2	BLA	Physical Therapy Clinic	11,276
3	BHC	Optometry Clinic	9,175
4	BHG	Occupational Health Clinic	7,146
5	BDA	Pediatric Clinic	6,749
6	BGZ	Family Practice Not Elsewhere Classified	5,468
7	BEA	Orthopedic Clinic	5,357
8	BFD	Mental Health Clinic	2,936
9	BAR	Physical Medicine Clinic	2,774
10	BEF	Podiatry Clinic	2,754
		Total	125,661

		NAVAL HOSPITAL LEMOORE	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	31,039
2	BHI	Immediate Care Clinic	17,659
3	BGZ	Family Practice Not Elsewhere Classified	15,858
4	BCB	Gynecology Clinic	12,830
5	BDA	Pediatric Clinic	9,606
6	BJA	Flight Medicine Clinic	9,210
7	BHA	Primary Care Clinics	8,658
8	BLA	Physical Therapy Clinic	6,932
9	FBN	Hearing Conservation	6,108
10	BAA	Internal Medicine Clinic	5,156
11	ACB	Obstetrics	456
12	ADB	Newborn Nursery	439
		Total	123,951

		NAVAL HEALTH CLINIC PATUXENT RIVER	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	32,339
2	BJA	Flight Medicine Clinic	27,092
3	BHA	Primary Care Clinics	17,294
4	BGZ	Family Practice Not Elsewhere Classified	8,484
5	BDA	Pediatric Clinic	8,256
6	BHG	Occupational Health Clinic	8,154
7	BLA	Physical Therapy Clinic	4,664
8	ELA	TRICARE/Managed Care Administration	3,518
9	BFD	Mental Health Clinic	2,959
10	FBN	Hearing Conservation	2,794
		Total	115,554

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NAVAL HOSPITAL GUAM-JOINT REGION MARIANAS GUAM-ANDERSON			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	47,026
2	BIA	Emergency Medical Clinic	16,510
3	BAA	Internal Medicine Clinic	9,337
4	BDA	Pediatric Clinic	8,876
5	BCB	Gynecology Clinic	7,475
6	BLA	Physical Therapy Clinic	6,103
7	BHC	Optometry Clinic	4,342
8	BGZ	Family Practice Not Elsewhere Classified	3,549
9	BFD	Mental Health Clinic	3,197
10	BEA	Orthopedic Clinic	3,167
11	AGA	Family Practice Medicine	883
12	ACB	Obstetrics	259
13	ADB	Newborn Nursery	209
14	ABA	General Surgery	162
15	AGH	Family Practice Newborn Nursery	101
16	AAH	Medical Intensive Care Unit (Refer to DJ accounts)	99
17	ADA	Pediatrics	76
18	AEA	Orthopedics	53
		Total	111,424

NAVAL HEALTH CLINIC CHARLESTON – JOINT BASE CHARLESTON			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters / Dispositions
1	BGA	Family Practice Clinic	23,972
2	BGZ	Family Practice Not Elsewhere Classified	16,786
3	BKA	Under seas Medicine Clinic	13,862
4	BCB	Gynecology Clinic	11,531
5	BDA	Pediatric Clinic	7,691
6	BLA	Physical Therapy Clinic	7,358
7	BHG	Occupational Health Clinic	7,139
8	BAA	Internal Medicine Clinic	6,782
9	BHC	Optometry Clinic	4,900
10	BFB	Psychology Clinic	3,503
		Total	103,524

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	NAVAL HEALTH CLINIC CORPUS CHRISTI		
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	29,046
2	BHA	Primary Care Clinics	13,015
3	BDA	Pediatric Clinic	10,887
4	BJA	Flight Medicine Clinic	9,750
5	BLA	Physical Therapy Clinic	6,177
6	BHC	Optometry Clinic	4,244
7	ELA	TRICARE/Managed Care Administration	3,302
8	BHG	Occupational Health Clinic	2,899
9	BFD	Mental Health Clinic	2,118
10	FBN	Hearing Conservation	1,584
		Total	83,022

	NAVAL HOSPITAL SIGONELLA		
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BHA	Primary Care Clinics	26,425
2	BHG	Occupational Health Clinic	11,328
3	BGA	Family Practice Clinic	10,747
4	BGZ	Family Practice Not Elsewhere Classified	5,347
5	BLA	Physical Therapy Clinic	3,764
6	BHC	Optometry Clinic	3,234
7	BIA	Emergency Medical Clinic	3,151
8	BCB	Gynecology Clinic	2,120
9	BDA	Pediatric Clinic	2,109
10	BFB	Psychology Clinic	1,842
11	ACB	Obstetrics	93
12	AGH	Family Practice Newborn Nursery	85
13	AGA	Family Practice Medicine	76
		Total	70,321

NAVAL HOSPITAL NAPLES			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	17,823
2	BLA	Physical Therapy Clinic	6,687
3	BDA	Pediatric Clinic	6,413
4	BIA	Emergency Medical Clinic	6,295
5	BGZ	Family Practice Not Elsewhere Classified	5,833
6	BAA	Internal Medicine Clinic	5,818
7	BHG	Occupational Health Clinic	5,719
8	BCB	Gynecology Clinic	5,527
9	BHF	Community Health Clinic	4,615
10	FBB	Preventive Medicine	2,416
11	ACB	Obstetrics	151
12	ADB	Newborn Nursery	127
13	AAA	Internal Medicine	67
14	ABA	General Surgery	61
		Total	67,552

NAVAL HOSPITAL ROTA			
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	15,315
2	BGZ	Family Practice Not Elsewhere Classified	5,185
3	BIA	Emergency Medical Clinic	3,316
4	BLA	Physical Therapy Clinic	2,953
5	BHG	Occupational Health Clinic	2,849
6	BCB	Gynecology Clinic	2,659
7	BHC	Optometry Clinic	2,394
8	BAA	Internal Medicine Clinic	2,050
9	BDA	Pediatric Clinic	1,996
10	BEA	Orthopedic Clinic	1,472
11	ACB	Obstetrics	83
12	ADB	Newborn Nursery	66
		Total	40,337

Appendix A to
Enclosure (1)

		NAVAL HOSPITAL GUANTANAMO BAY	
Rank	MEPRS3 Code	MEPRS Name	Total Encounters/ Dispositions
1	BGA	Family Practice Clinic	7,632
2	BLA	Physical Therapy Clinic	2,918
3	BIA	Emergency Medical Clinic	2,663
4	BAA	Internal Medicine Clinic	1,412
5	BGZ	Family Practice Not Elsewhere Classified	1,401
6	BHC	Optometry Clinic	1,343
7	BHG	Occupational Health Clinic	1,193
8	BEA	Orthopedic Clinic	1,170
9	BDA	Pediatric Clinic	1,159
10	BHF	Community Health Clinic	834
11	AGA	Family Practice Medicine	107
		Total	21,832

Appendix A to
Enclosure (1)

SAMPLE PHYSICIAN QUERY TOOL

Query Date:_____

Patient name _____

Admission date _____ Discharge date _____

Medical Record # _____ Register # _____

Coder name _____ Coder telephone number _____

Dear Dr. _____:

The documentation in this patient's record requires clarification to ensure coding compliance and accuracy. Please complete, sign, date, and return the following query.

The following information is recorded in *[state the specific location in the medical record of information contributing to the reason for query.]*

[List the information; for example,
"Sputum lab culture result verifying presence of {particular organism} in a patient with a documentation of pneumonia"]

I have the following question about this record:

[Example: "Was the patient's pneumonia caused by a specific organism?
If yes, please specify the organism."]

Please respond to this question in the space below.

[allow space for written entry]

Note: You must also add this information to the patient's medical record by an addendum to the progress notes or discharge summary.

_____   _____
Physician signature   Date

PHYSICIAN QUERY SUMMARY LOG

Date of Submission: _____

MTF Name	# of Queries	# Closed < = 7 days	Provider RVU	Coder RVU	Variance	Percent Difference

MTF Name	# of Queries	# Closed < = 7 days	Initial MS-DRG/ RWP	Post MS-DRG/ RWP	Variance	Percent Difference

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.

(3) The MTF commanders, commanding officers, and officers in charge will appoint a Medical Record Administrator (MRA), preferably a Registered Health Information Administrator (RHIA), or Registered Health Information Technician (RHIT), credentialed by the American Health Information Management Association. The MRA will manage the coding process and assist with the management of a closed medical records system. The MRA or designee shall conduct internal records audits per the Navy Medicine Standard Coding Audit Requirements and Guidelines. The MRA or designee shall conduct internal query compliance reviews at least quarterly to determine query appropriateness.

    f. Policy and Procedures. Define procedures for the following:

        (1) Guidelines for coding staff or clinical support staff to follow when the clinical documentation is not easily assigned a related code to include consultation with MTF MRA, NAVMED Region Command MRA, BUMED MRA, and the Navy Hotline at: https://edq.med.navy.mil.

        (2) How to obtain provider clarification of a diagnosis or procedure, as it relates to coding and documentation for late entries in the medical record.

        (3) Process to notify the medical staff of the presence of a provider query for clarification and specificity to accurately assign a code.

        (4) Process to track the number of requested queries and monitor unanswered provider queries.

        (5) Process to identify new or unusual diagnosis and procedure codes. If the code cannot be identified after consultation with the attending physician and related research, the issue should be referred to the respective NAVMED Region Command MRA.

Note: If the issue needs to be referred to the Unified Biostatistical Utility (UBU) Coding Committee and subsequently to American Hospital Association (AHA) for clarification and assistance, MTFs should enter a coding hotline ticket via https://edq.med.navy.mil and refer/defer to the NAVMED Region Command/BUMED.

        (6) Process to review 100 percent of other health insurance encounters prior to submitting claims to third party payers.

        (7) Process to correct inaccurate code assignments in the clinical database and the agencies and bill payers to which the codes have been reported.

        (8) Process to address issues identified by claims denials to include submission of appeals if justifiable.

(9) Process to review and revise codes as necessary for previously coded records when the required documentation was incomplete or without final diagnostic statement.

(10) Process to report errors identified by logic editors or with code file and tables in an automated system. Coding staff cannot rely solely on computerized encoders. Current coding manuals must be readily accessible and the staff must be educated appropriately to detect inappropriate logic or errors in encoding software. When errors in logic or code crosswalks are discovered, the coding supervisor must immediately report the issue to the system administrator to file a trouble ticket with the MHS Helpdesk. A copy must be sent to the respective NAVMED Region Command MRA, to include the trouble ticket number. If required, the NAVMED Region Command MRA will forward the issue to the BUMED MRA for resolution.

g. <u>Audit Plan Policy</u>. Each MTF shall implement the Navy Medicine Standard Coding Audit Requirements and Guidelines for conducting audits and standardizing medical record processes to improve documentation of patient encounters and coding.

h. <u>Provider Query Compliance</u>. Any chart awaiting a response to a query should not be 'final abstracted' until the physician's response is received. Each MTF must establish a written follow up process that includes routine attempts to obtain a physicians response to a query. If a provider does not respond in 24 hours for concurrent queries, or 5 days for retrospective review, a roster of delinquent queries will be forwarded to the Executive Committee of the Medical Staff ECOM committee chairman on at least a weekly basis for enforcement with copies to the provider's respective directorate. Each MTF shall create and maintain a process whereby providers will receive their own specific coding accuracy reports, on at least a quarterly basis.

i. <u>Provider Coding Reports</u>. Each MTF shall create and maintain a process whereby providers will receive their own specific coding accuracy reports, on at least a quarterly basis. The purpose is to identify coding trends and performance improvement practices within clinic specialty and across the facility.

NAVY MEDICINE STANDARD CODING AUDIT REQUIREMENTS AND GUIDELINES

Version 2.1

February 2012

TABLE OF CONTENTS

1. **Purpose of Document**

BUMED has embarked on several policy initiatives to standardize the medical coding function at Navy MTFs in order to reduce variations, increase consistency, and improve coding accuracy. Improving coding operations and addressing concerns for standard auditing requirements/guidelines is the goal of this policy document. The lack of standard auditing requirements and guidelines has lead to inconsistent and incomplete coding analysis that could result in misrepresenting coding accuracy to the MTF leadership, Navy Medicine, OSD(HA) and Congress.

Coded data is used by the Military Health System (MHS) for many organizational health care business decisions, necessitating policy development and standardization in this area. The auditing processes in this document will address coding accuracy, timeliness, and completeness, and provide a standard methodology for sampling, reporting, and calculations—yielding more consistent data analysis. This will aid leadership in identifying corrective actions that must be taken to improve Navy performance, capture workload and revenue, and improve clinical documentation. This, in turn, helps promote readiness throughout the Navy.

   1.1. *Why Audit?*

The use of medical coded data for decisions continues to grow and numerous decisions are being based upon clinically coded data. As such, the timeliness, completeness, and accuracy of these data become critically important. Therefore, the number of errors that are due to the lack of complete clinical documentation, transcription errors, and/or judgment errors should be minimized. Audits are a common method used in the civilian sector to monitor, understand, and address coding errors and operational and/or systems issues impacting productivity, third party collections, budget allocations, personnel requirements, health care measures, etc. These same issues are important for the MHS as well.

Audits conducted will compare what is clinically documented in the medical record to what was coded. Audits must be viewed as a compliance and communication vehicle for both providers and coders. As such, MTF audits should be treated as an important educational tool to evaluate policies, business practices and processes, and to help identify training opportunities for personnel. Audits that focus on coding corrections alone will not fundamentally allow for improvement in Navy clinically coded data, productivity, and/or financial posture within the MHS.

   1.2. **What Does it Offer Command Leadership?** Auditing has an important role in the resourcing of future operations as well as in the monitoring for high quality and acceptable standards of care. An active audit program reinforces the MTF's ability to produce accurate and complete medical coding data sets from clinical documentation recorded in individual patient medical records. Accurate and complete medical coding data sets directly impact an MTF's quality measures that are reported by existing Healthcare Effectiveness Data and Information Set (HEDIS) performance metrics and future Prospective Payment System (PPS) earnings.

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

   2.2. **What Comprises a Complete Medical Record for Audit Purposes?** Medical record audits must include review of the entire inpatient admission (from admission to discharge) for inpatient chart audits. For APV records, the medical record must include all the documents related to that encounter/episode of care. Audits for outpatient visits must include review of all applicable components of the encounter. Audits will be done on completed records only.

   a. At a minimum, Inpatient records shall include the following documentation where applicable:

- Summary sheet documenting the codes selected by the MTF personnel
- Discharge Summary
- Anesthesia Record
- History and Physical Exam
- Physician Orders
- Operative Reports
- Reports for any special procedures such as EKG, MRI, where applicable
- Consultation Reports
- Admission Note/ History & Physical (H&P)
- Progress notes from physician, nurse practitioner, physician assistant or other specialty provider
- Laboratory Reports
- Pathology Reports, where applicable
- Medication Records
- Nurses Notes
- Ancillary Reports
- * Emergency Department documentation
- * Outpatient visit documentation

* Also included when these encounters resulted in an admission. Ambulance records or copies of any records from transferring facilities would be included.

   b. At a minimum, APV records shall include the following documentation where applicable:

- Registration #
- Date of Service
- Summary sheet documenting the codes selected by the MTF personnel
- Discharge Summary and/or Progress Note
- Anesthesia Record
- History and Physical Exam
- Physician Orders
- Operative Reports
- Admission Note

- Progress notes from physician, nurse practitioner, physician assistant or other specialty provider
- Nurses Notes
- Ancillary Reports
- Laboratory Reports
- Pathology Reports, where applicable
- Medication Records
- Valid Physician Orders
- * Emergency Department documentation
- * Outpatient visit documentation

* Also included when these encounters resulted in an admission. Ambulance records or copies of any records from transferring facilities would be included.

    c. At a minimum, outpatient records shall include the following for the date of services requested where applicable:

- Providers notes
- Nurses notes
- Reports of any special procedures such as EKG, MRI, where applicable
- Laboratory Reports, where applicable
- Pathology Reports, where applicable

    2.3. Types of Audits. The following types of audits when, conducted by the coder/auditor for Inpatient, Outpatient, APV and Inpatient Professional Services; shall be conducted per these audit guidelines:

    a. Random Audits. Random audits are required by references (a) and (b) in Section 2. These audits are considered spot checks of overall data. The Data Quality Management Control (DQMC) requires that monthly random audits be conducted for inpatient, outpatient, and Ambulatory Procedure Visit (APV) encounters (see section 2.4). In addition to spot-checking overall data, random audits are performed at least once each fiscal year by the MTF to assess new *providers* who have just completed their professional training (i.e., residency, fellowship, or Nurse Practitioner training). These random audits are also performed at least once each fiscal year by the MTF on new *coders*.

    b. Audits of Providers. For the purpose of these audits, providers include many of those that fall into the categories of Skill Type 1 or Skill Type 2. Skill Type 1 is defined in the *Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities* (2000) as "clinicians to include physicians, dentists, and veterinarians." Skill Type 2 is defined in *MEPRS* as "direct care professionals, and non-physicians that are licensed or certified to deliver care to patients and include, but not limited to, physician assistants, nurse practitioners, physical and occupational therapists, psychologists, and

nurse midwives." Navy Medicine dental providers are explicitly excluded from review for the purpose of these audits. (Currently, dentists "code" their own encounters and have peer reviewers for Quality Assurance purposes. Further, medical record coders do no routinely have a competency level to perform audits on dental treatment records using the Current Dental Terminology coding set.). The auditing requirements for these providers are as follows:

- Providers who are just completing training (i.e., residency, fellowship) will be audited within 30-60 days of the start of their assignments.
- Providers who are new to the MTF will be audited within 30-60 days of the start of their assignments.
- If the provider accuracy is below 90 percent, the coding supervisor or designee will provide educational feedback in the area of deficiency with a follow up review of problem areas within 15-30 days.
- The audit will include a minimum of 10 records/encounters with a range of Evaluation and Management (E/M) categories and levels as well as procedures reported. If the provider provides more than one type of service (professional clinic, professional APV procedure visit, or inpatient facility rounds), 10 records from each type of service is required.
- If the Government finds a contract provider's accuracy is below 90 percent, the Government supervisor should provide sufficient information through the MTF chain of command to the appropriate PAD/COR designee so the contractor can be formally notified of the deficiency.
- If the provider is privileged and works in more than one specialty, an audit for each specialty is required.

    c. <u>Audits of Coders</u>. For the purpose of this audit, coders are defined as military, civilian, and contract coding personnel. The auditing requirements for coders are as follows:

- Coders new to the MTF will be audited within 30-60 days of the start of their assignments.
- If the coder accuracy is below 95 percent, the coding supervisor or designee will provide educational feedback in the area of deficiency with a follow up review of problem areas within 15-30 days.
- The audit will include a minimum of 10 records/encounters from each area of responsibility with a range of E/M categories and levels; a range of Diagnosis Related Groups; and procedures reported; and APV categories. If the coder codes for more than one type of service (professional clinic, professional APV procedure visit, or inpatient facility), an audit for each type of service is required.
- If the Government finds a contract coder's accuracy is below 95 percent, the Government supervisor should provide sufficient information to the COR so the contractor can be formally notified of the deficiency.

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 <u>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</u> (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.

2.5. ***Sample Size, Frequency, and Timeframes of DQMC Audits.*** *Per the DQMC requirements as outlined in DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," FY12 update for enclosure (1) and (2) prescribes the service headquarters will provide the random sampling pull list to the MTF.   For more specific details on process and reporting requirements refer to annual DQMC guidance.*

2.5.1. ***Random Audit Frequency.*** Per the DQMC requirements as outlined in DoD Instruction 6040.40, "Military Health System Data Quality Management Control Procedures," random audits must be accomplished on a monthly basis based upon the entire population of records/encounters for the audit data month.

2.5.2. ***Random Audit Timeframe.*** Random audits shall be conducted no earlier than 45 days after the close of the encounter date/month. This ensures the medical records are complete with proper signatures and clinical documentation.

2.6. **Who can Audit?** When determining who should perform the audit, consideration must be given to the focus of the audit. The coder/auditor should have knowledge of the MHS Coding Guidance and at least six months' coding experience with the types of services that are to be audited. For example, you would not want a coder who has 5 years of experience coding ob-gyn services to review orthopedic services. The coder/auditor is required to have the following appropriate credentials for conducting the review:

   a.   Inpatient or outpatient facility coding: CCS, RHIA, RHIT.

   b.   Inpatient or outpatient professional services coding, including APVs: RHIA, RHIT, CCS, CCS-P, CPC, CPC-H.

   c.   The coder/auditor performing the review will not have coded any of the records/encounters being reviewed. If an MTF is small, this may require retaining the services of an outside coder/auditor, or the MTF can contact their Navy Medicine Region Command to make arrangements to have another MTF assist as a coding/auditing resource.

   d.   The coder/auditors will need to complete the pertinent care setting coding Audit Scoresheet Tool for each inpatient episode of care or outpatient encounter audited. The Audit Scoresheet Tools recommended for use are:

- Evaluation and Management Services Worksheet: CMS 1995 or 1997 *Documentation Guidelines for Evaluation and Management Services* (depending upon the Outpatient Coding Protocol Plan) (available at Sections 4.5 and 4.6 of this document)
- APV Coding Audit Worksheet (available at Section 5.3 of this document)
- Inpatient Facility Services Worksheet (available at Section 3.2 of this document) (Please Note: As of 1 October 2008, the MHS utilizes the Medicare Severity-Diagnosis Related Groups.)

- Outpatient Clinic Visit Coding Audit Worksheet (available at Section 4.4 of this document)
- Inpatient Professional Services (IPS) Rounds Coding Audit Worksheet (available at Section 6.4 of this document)

Facilities must indicate in their Outpatient Coding Protocol Plan which set of CMS guidelines each clinical service will follow. The coder/auditor will audit using the same set of CMS coding guidelines required by the MTF's Outpatient Coding Protocol Plan. The coder/auditor will need to complete the following calculations and comment fields for each audit worksheet.

e. <u>RVU/RWP Difference</u>. Calculation of the difference between Audited RVU/RWP and Original RVU/RWP from CCE.

f. <u>Physician Query</u>. If the coder/auditor identifies that a query should have been made, he or she will note such in the physician query area of the audit sheet. If available, the CCE Review Hold report must be used to identify if comments were made and the reason they are on "review hold" status.

g. <u>Coder/Auditor Comments</u>. The coder/auditors will provide written comments regarding any disagreements between original and audited codes. The comments will be clear, concise statements.

h. <u>Error Reason Codes Definitions</u>. The coder/auditor shall assign the appropriate "Error Reason Code" to identify the type of discrepancy between the original codes and the audited codes. The table of Error Reason Codes can be found in Section 7.

2.7. **Retrospective Physician Query Process**

The American Health Information Management Association (AHIMA)'s document *Standards for Ethical Coding* indicates:

> "Query provider (physician or other qualified healthcare 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)."

In light of new official coding rules that have been implemented regarding discrimination between conditions that are present at the time of admission and conditions acquired during the admission, coders more than ever need to clarify information with providers.

This, in turn, means that coder/auditors might need to make these very same types of queries during the retrospective audit if important information was left illegible, incomplete, unclear, inconsistent, or imprecise when the chart was coded originally.

Since reimbursement can be driven by how precise diagnostic information is, an opportunity exists to make sure MTFs are making good use of a physician querying process and are asking the necessary questions to optimize diagnostic data capture. An important part of the audit process is to review the entire inpatient encounter, from the History and Physical document to the Discharge Summary and everything in between. Query the physician retrospectively as part of the audit process to determine if the initial coding had been optimized at the outset.

2.8. **Steps to Performing a Querying Process Audit**

a. Certain high-risk primary or secondary procedures and diagnoses have the potential to change an MS-DRG through retrospectively querying the physician. The coder/auditor may identify areas where source data is insufficient and a retrospective query needs to be initiated. This could yield opportunities to provide increased education to providers and coders on the high-risk procedures and diagnoses.

> *Example: Thirty charts were audited and three retrospective query opportunities were identified. Divide the number of query opportunities (3) by the combined total of thirty original charts. 3 divided by 30 equals 10.0 percent query rate.*

b. Similarly, certain procedures from a *CPT* standpoint are high-risk for providing inaccurate workload data. Whether a surgical procedure was done "open" or laparascopically, whether a procedure was an initial procedure or a subsequent procedure, whether a procedure was simple or complicated—all can affect the *CPT* code selection. A review should seek to confirm if coders are properly using query forms to clarify proper code selection.

c. Audit individual providers to confirm clarity and thoroughness of chart documentation. Improvement in documentation should result in a decreased number of queries for an individual provider.

d. The querying process could be misused or overused. The coder/auditor may identify areas where retrospective querying was unnecessary. Unnecessary querying might include questioning a provider's clinical judgment.

Querying a provider shall be limited to situations regarding:

- **Legibility.** This might include an illegible handwritten entry in the provider's progress notes, and the reader cannot determine the provider's assessment on the date of discharge.

- **Completeness.** This might include a report indicating abnormal test results without notation of the clinical significance of these results (e.g., an x-ray shows a compression fracture of lumbar vertebrae in a patient with osteoporosis and no evidence of injury).

- **Clarity.** This might include patient diagnosis noted without statement of a cause or suspected cause (e.g., the patient is admitted with abdominal pain, fever, and chest pain and no underlying cause or suspected cause is documented).

- **Consistency.** This might include a disagreement between two or more treating providers with respect to a diagnosis. (For example, the patient presents with shortness of breath. The pulmonologist documents pneumonia as the cause and the attending documents congestive heart failure as the cause.)

- **Precision.** This might include an instance where clinical reports and clinical condition suggest a more specific diagnosis than is documented (e.g., congestive heart failure is documented when an echocardiogram and the patient's documented clinical condition on admission suggest acute or chronic diastolic congestive heart failure.)

    Example: Thirty physician query forms were audited for negative and positive provider responses. A high negative response rate may indicate overuse of the query by the coding staff; a high positive response rate may indicate a pattern of incomplete documentation that needs further investigation.

Performing retrospective physician queries as part of a retrospective audit does not constitute a change in the Scope of Work; it is merely a necessary step that a coder/auditor might need to take in order to determine how a chart properly should have been coded.

3. Inpatient Audit Methodology. It is desirable to have an otherwise random sample of MS-DRGs within the targeted sample selected for review.   If one MS-DRG is overly inclusive, replace it with another random chart.

a. Develop Audit Selection Criteria. Determine what type of audit will be conducted and determine an appropriate focus for targeted audits.

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 charts from the medical record department.

    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 on NAVMED 6150/44 (01-2010), Impatient Coding Audit Worksheet; this worksheet is 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. Coder/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 shall be provided to the MTF designee(s) and shall include NAVMED 6150/48 (01-2010), Inpatient Coding Audit Summary; available from Naval Forms Online at: https://navalforms.documentservices.dla.mil/. The audited records and audit sheets shall be retained by the MTF designee(s) for a period of 2 years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95 percent accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow-up audits to be performed. In the event the coder remains below 95 percent, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

    j.   Plan of Action. The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Regional Command for assessment. Regional Commands should assist the MTFs in developing the action plan and should monitor MTF progress towards resolution.

3.1. MS-DRG Accuracy

The coder/auditor will recode the inpatient chart, group using CCE and compare the audit MS-DRG to the original MS-DRG. Since a chart can and must have one and only one principal diagnosis, an accuracy rate will be determined by dividing the number of *correct* principal diagnosis codes by the number of charts audited in the sample by the coder/auditor. For an individual inpatient medical record, the accuracy percentage will always be 100 percent or 0 percent.

> *Roll-up Example: Thirty charts were audited and there were two principal diagnosis errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

3.1.1. Principal Diagnosis Accuracy

The coder/auditor will recode the inpatient chart and compare the audit principal diagnosis to the original principal diagnosis. Since a chart can and must have one and only one principal diagnosis, an accuracy rate will be determined by dividing the number of *correct* principal diagnosis codes by the number of charts audited in the sample by the coder/auditor.

> *Roll-up Example: Thirty charts were audited and there were two principal diagnosis errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3 percent accuracy.*

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

3.1.2. Major Complication and Co-Morbidity (MCC) Accuracy

The accurate capture--or failure to capture--MCCs needs to be tracked since the MCCs have the potential to change MS-DRGs. The coder/auditor will recode the inpatient chart and compare the coder/auditor's MCCs coded to the original MCCs coded. An accuracy rate will be determined by dividing the number of *correct* MCC codes by the sum total of codes contained in the union of the set of MCC codes reported by the original coder and the set of MCC codes reported by the coder/auditor.

> *Example: The original coding showed 2 MCCs (both deemed correct), while the coder/auditor determined that 3 additional MCCs should have been coded. Divide the number of correctly coded MCCs (2) by the combined total of codes reported by coder and the coder/auditor (2 + 3 = 5). 2 divided by 5 equals 40.0 percent accuracy.*

*Roll-up Example: Thirty charts were audited and there were
75 MCCs reported of which 70 were found to be correct.
Seventy is divided by the combined total of 75 original MCC
codes plus 8 additional MCC 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.

3.1.3. <u>Complication and Co-Morbidity (CC) Accuracy</u>

The accurate capture--or failure to capture--CCs needs to be tracked as they
have the potential to change MS-DRGs. The coder/auditor will recode the inpatient chart and
compare the coder/auditor's CCs coded to the original CCs coded. An accuracy rate will be
determined by dividing the number of *correct* CC codes by the sum total of codes contained in
the union of the set of CC codes reported by the original coder and the set of CC codes reported
by the coder/auditor.

*Example: The original coding showed 2 CCs (both deemed
correct), while the coder/auditor determined that 3 additional
CCs should have been coded. Divide the number of correctly
coded CCs (2) by the combined total of codes reported by coder
and the coder/auditor (2 + 3 = 5). 2 divided by 5 equals 40.0
percent accuracy.*

*Roll-up Example: Thirty charts were audited and there were 75
CCs reported of which 70 were found to be correct. Seventy is
divided by the combined total of 75 original CC codes plus 8
additional CC 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.

3.1.4. <u>Present on Admission Indicator (POA) Accuracy</u>

MS-DRGs require that *each diagnosis* have a corresponding POA indicator.
The purpose of this indicator is to identify Hospital Acquired Conditions (HAC) that may be
excluded from the MS-DRG calculation. The coder/auditor will review the record and determine
the correct POA indicator for each diagnosis coded. The coder/auditor will compare the
coder/auditor's POA indicators to the original POA indicators. Since each diagnosis can and
must have one and only one POA indicator, an accuracy rate will be reported by dividing the
number of *correct* POA indicators by the total number of diagnosis codes audited in the sample
by the coder/auditor.

Roll-up Example: Thirty charts were audited. There were 126 diagnoses--and some POA indicators were assigned. Review showed that 4 of the POA indicators were incorrect and 2 were missing altogether. (120 POA indicators were correct.) Divide the number of correct POA indicators (120) by the total number of diagnosis codes audited in the sample by the coder/auditor. 120 divided by 126 equals 95.2 percent accuracy.

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

3.1.5. Principal Procedure Accuracy

The coder/auditor will recode the inpatient chart and compare the coder/auditor's principal procedure code to the original principal procedure code. An accuracy rate will be reported by dividing the number of *correct* principal procedure codes by the sum total of codes contained in the union of the set of principal procedure codes reported by the original coder and the set of principal procedure codes reported by the coder/auditor.

Roll-up Example: Thirty charts were audited and there were two principal procedure errors. (Twenty-eight were correct.) Twenty-eight is divided by the 30 charts audited. 28 divided by 30 equals 93.3 percent accuracy.

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

3.1.6. Relative Weighted Product (RWP) Changes

For TRICARE, inpatient workload is measured by the TRICARE Relative Weight Product (RWP). RWP is directly related to the MS-DRG assigned; RWP accuracy would be equal to the MS-DRG accuracy described above. The usefulness of measuring RWP changes comes from trending the monthly gain or loss over time. The coder/auditor will recode the chart, group using CCE, and compare the audit MS-DRG RWP to the original MS-DRG RWP. Coder/auditor will note a gain (+) or loss (-) for each MS-DRG change.

Example: Thirty charts were audited and there were 2 MS-DRG errors. The first MS-DRG RWP change gained +0.7654 while the second MS-DRG RWP change lost -0.0476 for a net gain of +0.7178 RWP.

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

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.

The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95 percent or provider falling below 90 percent accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow up audits to be performed. In the event the coder remains below 95 percent or the provider remains below 90 percent accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

   j.   <u>Plan of Action</u>. The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Regional Command for assessment.

4.1. <u>Diagnosis Accuracy</u>

        The coder/auditor will recode the outpatient encounter and compare the audit diagnoses to the original diagnoses. An accuracy rate will be reported by dividing the number of original correct diagnoses by the sum total of diagnosis codes contained in the union of the set of diagnosis codes reported by the original coder and the set of diagnosis codes reported by the coder/auditor.

> *Example: An outpatient encounter was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

> *Roll-up Example: There were 30 encounters audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found five others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

4.2. Current Procedural Terminology (CPT) *Accuracy*

The coder/auditor will recode the outpatient encounter and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *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. "Correct" for the purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

> *Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that 2 of these were correct. The coder/auditor also identified one further CPT code that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

> *Roll-up Example: There were 30 outpatient encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/ auditor with 70 being correct. The coder/auditor also identified six additional CPT codes that the coder should have captured but did not. Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

4.3. Evaluation and Management (E/M) Accuracy

The coder/auditor will recode the outpatient encounter and compare the audit E/M level to the original E/M level. An accuracy rate will be reported by dividing the number of correct E/M levels assigned by the coder by the by the sum total of E/M codes contained in the union of the set of E/M codes reported by the original coder and the set of E/M codes reported by the coder/auditor.

> *Example: The coder/auditor reviewed an encounter which had one E/M level assigned by the coder. This was found to be an incorrect code. Additionally, the coder/auditor identified a second E/M code that should have been reported but was not. Divide the number of correct E/M levels (0) by the combined total number of E/M codes that were missed (1 + 1 = 2). 0 divided by 2 yields 0.0 percent accuracy.*

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Roll-up Example: There were 30 outpatient encounters audited with a collective total of 32 E/M codes assigned by the provider/coder. Of these 32 E/M codes, 3 were found to be incorrect by the coder/auditor with 29 being correct. The coder/auditor also identified two further E/M codes that the coder should have captured but did not. Divide the total number of correct E/M codes (29) by the combined total number of E/M codes assigned by the initial coder plus the two that were missed by the coder (32 + 2 = 34). 29 divided by 34 yields 85.3 percent accuracy.

This is a Targeted Audit element which is also a DQMC-required element.

4.3.1. <u>Modifier Accuracy</u>

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

Example: The original coding showed 4 modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.

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.

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.*

E/M Worksheet (1995 Guidelines)

History: Requires 3 of 3 (HPI, ROS, and PFSH) levels be met

Level		PF		EPF		Detailed		Comprehensive
HPI		Brief 1-3 Elements				Extended 4+ Elements		
		Location		Duration		Severity		Context
		Timing		Quality		Modifying Factors		Assoc. Signs & Sym
ROS		None		Pertinent (1)		Extended (2-9)		Complete (10+)
		Const		Eyes		Resp		GI
		Skin		ENT		CB		GU
		Musc		Neuro		Psych		Hem
		Lymph		Endo		Allergy		Immunology
PFSH		None		None		Pertinent 1-2 (New), 1 (Est)		Extended 3 (New), 2-3 (Est)
		Past		Family		Social		

Examination

Level		PF (1)		EPF (2-7 limited)		Detailed (2-7 extended)		Comprehensive (8 or more)
Body Areas		Head		Neck		Back		Abdomen
		Chest		Groin		Genitalia		Buttocks
		RUE		LUE		RLE		LLE
Organ Systems		Cons		Eyes		Resp		GI
		Skin		ENT		CV		GU
		Musc		Neuro		Psych		Hem/Lymph/Immun

Medical Decision Making: 2 of 3 (A, B, and C) levels must be met or exceeded

Level		Straight-forward		Low		Moderate		High
Table A		1 point		2 points		3 points		4+ points
Table B		0-1 point		2 points		3 points		4+ points
Table C		Minimal		Low		Moderate		High

4.5. _E/M Calculation (1997) Guidelines._ _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 2.6(c) of this document.

E/M Worksheet (1997 Guidelines)

HISTORY

HPI: ①	Not documented by Physician
Timing	Assoc. S & S
Location	Context
Quality	Modifying Factors
Severity	3+ Chronic Conditions
Duration	**TOTAL HPI:**

ROS: ②

Constitutional (wt. loss, vitals)	Eyes	ENMT
GI	Respiratory	Cardiovascular
Integumentary w/skin, breast	GU	Musculo	Neuro
Psych	Allergy/Immuno	Lymphatic/Hemat
Endocrine		

TOTAL ROS: _____

Statement: All remaining systems negative

PFSH: ③

Past (includes illness, surgical hx, injuries, etc.)

Family (includes hereditary conditions)

Social (Includes drinking, smoking, substance abuse)

Table A: History Matrix (All 3 satisfied)

HPI①	PF 1-3	EPF 1-3	Detailed 4+ elements or 3+ Chronic/ Inactive conditions	Comprehensive 4+ elements or 3+ Chronic/ inactive conditions
ROS②	None	1 pertinent to problem	2-9	10+ or some with All others negative
PFSH③	None	None	(1) Pertinent	*Complete 2-3 areas

*Complete PFSH 2 hx areas: a) Estab pts office (outpt) care, domiciliary care, home care, b) Emergency dept. c)Subseq nurs. Facility care
3 hx areas: a) New pts. Office (outpt) care, domiciliary care, home care, b) Consultations, c) Initial hospital care, d) Hospital Observation, e)Comprehensive nursing facility assmts.)

E/M Worksheet (Continued)
1997 Guidelines

Content and Documentation Requirements

Level of Exam	Perform and Document
Problem Focused	**One to five** elements identified by a bullet.
Exp. Prob. Focused	**At least six** elements identified by a bullet.
Detailed	**At least two** elements identified by a bullet **from each of six areas/systems** OR **at least twelve** elements identified by a bullet **in two or more areas/systems**.
Comprehensive	**At least two** elements identified by a bullet **from each of the nine areas/systems**.

General Multi-System Exam

Constitutional   **Eyes**
Vitals – 3   Conjunctivae/Lids
Appearance   Pupils/Irises
                    Ophthalmoscopic

Ears/Nose/Mouth/Throat
External inspection (ears/nose)
Auditory canals/tympanic membranes
Hearing
Nasal mucosa/septum and turbines
Lips/teeth/gums   Oropharynx

Neck   **Respiratory**
Thyroid   Effort   Percussion
Masses   Auscultation   Palpation

Cardiovascular
Auscultation   Palpation   Carotid Arteries
Femoral Art.   Pedal pulses   Ext/edema/varicose

GI
Abd mass/tenderness   Liver/Spleen   Hernia Present
Anus/rectum/hemorrhoids/mass   Stool Sample

Genitourinary: (Male)
Scrotal contents   Penis   Prostate

Genitourinary: (Female)
Ext. Genitalia/Vagina
Urethra   Uterus   Cervix
Bladder   Adnexa

Lymphatic (must have at least 2): Neck Axillae Groin Other

Neurologic: Cranial DTRs Sensation

Psychiatric: Orientation   Mood/Affect Judgment Memory

Skin: Inspection   Palpation

Musculoskeletal: Gait/Station   Nails/Digits
Joints, bones, and muscles of one or more areas.
Head/Neck   Spine/Ribs/Pelvis
Right Upper Extremity   Right Lower Extremity
Left Upper Extremity   Left Lower Extremity
Exam includes:
   Inspection/palpation noting any effusion, crepitation
   Assessment of ROM   Assessment of stability
   Assessment of muscle strength and tone

Chest/Breasts:
Inspection of breasts (symmetry, discharge, nipples)
Palpation of breasts and axillae (masses, lumps, tenderness)
            EXAM TOTAL: _____

E/M Worksheet (Cont.)
1997 Guidelines

Table A: Number of Diagnoses or Treatment Options				
Problems to Exam Physician	Number X Points = Result			
Self-limited or minor (stable, improved or worsening)			1	*Max = 2*
Est. problem (to examiner); stable, improved			1	
Est. problem (to examiner); worsening			2	
New problem (to examiner); no additional workup planned			3	*Max = 3*
New prob. (to examiner); add workup planned			4	
				TOTAL _____

Table B: Complexity of Data

1 pt. = Diag. Tests ordered/Reviewed (Lab, X-ray, EKG) [1 pt. per test type]
1 pt. = Test results discussed w/performing MD
1 pt. = Obtain old records/history from outside source
2 pts. = Review and Summarize old Medical Records
2 pts. = Direct reading of image, tracing/specimen   **Total = _____**

Table C: Table of Risk				
Level of Risk	Presenting Prob.	Diag. Procedures Ordered	Management Options	
Minimal	*One self-limited or minor problem (e.g., cold, insect bite, tinea corporis)	*Lab tests – venipuncture *Chest X-ray *EKG/EEG *Urinalysis *Urinalysis *KOH Prep	*Rest *Gargle *Elastic bandages *Superficial dressings	
Low	*Two/more self-limited minor prob. *One stable chronic illness *Acute uncomplicated illness or injury	*Physiologic tests not under stress (e.g., pulmonary funct.) *Non-cardio imaging w/contrast (e.g., B/E) *Superficial needle/skin BX *Clinical lab tests = arterial punct	*Over-the-counter drugs *Minor surgery/no risk factors *PT *OT *IV fluids w/o additive	
Moderate	*One/more chronic illnesses w/mild progression-side effect TX *Two/more stable chronic illnesses *UnDX'd new problem w/uncertain prognosis *Acute illness w/systemic SX (e.g. pneumonia, colitis) *Acute uncomplicated injury	*Physiologic tests under stress *DX endoscopies w/o risk factor *Deep needle BX *Refer patient for consult *Cardio imaging studies w/contrast, w/o risk factors *Obtain body cavity fluid	*Minor surgery w/risk factor *Elective major surgery w/o risk factor *Prescription management *TX nuclear medicine *Closed FX treatment/dislocation w/o reduction *IV fluids w/additives	
High	*One/more chronic illness w/severe progression – side effect of TX *Acute/chronic illnesses/injuries threat to life *Abrupt neurologic change	*Cardio imaging studies w/contrast, w/risk factor *Cardiac electrophysiologic tests *Diag. endoscopies w/risk factor *Discography	*Elective major surgery w/risk factor *Emergency major surgery *Parenteral controlled substances *Drug TX w/intense monitor for toxicity *Decision not to resuscitate or to de-escalate care due to poor prognosis	

Medical Decision Making Matrix (2 of 3 Satisfied)				
MDM Type	SF	LC	MC	HC
Table A	0-1 Minimal	2 Limited	3 Multiple	4 Extensive
Table B	0-1 Minimal	2 Limited	3 Multiple	4 Extensive
Table C	*Minor, Self Limited Problem	*2+ Minor, *1 chronic stable *1 acute	*2+ chronic w/1 serve *New prob.? *1 acute w/system SX	*1+ chronic w/severe exacerb. *a/c threat to life *neuro

5. **Ambulatory Procedure Visit (APV) Audit Methodology.** It is desirable to have an otherwise random sample of charts within the targeted sample selected for review. If fewer than 30 APVs were performed in any month, then all APVs would be audited.

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 charts from the medical record department.

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 shall be provided to the MTF designee(s) and shall 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 records and audit sheets shall be retained by the MTF designee(s) for a period of 2 years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95 percent or provider falling below

90 percent accuracy.   If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow up audits to be performed. In the event the coder remains below 95 percent or the provider remains below 90 percent accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

   j. Plan of Action. The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Regional Command for assessment.

5.1. Diagnosis Accuracy

The coder/auditor will recode the APV encounter and compare the audit diagnoses to the original diagnoses codes. An accuracy rate will be reported by dividing the number of original correct diagnoses by the sum total of diagnosis codes contained in the union of the set of diagnosis codes reported by the original coder and the set of diagnosis codes reported by the coder/auditor.

> *Example: An outpatient encounter was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

> *Roll-up Example: There were 30 APV encounters audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found 5 others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

5.2. Current Procedural Terminology (CPT) Accuracy

The coder/auditor will recode the APV encounter and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *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. "Correct"

for the purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

> *Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that 2 of these were correct. The coder/auditor also identified one further CPT code that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

> *Roll-up Example: There were 30 APV encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/auditor with 70 being correct. The coder/auditor also identified six additional CPT codes that the coder should have captured but did not.   Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

5.2.1. <u>Modifier Accuracy</u>

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

> *Example: The original coding showed 4 modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

*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

day will be audited. Odd registration numbers will be audited for the first day and even registration numbers will be audited for the second day. All attending professional services documented on the selected day will be audited for correct coding.

b. Coder/auditors will either review the hard copy documentation (inpatient chart) or the electronic record (Essentris). If the coder/auditor is utilizing the hard copy, the coder/auditor will provide a list of charts to the medical records department for them to pull.

c. Conduct Audit. The coder/auditor reviews the medical record documentation to determine appropriate assignment of the diagnostic and procedural codes. As with other types of charts, the patient sex, age, and disposition type for each chart must be verified for accuracy.

d. Record Audit Findings. The coder/auditor will record the audit findings in NAVMED 6150/47 (01-2010), IPS RNDS 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.

e. 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).

f. 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.

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

h. 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 shall be provided to the MTF designee(s) and shall 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 records and audit sheets shall be retained by the MTF designee(s) for a period of 2 years. The coder/auditor will then meet with the MTF designee(s) (i.e., provider, coder, specialty leader) to review these audit findings and discuss corrections and opportunities for improvement. A plan of action will be required for any coder falling below 95 percent accuracy. If a plan of action is required, it will be developed at this meeting and distributed to the participants, including any follow-up audits to be performed. In the event the coder remains below 95 percent accuracy, the department head will be notified. Department head will develop a Plan of Action and Milestones document toward meeting coding compliance by relevant individuals.

i. Plan of Action. The MTF designee(s) will ensure that the plan of action developed during feedback meetings is forwarded to the Regional Command for assessment.

j. Follow-up Report. The MTF designee(s) will provide a report of actions and results of the plan of action to the MTF Commander and the Navy Medicine Region Command for forward reporting to BUMED.

6.1. Diagnosis Accuracy

The coder/auditor will recode the IPS rounds and compare the audit-obtained diagnoses to the original diagnoses. An accuracy rate will be reported by dividing the number of original correct diagnoses by the total number of encounters audited.

> *Example: An inpatient round was originally assigned four diagnoses codes. The coder/auditor determined that only three of the four diagnoses codes were appropriately addressed in the documentation and the fourth diagnosis code was therefore inappropriately assigned. Divide the number of correct diagnosis codes (3) by the combined total number of diagnosis codes that were found by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.*

> *Roll-up Example: There were 30 inpatient rounds audited. Twenty-six of these encounters had multiple diagnoses. There was a collective total of 66 originally-assigned diagnoses. The coder/auditor determined that 50 of these diagnoses codes were correct and also found five others that the coder should have reported by did not. Dividing the number of correct diagnoses codes (50) by the combined total number of diagnoses codes originally assigned plus the codes that were missed (66 + 5 = 71) yields 70.4 percent accuracy.*

This is a Targeted Audit element which is also a DQMC-required element.

6.2. Current Procedural Terminology (CPT) Accuracy

The coder/auditor will recode the IPS rounds and compare the audit *CPT* codes to the original *CPT* codes. An accuracy rate will be reported by dividing the number of correct *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. "Correct" for the purposes of these audits means that both the primary *CPT* code is correct and all other non-primary *CPT* codes are correct (although the relative positions of these non-primary *CPT* codes is unimportant.

> *Example: There were three procedures (CPT) codes assigned by the coder and the coder/auditor determines that 2 of these were correct. The coder/auditor also identified one further CPT code*

that the coder should have captured but did not. Divide the number of correct CPT codes assigned (2) by the combined total of the number of CPT codes assigned by the coder plus any additional codes that were found by the coder/auditor but which were missed by the original coder (3 + 1 = 4). 3 divided by 4 equals 75.0 percent accuracy.

Roll-up Example: There were 30 encounters audited with a collective total of 80 CPT codes assigned by the provider/coder. Of these 80 CPT codes, 10 were found to be incorrect by the coder/auditor with 70 being correct. The coder/auditor also identified six further CPT codes that the coder should have captured but did not. Divide the total number of correct CPT codes (70) by the combined total number of CPT codes assigned by the initial provider/coder plus the number of CPT codes that the coder should have captured but did not (80 + 6 = 86). 70 divided by 86 yields 81.4 percent accuracy.

This is a Targeted Audit element which is also a DQMC-required element.

6.3. <u>Evaluation and Management (E/M) Accuracy</u>

The coder/auditor will recode the IPS rounds and compare the audit E/M level to the original E/M level. An accuracy rate will be reported by dividing the number of correct E/M levels assigned by the coder by the sum total of E/M codes contained in the union of the set of E/M codes reported by the original coder and the set of E/M codes reported by the coder/auditor.

Example: The coder/auditor reviewed an inpatient round which had one E/M level assigned by the coder. This was found to be an incorrect code. Additionally, the coder/auditor identified a second E/M code that should have been reported but was not. Divide the number of correct E/M levels (0) by the combined total number of E/M codes that were missed (1 + 1 = 2). 0 divided by 2 yields 0.0 percent accuracy.

Roll-up Example: There were 30 inpatient rounds audited with a collective total of 32 E/M codes assigned by the provider/coder. Of these 32 E/M codes, 3 were found to be incorrect by the coder/auditor with 29 being correct. The coder/auditor also identified two further CPT codes that the coder should have captured but did not. Divide the total number of correct E/M codes (29) by the combined total number of E/M codes assigned by the initial coder plus the two that were missed by the coder (32 + 2 = 34). 29 divided by 34 yields 85.3 percent accuracy.

This is a Targeted Audit element which is also a DQMC-required element.

6.3.1. <u>Modifier Accuracy</u>

Often modifiers are necessary to fully explain the care provided. The coder/auditor will recode the outpatient encounter and assign modifiers as appropriate. An accuracy rate will be determined by dividing the number of *correct* modifiers by the sum total of modifiers contained in the union of the set of modifiers reported by the original coder and the set of modifiers reported by the coder/auditor.

> *Example: The original coding showed 4 modifiers assigned and three were deemed correct by the coder/auditor. Divide the number of correct modifiers (3) by the combined total of modifiers reported by the coder (4) plus the number of modifiers that were found by the coder/auditor but which were missed by the original coder (4 + 0 = 4). 3 divided by 4 equals 75.0 percent accuracy.*
>
> *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.

6.3.2. <u>Units of Service Accuracy</u>

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 seven (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.

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*

*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 "Rounds Applied to the Correct Attending Physician" metric is a unique metric which does not currently exist in the DQMC standard.

7. <u>Error Reason Codes Definitions</u>

	Inpatient Institutional - Diagnosis Coding Reason Code List
D1	A secondary diagnosis reported should have been listed as the principal diagnosis; the audited principal diagnosis changed the MS-DRG.
D2	A secondary diagnosis reported should have been listed as the principal diagnosis; the audited principal diagnosis did not change the MS-DRG.
D3	None of the diagnoses reported were the correct principal diagnosis. (Excludes specificity errors which should be reported with codes D6-D8.) The audited principal diagnosis changed the MS-DRG.
D4	None of the diagnoses reported were the correct principal diagnosis. (Excludes specificity errors which should be reported with codes D6-D8.) The audited principal diagnosis did not change the MS-DRG.
D5	A secondary diagnosis reported cannot be substantiated in the supporting documentation.
D6	A diagnosis code is not coded to greatest specificity.
D7	[Error Reason Code Deleted]
D8	A diagnosis code with an extender digit matches all reported numbers within the code except the extender digit.
D9	A documented MCC was not coded, which causes the DRG to change.
D10	A documented MCC was not coded, which does <u>not</u> cause a change in the MS-DRG.
D11	Based upon the supporting documentation, the MCC should not have been coded. Removing the MCC changes the MS-DRG.
D12	Based upon the supporting documentation, the MCC should not have been coded. Removing the MCC does not change the MS-DRG.
D13	Based upon the supporting documentation, a complication/co-morbidity should have been assigned and will result in a change to the MS-DRG assignment.
D14	Based upon the supporting documentation, a complication/co-morbidity should have been assigned and will not result in a change to the MS-DRG assignment.
D15	Based upon the supporting documentation, a complication/co-morbidity code should not have been assigned and will change the MS-DRG assignment.
D16	Based upon the supporting documentation, a complication/co-morbidity code should not have been assigned and will not result in a change to the MS-DRG assignment.
D17	Based upon the supporting documentation, a diagnosis/diagnoses, should have been assigned as a secondary diagnosis and will not result in a change to the MS DRG.
	Inpatient Institutional – POA Reason Code List
D18	Present on Admission indicator was left blank, and the audited POA changed the MS-DRG.
D19	Present on Admission indicator was left blank, and the audited POA did not change the MS-DRG.
D20	The POA was changed; the audited POA indicator changed the MS-DRG.
D21	The POA was changed; the audited POA indicator did not change the MS-DRG.
D22	A different disposition code should have been assigned; the audited disposition code changed the MS-DRG.
D23	A different disposition code should have been assigned; the audited disposition code did not change the MS-DRG.

	Inpatient Reason Codes for Querying
Q1	Query for principal diagnosis may impact MS-DRG.
Q2	Query for medical MCC may impact MS-DRG.
Q3	Query for medical CC may impact MS-DRG.
Q4	Query for surgical MCC may impact MS-DRG.
Q5	Query for surgical CC may impact MS-DRG.
Q6	Query for procedure code added query changes MS-DRG.
Q7	Query for diagnosis that does not impact MS-DRG.
	Inpatient Facility - Procedure Coding Reason Code List
I1	Principal procedure—incorrect sequencing; secondary procedure is principal procedure, affecting MS-DRG.
I2	Principal procedure—incorrect sequencing; secondary procedure is principal procedure, not affecting MS-DRG.
I3	Principal procedure—wrong code assigned; secondary procedures are not principal either, affecting MS-DRG.
I4	Principal procedure—wrong code assigned; secondary procedures are not principal either, not affecting MS-DRG.
I5	Documentation does not support coded secondary procedure, affecting MS-DRG.
I6	Documentation does not support coded secondary procedure, not affecting MS-DRG.
I7	Procedure not coded to appropriate level of specificity, affecting MS-DRG.
I8	Procedure not coded to appropriate level of specificity, not affecting MS-DRG.
I9	Failure to code documented procedure, affecting MS-DRG.
I10	Failure to code documented procedure, not affecting MS-DRG.
	APV / Outpatient/Inpatient Professional – E/M Coding Reason Code List
E1	The category of E/M code audited was not the same category of E/M code submitted. (New vs. Est., Consult vs. New, Inpt. Admit vs. Subsq. Day, Critical Care vs. Subsq. Day)
E2	The E/M code audited was 1 level below the reported E/M code.
E3	The E/M code audited was 2 levels below the reported E/M code.
E4	The E/M code audited was 3 levels below the reported E/M code.
E5	The E/M code audited was 4 levels below the reported E/M code.
E6	The E/M code audited was 1 level above the reported E/M code.
E7	The E/M code audited was 2 levels above the reported E/M code.
E8	The E/M code audited was 3 levels above the reported E/M code.
E9	The E/M code audited was 4 levels above the reported E/M code.
E10	Based upon the supporting documentation, an E/M code should not have been reported.
E11	Based upon the supporting documentation, an additional E/M code should have been reported.
E12	Based upon the supporting documentation, an E/M code should have been reported.
	APV / Outpatient/Inpatient Professional - Diagnosis Coding Reason Code List
V1	A secondary diagnosis reported should have been listed in the first diagnosis position.
V2	None of the diagnoses reported were the correct primary diagnosis.
V3	A diagnosis reported cannot be substantiated in the supporting documentation.
V4	A diagnosis code is not coded to greatest specificity.
V5	[Error Reason Code Deleted]
V6	A diagnosis code with an extender digit matches all reported numbers within the code except the extender digit.
V7	Based upon the supporting documentation, diagnosis code(s) should have been assigned as an additional (non-primary) code.
V8	The diagnosis linked for this procedure (*CPT*/HCPCS) code was appropriate for another procedure (*CPT*/HCPCS) listed on the encounter, but not for this procedure (*CPT*/HCPCS) code.

	APV / Outpatient/Inpatient Professional - Modifiers Reason Code List	
M1	A modifier was not reported for an E/M or *CPT*/HCPCS procedure; however, the supporting documentation and/or coding rules indicate that a modifier should be assigned.	
M2	Based upon the supporting documentation, the modifier reported for an E/M or *CPT*/HCPCS procedure should be replaced by a different modifier.	
M3	Based upon the supporting documentation, the modifier reported for an E/M or *CPT*/HCPCS procedure should not have been assigned.	
M4	Based upon the supporting documentation, the modifiers reported for a procedure were incorrectly sequenced.	
	APV / Outpatient/Inpatient Professional - Quantity Reason Code List	
U1	Based upon the supporting documentation, the number listed in the units of service field should have been higher than the number reported.	
U2	Based upon the supporting documentation, the number listed in the units of service field should have been lower than the number reported.	
	APV / Outpatient/Inpatient Professional - Procedure Reason Code List	
P1	A procedure code reported was not coded to greatest specificity.	
P2	The procedure code reported should have been reported with a different *CPT* code.	
P3	A procedure code reported should not have been reported because it is included, by definition of the procedures, within one other procedure reported on the same encounter.	
P4	A procedure code was not reported in ascending RVU value order (highest value to lowest value).	
P5	Based upon the supporting documentation, a procedure should not have been reported.	
P6	Based upon the supporting documentation, a procedure should have been reported.	
P7	A *CPT* code should have been reported versus a HCPCS code (Level II).	
P8	A HCPCS code should have been reported versus a *CPT* code.	
	APV / Outpatient/Inpatient Professional - Query	
C1	Query for documentation that may affect coding.	

8. <u>Roles and Responsibilities</u>

8.1. <u>BUMED</u>

    a. BUMED-M3/5 HCO3 (Health Information Management) is responsible for representing Navy at the UBU which, in turn, develops polices concerning inpatient and outpatient coding standard business practices, processes, and reporting requirements.

    b. BUMED-M3/5 HCO3 develops annual performance metrics, reporting requirements, and a tracking mechanism to monitor and ensure MTF compliance with coding and auditing of the closed medical record system.

    c. BUMED-M3/5 HCO3 analyzes data and develops written Navy policies concerning inpatient and outpatient coding standard business "best practices," processes, and reporting requirements, and promulgates these policies on a timely basis.

    d. BUMED-M3/5 HCO3 develops policies for Coding Audit Guidelines and works with the DQMC manager to ensure compliance with Coding Audit Guidelines and determines oversight activities that are required for successful execution of Coding Audits.

Enclosure (3)

8.2. MTF Regional Commands. MTF Region Commands are responsible for assisting MTFs within their respective area of responsibility (AOR) in implementation of the policies and procedures defined in these Coding Audit Requirements and Guidelines. MTF Regional Commands will ensure correct and timely reporting, and will conduct external/shadow audits when necessary.

8.3. MTF Responsibilities

a. The MTF commanding officer has the ultimate responsibility to ensure that all clinical documentation, clinical coding, and administrative procedures surrounding patient encounters are conducted following the requirements of these Coding Audit Requirements and Guidelines, applicable State and Federal laws, and The Joint Commission standards. MTFs and MTF designee(s) will generate Follow-Up Reports as outlined in Section 6, and will ensure training programs are in place to correct noted deficiencies—including (but not limited to): individual and group education, feedback and query processes, and ensuring bilateral communication between providers and coders.

b. The MTF commanding officer will ensure that a process is in place to correct retrospectively any specific coding errors that are identified during the course of the audit.

c. The PAD is responsible to the commanding officer for ensuring compliance with these Guidelines and has functional oversight of the administrative coding process supporting both inpatient admissions and outpatient encounters.

d. The MRA reports to the PAD or appropriate designee. The MRA is responsible for oversight of the inpatient and outpatient coding staff, and coding processes and practices—including audits. The MRA is further responsible for ensuring that clinical documentation in the patient record supports and justifies the coding assigned for the episode of care. Deficiencies must have corrective action when identified.

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

MID	Management Information Department
MRA	Medical Record Administrator
MRI	Magnetic Resonance Imaging
MS-DRG	Medicare Severity-Diagnosis Related Group
MSA	Medical Services Account
MTF	Medical Treatment Facilities
NAVMED	Navy Medicine
NMETC	Naval Medical Education and Training Command
OASD(HA)	Office of the Assistant Secretary of Defense, Health Affairs
OHI	Other Health Insurance
ORYX	ORYX is The Joint Commission's performance measurement and improvement initiative first implemented in 1997
OSD	Office of the Secretary of Defense
PAD	Patient Administration Department
PL	Public Law
POA	Present on Admission
PPS	Prospective Payment System
RHIA	Registered Health Information Administrator
RHIT	Registered Health Information Technician
RNDS	Rounds (attending physician visits to hospitalized inpatients)
RVUs	Relative Value Units
RWPs	Relative Weighted Product
SADR	Standard Ambulatory Data Record
S&S	Signs and Symptoms
TJC	The Joint Commission
TMA	TRICARE Management Activity
TPOCS	Third Party Outpatient Collections System
UBU	Uniformed Biostatistical Utility
WBC	White Blood Count

Enclosure (4)