Role of a Medical Staff Coding Committee in Documentation, Coding, and Billing Compliance

Nelson P. Gruber, M.D.
Helen Shepherd, M.P.A.
Roy V. Varner, M.D.

Physician documentation, Current Procedural Terminology (CPT) coding, and compliance with federal billing regulations are essential given the government's significant efforts to address fraud and abuse and the grave financial and legal consequences of noncompliance. Because Medicare guidelines do not focus substantially on psychiatric care, compliance is especially challenging for psychiatrists and psychiatric centers. Four years ago, the University of Texas–Harris County Psychiatric Center formed a medical staff coding committee to assist the center and its psychiatrists in dealing with compliance issues. The committee has evolved into a highly effective and important component of the institution's overall compliance program. The authors discuss the origins, development, and accomplishments of the medical staff coding committee. (*Psychiatric Services* 53:1629–1631, 2002)

Physician documentation, Current Procedural Terminology (CPT) coding, and compliance with federal billing regulations are essential given the government's significant efforts to address fraud and abuse and the grave financial and legal consequences of noncompliance (1,2). Compliance has been especially challenging for psychiatrists and psychiatric centers, because Medicare guidelines do not focus substantially on psychiatric care.

At the 250-bed University of Texas–Harris County Psychiatric

Center (UT-HCPC), compliance issues have been a top priority. Four years ago, a medical staff coding committee was formed to help the center and its psychiatrists address compliance issues. This report discusses the origins, development, and accomplishments of the committee.

Medicare fraud and abuse

A 1996 audit by the U.S. Office of Inspector General concluded that about 14 percent of that year's Medicare dollars ($23 billion) were spent inappropriately. About $5 billion of that amount was for physician services. Major errors responsible for these payments included lack of medical necessity, incorrect coding, and insufficient or no documentation. Thus physicians became increasingly accountable for appropriately documenting their services as well as for the accuracy of their coding and billing processes. Special federal funding allowed coordinated federal, state, and local investigation and prosecution of Medicare fraud and abuse. Lack of awareness or misunderstanding of complex rules of federal programs provided little protection. High-profile cases against medical schools and private institutions were well publicized (3–5).

Response to the problem

The University of Texas Health Science Center at Houston (UTHSC-H) assigned a high priority to responding to these compliance challenges. The medical school established documentation expectations and implemented a formal chart audit process for all its clinicians. Medicare evaluation and management documentation guidelines were adopted as the "corporate standard" for all patient care. Compliance with Medicare teaching physician rules was ranked as the most important compliance issue. The potential for severe consequences of noncompliance was emphasized.

UT-HCPC, a component institution of UTHSC-H, developed a statement of policy on ethical patient care and billing practices after the Office of Inspector General had issued compliance program guidelines for hospitals (6). This statement affirmed the institution's duty to maintain the highest level of ethical conduct and standards. Employees were required to be generally aware of the laws and regulations that applied to clinical documentation, coding, and billing and also to have job-specific knowledge in these areas. However, although the statement was prescriptive of compliance, it provided little practical information on how to achieve it. Thus the medical director and the chief financial officer jointly developed the idea of a medical staff coding committee. This committee was incorporated as a medical staff committee, and initial charges for the committee were established.

The medical staff coding committee

The charges developed over the first year of the committee's functioning were to ensure communication about documentation; coordinate oversight with UT-HCPC's compliance program; develop a working relationship with the coding staff, ensuring a common perspective; establish expectations for documentation compliance; determine which would be the best evaluation and management guidelines to use (the 1995 guidelines or the 1997 guidelines) and clarify them for daily use; decide on the documentation content for coding levels; clarify and integrate teaching physician guidelines; provide ongoing education about evaluation and management guidelines; develop standards for internal auditing; review audits of all medical records; provide feedback on documentation; increase physician charges by optimizing documentation; and address future related issues.

In retrospect, the committee was establishing a voluntary compliance program—and in advance of recommendations by the Office of Inspector General to do so. The components of such a program are monitoring and auditing; establishing practice standards and procedures; designating a compliance officer or contact; conducting appropriate training and education; responding to detected offenses and developing action initiatives; developing open lines of communication; and enforcing disciplinary standards through publicized guidelines (4,5).

The medical staff coding committee initially included the medical director, medical staff members, coding staff, the compliance officer, and the chief financial officer. As the committee evolved, the medical director became an ex officio member and consultant for the committee, the chief financial officer attended committee meetings as needed, and the chief hospital administrator's attendance was sought once each quarter. Meetings were scheduled on a monthly basis and included a review of documentation, coding, and billing performance on all closed medical records of the previous month, plus new business.

Initial efforts focused on clarification of Medicare guidelines. The committee worked extensively with coding staff, using Medicare-related references and resources as well as UTHSC-H institutional compliance standards, to understand evaluation and management guidelines from a hospital psychiatry perspective. Developing such an understanding was critical, because some important areas of the evaluation and management guidelines were directed more toward general medicine than toward psychiatry. It was necessary to translate elements needed for history, examination, and medical decision making into tangible components that made sense in the context of daily inpatient psychiatry practice. Every effort was made to ensure that documentation would support the level of care provided. With this task accomplished, usual coding levels as well as the documentation content for admission, subsequent care, and discharge notes were established.

Similar attention was devoted to

At the time of this study, all authors were affiliated with the University of Texas–Harris County Psychiatric Center and the department of psychiatry and behavioral sciences of the University of Texas Health Science Center at Houston. Ms. Shepherd recently left the University of Texas System and is currently with the Memorial Hermann Healthcare System in Houston. Send correspondence to Dr. Gruber, UT-HCPC 2D-08, 2800 South Macgregor Way, Houston, Texas, 77021 (e-mail, ngruber@mind.hcpc.uth.tmc.edu).

fully understanding Medicare teaching physician rules and how best to incorporate them into routine charting. Integration and cross-referencing of attending and resident documentation were standardized. Routine internal auditing was established for all closed medical records. The coding staff began providing monthly information on coding levels, legibility, insufficient and missing documentation, discharge documentation, and appropriate referencing of residents' documentation, among other topics. Education was provided through routine and special meetings, comprehensive user-friendly handouts, and general and individual feedback via memos to ensure that clarifications materialized in daily practice. Finally, the monthly committee meeting became the venue in which performance was reviewed and discussed, trends were noted and investigated, and new documentation, coding, and billing issues were assessed.

Discussion and conclusions

The results of the process have been gratifying. The medical staff coding committee has developed and matured into an effective, medical staff–driven documentation, coding, and billing compliance program. It is an important component of the institution's overall compliance program. Evaluation and management guidelines are understood and integrated with Medicare teaching physician rules. Focused teaching materials support documentation education. Collaboration with the coding staff has been strengthened, which has ensured that any problems receive prompt attention. Attending and resident physicians accept the Medicare-derived documentation and coding standards; the compliance rate is typically higher than 95 percent. Nearly all potential physician charges are captured, because the coding levels, supported by appropriate documentation, match the services provided. An infrastructure for addressing documentation and related issues is in place. The benefits of these efforts have accrued to the institution.

No operating problems with the structure and functioning of the committee have been experienced. Documentation and coding standards have been incorporated into routine practice. Additional work by the coding staff has been minimal. Most issues can be addressed during the monthly committee meeting. Usually only a modest amount of work needs to be done outside of committee meetings. Minor slippage in established documentation procedures occasionally occurs; in such cases, memos are issued that reiterate expectations to ensure compliance.

The most difficult aspect of ensuring compliance was gaining initial acceptance by physicians of the type and amount of content that Medicare documentation rules demand. Reasonable documentation efforts by physicians sometimes fell short of meeting Medicare standards because of the somewhat unclear evaluation and management guidelines and a broader lack of awareness about them. As a result of defining achievable documentation requirements and providing access to education about them, the medical staff and residents changed their practices and achieved full compliance.

In conclusion, the creation of a medical staff coding committee is an effective strategy for ensuring widespread and knowledgeable daily use of federal evaluation and management documentation, coding, and billing guidelines by physicians. The many practical benefits of instituting a medical staff coding committee make it well worth the effort. ♦

Acknowledgments

The authors acknowledge current and former members of the medical staff coding committee for their efforts. Members include Miriam Aponte, M.D., James Ferrero, M.D., Pushpa Gummattira, M.D., Jon-Paul Hamilton, M.D., Sharon Morgan, Ph.D., Hanan Shaheen, M.D., and Debra Stokan, M.D. The authors also thank Lori Dunham, C.P.C., Dasha Wheeler, C.P.C., Angela Oren, J.D., and Lee Ann Henry.

References

1. Coles TS, Babb EF: Accurate documentation, correct coding, and compliance: it's your best defense. Missouri Medicine 96:236–239, 1999
2. Guglielmo WJ: The Feds take aim at fraud and abuse. Medical Economics 75:166, 171–4,177–178, 1998
3. Schutte JE: Fraud and Abuse Prevention: What Physicians Need to Know. Austin, Texas Medical Association, 1998
4. Schutte JE, Devine T, Farris D, et al (eds): Fraud and Abuse Prevention: What Physicians Need to Know, 2nd ed. Austin, Texas Medical Association, 2001
5. Withrow SC: Managing Healthcare Compliance. Chicago, Health Administration Press, 1999
6. US Department of Health and Human Services, Office of Inspector General: Compliance program guidance for hospitals. Federal Register 63(Feb):87,89, 1998

First-Person Accounts Invited for Column

Patients, former patients, family members, and mental health professionals are invited to submit first-person accounts of experiences with mentalillness and treatment for the Personal Accounts column of Psychiatric Services. Maximum length is 1,600 words. The column appears every two months.

Material to be considered for publication should be sent to the column editor, Jeffrey L. Geller, M.D., M.P.H., at the Department of Psychiatry, University of Massachusetts Medical School, 55 Lake Avenue North, Worcester, Massachusetts 01655. Authors may publish under a pseudonym if they wish.