CMS, OIG increase audits of provider claims

The Centers of Medicare and Medicaid Services (CMS) and the Office of the Inspector General (OIG) are increasing audits of patient diagnosis coding on provider claims submitted to health plans. They believe that diagnosis coding on provider claims isn't compliant with the ICD 10 CM guidelines and leads to millions of dollars in overpayment to health plans. Revenue associated with the unsupported diagnoses is pulled back by CMS.

Additionally, CMS could assess fines or extrapolate an error rate associated with an HCC diagnosis to a health plan's entire population. This could result in significant negative financial and reputational impact to the health plan.

Diagnoses that have been under OIG scrutiny for overpayment include the following:

- Acute myocardial infarction
- Acute stroke
- Embolism
- Cancer
  - Breast
  - Prostate
  - Lung
  - Colon
  - Ovarian
- Sepsis
- Pressure ulcer

Documentation and coding specificity and accuracy is essential for complete and accurate depiction of patient health status. Keep the following in mind when evaluating patients and writing your documentation to support the conditions you code on your claim.

Diagnosis: **document the patient's current diagnosis as specifically as possible**. This includes documenting the following details about the conditions:

- Chronicity: acute, chronic or acute on chronic
- Type: 1,2, ischemic, infectious, etc.
- Stage: mild, moderate, severe, 1-5, etc.
- Relationship with other conditions: indicate if diagnosis is caused by or is causing another condition. Phrasing might include "due to," "caused by" or "-ic", such as "diabetic neuropathy" or "alcoholic cirrhosis"

Status: note if the condition stable, unstable, worsening, improved or resolved. Include the following to support the patient status:

- Lab values
- Diagnostic studies
- Vitals signs and other exam findings
- Patient signs and symptoms
- Response to treatment
- Progression or regression of disease

Plan: indicate what is being done to manage or further evaluate the condition.

- Treatment: medication (link to the diagnosis it treats), dietary or other therapies
- Referral to other providers or specialists
- Follow-up evaluation

Providing the **diagnosis, status and plan** for every condition you evaluate, treat or take into consideration in the care of your patient at the time of the visit will ensure complete and compliant diagnosis coding.

Additional tips

- Use "history of" only when referring to conditions that have resolved and no longer exist.
- Do not code suspect, probable or possible diagnoses. In this scenario, code the patient signs and symptoms until the diagnosis is clear
- **Golden Rule:** never code more specifically than your documentation.