



Coding and Documentation Analysis

To ensure full and accurate reimbursement for healthcare services rendered by your facility, coding should always be driven by well documented patient care. Unfortunately, it is all too common for pertinent clinical information to be absent from a patient's chart. While incomplete documentation has always put hospitals at financial risk, it is becoming an increasing concern due to the implementation of accountable care, pay-per-performance, ICD-10, and value-based purchasing initiatives. We will:

- Monitor your organization's compliance with established and impending coding and documentation standards.
- Provide a quality review of each chart's documentation and coding by a certified coding professional.
- Provide an assessment of potential liability along with a detailed executive summary of findings along with recommendations and cross references to official sources and coding guidelines.
- Follow up exit interview with key hospital staff to review the summary report and provide education and recommendations based on findings.

Correct medical coding is critical to getting paid for what you do and for avoiding external audits by Medicare, Medicaid and other payers. The only way to determine whether medical coding is appropriate is to compare it against the actual clinical documentation recorded in the medical record. A medical record chart review and coding analysis can reveal whether any variation from national averages is due to inappropriate medical coding or to atypical levels of intensity among your patients. Such a medical audit can serve two main purposes:

- Help make corrections before payers challenge any inappropriate coding
- Provide you the confidence to fully code the more intense encounters.

Blue's professional team of certified coding and Clinical Documentation Improvement (CDI) consultants have extensive experience performing independent coding reviews in both the inpatient and outpatient settings. We review not only inpatient encounters, but also outpatient surgery, ancillary services, physical therapy services, anesthesia and more.

Our Medical Record Chart Reviews are performed in compliance with AMA, CMS and insurance carrier coding guidelines and comply with both HIPAA and the National Correct Coding Initiative. As such, Blue's Medical Record Chart Reviews typically evaluate the accuracy of procedure and diagnosis coding, modifier usage, completeness of documentation, medical necessity, potential lost revenue and charge-based opportunities.

Appropriate documentation is your organization's best defense against a carrier audit. Let Blue help you identify and reduce your coding and documentation risks.

Please contact Lynette Thom, RHIT, CDIP and AHIMA Approved ICD-10-CM/PCS Trainer at 317-713-7926 or lthom@blueandco.com to discover how Blue & Co., LLC can help your organization.