

**Texas Tech University Health Sciences Center  
Billing Compliance Program**

<b>BCO 3.0 Coding and Documentation Improvement Program</b>	
<b>Approved Date:</b> March 13, 2008	<b>Effective Date:</b> April 1, 2008
<b>Last Revision Date:</b> September 1, 2016	

**A. PURPOSE**

To establish a means of improving the quality of coding and documentation of health care items/services provided by Texas Tech University Health Sciences Center (TTUHSC) employees (faculty, residents and staff) and contractors.

**B. POLICY**

TTUHSC providers are expected to strive for one hundred percent (100%) compliance with the billing documentation and coding requirements required by federal and state laws and regulations as well as private third party payer agreements.

See [BCP 5.2 Billing Compliance Monitoring](#). New and returning Providers shall be monitored within 120 days after their orientation pursuant to BCO 2.0 New Provider Orientation. In some case, it may be necessary to exceed the 120 days if there are insufficient number of encounters to audit.

**C. SCOPE**

This policy applies to all TTUHSC providers and coders/billers.

**D. PROCEDURE**

**1. Measuring Need for Participation in Improvement Program**

The Audit Score Methodology provides the legend for the scoring system, which is based on the point system. Chart (Exhibit 1)

Provider Finding Detail located in MD Audit should be used to identify who is responsible for errors identified during the monitoring and/or auditing process.

**2. Provider Improvement Plan**

- a. TTUHSC providers who fail to perform within 100% of the compliance objective during a monitoring period (calendar quarter) will be required to participate in the improvement plan outlined below.

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POINTS	IMPROVEMENT PLAN	RESPONSIBLE PARTY
0-2	a. Written notice to provider (Signature Letter) of monitoring results	a. Clinical or Central Coding Department, or Billing Compliance Office (BCO)
3-6	a. Written notice ( Signature Letter) to provider of identified errors. b. As needed, meet with provider to answer questions.	a. Clinical or Central Coding Department, or BCO b. Clinical or Central Coding Department, or BCO
7-12	a. Written notice ( Signature Letter) to provider of errors. b. Provide and document training on noted errors within a reasonable time.	a. Clinical or Central Coding Department, or BCO b. Clinical or Central Coding Department, or BCO
13 or more	a. Written notice ( Signature Letter) to provider, copy to Department Chair, Administrator, and campus BCD. b. Provide training on identified errors within thirty (30) days of written notice. (May be extended as necessary.) Notify BCD when completed. c. If training not completed within the allotted time period, refer the matter to Department Chair for further action, copy to BCD. d. Audit of 10 encounters focused on problem areas identified in previous monitoring within thirty (30) days from training with written report to BCD. If no improvement refer the matter to Institutional Compliance Office for further action.	a. Clinical or Central Coding Department or BCO b. Clinical or Central Coding Department or BCO c. BCO and Department Chair d. Clinical or Central Coding Department or BCO
High risk* findings (total score may or may not exceed 12 points)  * trends of coding and/or documentation that could result in overpayments or identified risk areas from national benchmark data	a. Written notice ( Signature Letter) to provider, copy to Department Chair, Administrator, and campus BCD. b. Provide training on identified errors within thirty (30) days of written notice. (May be extended as necessary.) Notify BCD when completed. c. If training not completed within the allotted time period, refer the matter to Department Chair for further action, copy to BCD. d. Audit of 10 encounters focused on problem areas identified in previous monitoring within thirty (30) days from training with written report to BCD. If no improvement refer the matter to Institutional Compliance Office for further action.	a. Clinical or Central Coding Department or BCO b. Clinical or Central Coding Department or BCO c. BCO and Department Chair d. Clinical or Central Coding Department or BCO

b. Refunds of Identified Overpayments. See [BC 3.1 Report and Return of Overpayments.](#)

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**3. Non-Provider Employee Improvement Plan**

- a. Non-provider employees include any individuals who are responsible for selecting CPT codes, ICD-10 codes, modifiers and/or other information that is utilized to bill for health care items or services.
- b. In the event errors identified during the monitoring/auditing process due to a non-provider employee's errors resulting in twelve (12) or more points in a given calendar year, the Department shall work with the campus Billing Compliance Director/Officer (BCD/O) to implement appropriate training to address the identified errors. It shall be the responsibility of the Clinical Department to provide appropriate training to the non-provider employee regarding any noted deficiencies totaling 12 or more points. This policy is neither structured nor intended to define a threshold for progressive disciplinary action. However, nothing herein shall prevent a Department from pursuing progressive discipline under TTUHSC's policies. Furthermore, nothing herein shall prevent the Billing Compliance Office from intervening when a Clinical Department fails or refuses to adequately address employee behavior resulting in health care billing non-compliance.
- c. It will be the responsibility of each Clinical Department to ensure that the Position Description (PD) of each non-provider employee described in C.1 includes the following:
  - 1) Function: accurate coding of health care items and services in accordance with TTUHSC's policies and applicable payer standards.
  - 2) Performance measures:
    - a) Points accumulated in billing compliance monitoring and/or auditing activities and applicable policies;
    - b) Internal or external audits or investigations that assess the accuracy of coding for health care items and/or services.

**4. Fraudulent Behavior**

Fraudulent behavior or willful misconduct (e.g., falsifying documentation for billing purposes, etc.) will not be tolerated. Any employee (including faculty) engaging in fraudulent activity will be directed to the appropriate Institutional Compliance Working Committee and/or Dean for further disciplinary action, including, but not limited to, termination of faculty contract or employment, as may be applicable.

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**E. ADMINISTRATION AND INTERPRETATION, REVISIONS OR TERMINATION**

Refer to Billing Compliance Program Policy and Procedure [1.0 Policy Development and Implementation](#)

Failure to comply with this policy shall result in appropriate disciplinary action.

Questions regarding this policy may be addressed to the TTUHSC Institutional Compliance Officer or BCD/O.

This policy shall be reviewed no later than April 1 in each odd-numbered year.

# Audit Score Methodology

The scoring methodology assigns points based on the findings of the documentation review. The lower the score the better, so a total score of 0 is perfect. A higher score may indicate that immediate improvement is needed. Based on the assigned points a meeting with the provider to review the audit results in detail, provide instruction or additional education and answer questions may be necessary. The category of administrative errors are those findings that are attributed to the administrative or billing staff processes, which now are beyond the control of the provider. The legend for the scoring system is presented below.

## Provider Findings

### Diagnosis

#### Disagree

- 0.00 OX- Diagnosis Billed but not Addressed at Visit
- 0.00 OX- Diagnosis Billed is Symptom of Primary Condition
- 1.00 DX- Diagnosis Code Added
- 1.00 OX- Diagnosis Documented is Different than Diagnosis Selected
- 1.00 DX- Diagnosis Not Documented
- 0.00 DX- Diagnosis Not Reviewed by Coder/Auditor

#### External Coder Error

- 0.00 Xtrnl- DX- Agree with Selected Diagnosis
- 0.00 Xtrnl- OX- Diagnosis Billed is Symptom of Primary Condition
- 1.00 Xtrnl- OX- Diagnosis Code Added
- 1.00 Xtrnl- OX- Diagnosis Documented is Different than Diagnosis Selected
- 1.00 Xtrnl- DX- Diagnosis Not Documented
- 0.00 Xtrnl- OX- Diagnosis Not Reviewed

### Procedure

#### Disagree

- 2.00 Mod- Disagree with Selected Modifier- Upcoding
- 3.00 Px- CPT Bundling/Unbundling
- 3.00 Px- Incorrect Units for Px Billed- up-coding

#### E&M Category Change

- 1.00 EM- Consult Criteria Not Met
- 3.00 EM- Incorrect E&M Category

#### E&M Non-Billable

- 2.00 EM- Billing Provider Signature Missing
- 2.00 EM- E&M Bundling, separate E&M not appropriate
- 6.00 EM- No Note Found (No Documentation to Support Code)
- 2.00 EM- Service performed and billed but not billable

#### External Coder Error

- 6.00 Xtrnl- Anesthesia Medical Direction Rules Not Met
- 6.00 Xtrnl- Anesthesia Medical Supervision Rules Not Met
- 1.00 Xtrnl- Conflicting Elements i.e. history, exam, etc. i.e./in an EMR note
- 0.00 Xtrnl- EM- Agree with Selected E&M
- 1.00 Xtrnl- EM- Consult Criteria Not Met
- 2.00 Xtrnl- EM- E&M Bundling, separate E&M not appropriate
- 1.00 Xtrnl- EM- E&M Service Added
- 3.00 Xtrnl- EM- E&M Service Overcoded Four Levels
- 2.00 Xtrnl- EM- E&M service Overcoded One Level
- 3.00 Xtrnl- EM- E&M Service Overcoded Three Levels
- 2.00 Xtrnl- EM- E&M Service Overcoded Two Levels
- 2.00 Xtrnl- EM- E&M Service Undercoded Four Levels
- 0.00 Xtrnl- EM- E&M Service Undercoded One Level
- 2.00 Xtrnl- EM- E&M Service Undercoded Three Levels
- 1.00 Xtrnl- EM- E&M Service Undercoded Two Levels
- 1.00 Xtrnl- EM- E&M Unbundling, additional E&M should have been billed
- 3.00 Xtrnl- EM- Incorrect E&M Category
- 2.00 Xtrnl- EM- Insufficient Documentation for E&M Service Billed
- 4.00 Xtrnl- EM- Insufficient Teaching Physician Documentation
- 6.00 Xtrnl- EM- No Documentation to support the code (documentation does not exist)
- 6.00 Xtrnl- EM- PCE Exception Rules Not Met
- 0.00 Xtrnl- Mod- Agree with Selected Modifier
- 2.00 Xtrnl- Mod- Disagree with Selected Modifier- Upcoding
- 0.00 Xtrnl- Mod- Modifier Not Reviewed
- 0.00 Xtrnl- Px- Agree with Selected Procedure

- 3.00 Xtrnl-PxCPT Bundling/Unbundling
- 3.00 Xtrnl-Px- Incorrect Units for Px Billed-up-coding
- 3.00 Xtrnl- Px- Insufficient Documentation for Procedure Billed
- 4.00 Xtrnl- Px- Insufficient Teaching Physician Documentation
- 6.00 Xtrnl- Px- No Documentation to support the code (documentation does not exist)
- 1.00 Xtrnl- Px- Procedure Code Added
- 3.00 Xtrnl- Px- Procedure Documented is Different Than Procedure Selected

#### **Missed Revenue**

- 1.00 EM- E&M Service Added
- 1.00 EM- E&M Unbundling, additional E&M should have been billed
- 1.00 Px- Procedure Code Added

#### **Not Reviewed**

- 0.00 Mod- Modifier Not Reviewed

#### **Overcoded E&M**

- 4.00 EM- E&M Service Overcoded Four Levels
- 2.00 EM- E&M Service Overcoded One Level
- 3.00 EM- E&M Service Overcoded Three Levels
- 3.00 EME&M Service Overcoded Two Levels
- 2.00 EM- Insufficient Documentation for E&M Service Billed

#### **Procedure Code Change**

- 3.00 Px- Procedure Documented is Different Than Procedure Selected

#### **Procedure Non-Billable**

- 3.00 Px-Insufficient Documentation for Procedure Billed
- 6.00 Px- No Note Found (No Documentation to Support Code)

#### **Teaching Physician Rules**

- 6.00 Anesthesia Medical Direction Rules Not Met
- 6.00 Anesthesia Medical Supervision Rules Not Met
- 1.00 Conflicting Elements i.e. history, exam, etc. i.e./in an EMR note
- 4.00 EM- Insufficient Teaching Physician Documentation
- 6.00 EM- PCE Exception Rules Not Met
- 4.00 Px- Insufficient Teaching Physician Documentation

#### **Undercoded E&M**

- 2.00 EM- E&M Service Undercoded Four Levels
- 0.00 EM- E&M Service Undercoded One Level
- 2.00 EM- E&M Service Undercoded Three Levels
- 1.00 EM- E&M Service Undercoded Two Levels

## **Administrative Findings**

### *Diagnosis*

#### **Disagree**

- 0.00 Ox- Diagnosis not coded to highest specificity
- 1.00 Ox- Incorrect Diagnosis Link/Sequencing

### *Procedure*

#### **Administrative Error**

- 2.00 Billed DOS Differs From Documented DOS
- 2.00 Billed Place of Service (POS) Differs from Documented POS
- 1.00 Billing Provider Differs From Documenting Provider
- 6.00 Performed by Unlicensed Provider; service out of scope of practice; provider on OIG Exclusion List
- 1.00 Px- No Advanced Beneficiary Notice (ABN)
- 2.00 Service billed to wrong patient

#### **Disagree**

- 1.00 Mod- Disagree with Selected Modifier- No Upcoding
- 1.00 Px- Incorrect Units for Px Billed- no up-coding

#### **External Coder Error**

- 2.00 Xtrnl-Billed DOS Differs From Documented DOS
- 1.00 Xtrnl- Billing Provider Differs From Documenting Provider
- 1.00 Xtrnl- Mod- Disagree with Selected Modifier- No Upcoding
- 1.00 Xtrnl- Mod- Modifier Added
- 6.00 Xtrnl- Performed by Unlicensed Provider; service out of scope of practice; provider on OIG Exclusion List
- 1.00 Xtrnl- Px- Incorrect Units for Px billed- no up-coding
- 1.00 Xtrnl- Px- No Advanced Beneficiary Notice (ABN)
- 1.00 Xtrnl- Resident documentation not signed by resident
- 2.00 Xtrnl- Service billed to wrong patient
- 2.00 Xtrnl- Wrong Place of Service

#### **Missed Revenue**

- 1.00 Mod- Modifier Added

#### **Teaching Physician Rules**

- 1.00 Resident documentation not signed by resident