Audit Tool for Coding

Preparation

1. Prior to reviewing a group of cases with similar diagnoses and procedures, review related coding conventions and guidelines.

2. Identify possible coding problems that can occur.

Record/Claim Review (Document findings below)

	Yes	No
1. Does the medical record:		
a. match the claim being reviewed (patient name/admission date);	____	____
b. contain an inpatient admission order for the date of admission and the level of care billed; and	____	____
c. match the provider number billed, e.g., PPS versus non-PPS?	____	____
2. Is medical record documentation present to substantiate the principal diagnosis as:		
a. present on admission;	____	____
b. a principal reason for admission; and	____	____
c. treated or evaluated during the stay?	____	____
3. Is medical record documentation present to support secondary diagnoses and complications/ comorbidities billed?	____	____
4. Are there any secondary diagnoses or complications/comorbidities that are supported by medical record documentation and affect the DRG but were not billed?	____	____
5. Is medical record documentation present to support procedures billed?	____	____
6. Are there any procedures that are supported by medical record documentation and affect the DRG but were not billed?	____	____
7. Is medical record documentation present to support the patient's age and discharge status?	____	____
8. Are there any other coding errors?	____	____

If Yes, note the problem area below:

- ☐ code does not match diagnosis/procedure
- ☐ code lacks specificity
- ☐ sequencing is incorrect
- ☐ coding does not follow ICD-9-CM coding conventions
- ☐ coding does not follow *Coding Clinic* guidelines

Findings

Billed Diagnostic Code	Supported by Medical Record (x if yes)	Not Supported by Medical Record (x if no)	Coded Correctly Yes / No	If Not Supported, Note Problems
Principal			/	
Secondary			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
			/	
Billed Procedure Codes			/	
			/	
			/	
			/	
			/	
			/	
			/	
Billed Discharge Status			/	

DRG: _______________

Review of Possible Problems/Regrouping Codes

1. When necessary, refer to the physician for clarification.

2. Code and regroup to determine if changes affect the DRG.
   Note discharge date ____________, age__________ gender ____________

Revised Diagnosis Codes	Narrative
Principal	
Secondary	
Revised Procedure Codes	
Discharge Status	

DRG: ______________________

3. Does coding affect the DRG?
   ☐ Yes ☐ No

4. Identify the cause of any DRG change
   ☐ principal diagnosis not present at admission
   ☐ principal diagnosis not treated/evaluated during stay
   ☐ principal diagnosis not principal reason for hospitalization
   ☐ secondary diagnosis or complication/comorbidity billed by not substantiated
   ☐ secondary diagnosis or complication/comorbidity substantiated in record but not billed and it changes the DRG
   ☐ procedure omitted from claim
   ☐ procedure billed but not substantiated in record
   ☐ procedure determined to be medically unnecessary and must be removed from the DRG
   ☐ disposition status is incorrect and it changes the DRG
   ☐ patient's age is incorrect and it changes the DRG
   ☐ correct diagnosis or procedure is incorrectly coded
   ☐ other: ____

5. If a DRG change occurred, note the following:

Original DRG: ______________________________ Revised DRG: ____________________________
Reimbursement: ____________________________ Reimbursement: __________________________

Problems Identified

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Recommendations

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Auditor: ____ Date: _______________