ABCs of Health Plan Audits

Save to myBoK

By Dawn Crump, MA, SSBB, CHC, and Jeannie Hennum

The Affordable Care Act (ACA) has a dramatic ripple effect on the healthcare industry—and will continue to create seismic shifts for many years to come. One important change for health information management (HIM) professionals to understand is the impact of ACA on health plan audits. Already tenuous, the connection between payers, plans, and providers is at risk for further deterioration in 2015 as the volume and scope of audits continue to rise.

HIM professionals hold a unique position when it comes to audits. They have the ability to improve health plan and payer relationships through knowledge, communication, and responsiveness to auditor requests. This article provides practical advice for HIM professionals and audit teams to build stronger bridges across the great payer-provider divide.

Rationale for the Rise

Due to the implementation of ACA, more people are insured under more diverse managed-care plans than ever before. Plan payments are dependent on the level of severity of the condition of that plan's patients. Meanwhile, the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) just announced more changes. All of these factors are increasing the burden on HIM and audit teams.

In order to save time, hassles, and headaches for both sides of the audit seesaw, standards must be established. Clear and concise communication among plans, payers, and providers is required to increase efficiency. There are three specific ways that HIM departments can help alleviate the added audit pressure in 2015.

1. Centralize medical record request receipt process—Assign receiving and logging requests to one department.

   Result: Reduces administrative expenses, streamlines process, and allows for duplicate detection and a basis for actionable reports.

2. Verify minimum necessary documentation—NCQA documentation list by measure for HEDIS, CMS documentation list for risk adjustment.

   Result: Ensures appropriate date-of-service (DOS) and chart sections are released.

3. Utilize electronic receipt of requests—Chart chase list direct from health plan, upload into workflow system.

   Result: Improves data integrity, eliminates manual data entry, and removes unknown third parties.

4. Establish electronic delivery to health plans (electronic requests are currently accepted by one-third of the nation's hospitals)—Include receipt acknowledgement.

   Result: Ensures proof of delivery and better HIPAA compliance.

5. Understand health plan filing dates—Additional time may be available for processing large volume requests.

   Result: Improves resource allocation and planning for future request waves.

Three Ways to Reduce Pressure

From an HIM perspective, the best way to deal with elevated audit pressure is to focus on awareness and education in these three areas:

1. Instruct all HIM staff on the ins and outs of health plan audits, either individually within your department, or in collaboration with your audit team and regional payers.
2. Educate HIM teams on payer vernacular (ensuring members are current with all the various audits and reasons for each will help to achieve this goal).
3. Stay up to date on changes to the Recovery Audit Contractor (RAC) program, as well as changes to all other audit types.

Knowledge is Power

A key reason hospitals run into problems keeping tabs on all record requests is that so many other departments are affected. Collaborative education is important. Besides the audit team, the denials team and the managed care contracting office should be involved.

Begin by identifying participants for audit education. Go beyond HIM and release of information (ROI) to consider where health plans' record requests land within your health system. In addition to audit, denial, and managed care teams, quality, compliance, physician practices, billing, and chief operating officers may also receive health plan requests. Lunch and learns are an ideal forum for educating these teams.

All staff involved should understand exactly what the auditors are requesting, the various types of audits, and what each is for. Variances in audit vernacular are also important. For example, while HIM professionals on the provider side call requests for additional documentation "ADRs or request letters," staff at the health plan may call them "pull lists" or "chart chase lists." And many more examples exist across regions, payers, and plans.

Educational efforts should focus on understanding each audit, including quality, government payment, or managed care plan audits. Throughout the audit education process, HIM professionals should keep the following four questions in mind:

- Are there better ways to process and manage the system to improve efficiency?
- Are record requests received and processed throughout the organization? If so, can these requests be centralized within HIM to eliminate redundancy, duplication of work, and potential ROI errors?
- Can quality audits conducted by health plans be leveraged to also meet provider-based quality reporting requirements?
- Is there a single software system and standardized process to log, monitor, and manage all audit requests regardless of source?

Often, commercial audits intersect reviews being simultaneously conducted by the provider. In some cases, two or three contractors will work for the same payment plan. Providers may get a second request for the same case before the first request is completed, making a centralized audit effort important to improving communication and fostering better payer relationships. If this is known in advance, a great deal of redundancies can be removed from the HIM workflow.

The Provider's Side: Top 10 Documentation Fulfillment Pain Points

1. Significant increase in request volume
2. Phone calls, faxes, and mail
3. Data entry
4. Duplicate requests and incorrect lists
5. Accommodating unknown third parties
6. EMR system partitioning
7. Delivery acknowledgement
8. Re-use of chart
9. HIPAA concerns
10. Impact on administrative expenses

Know Your Most Common Health Plan Audits

Providers should possess comprehensive knowledge about the most common health plan audits, as well as the payers' reasons for conducting them. Educate staff on the following main commercial plan audits and their respective timeframes.

Risk adjustment medical record reviews (MRRs): Medicare Advantage, Medicaid, and Commercial Exchange audits—year round, with request waves received according to filing dates.

Health plans and payers conduct these audits to ensure medical record documentation validates claims data received, and to determine if other chronic conditions exist that may not have been submitted with the claim. The onus is on providers to prove that their patients have the risks, complications, and comorbidities stated. If proven, Medicare helps subsidize the plans. Risk adjustment audits are similar to the quality improvement audits conducted by providers and, as such, are important to providers and payers alike. While commercial audits will be focused in first quarter each year, it is expected that all risk adjustment audit types will be conducted throughout the year.

Risk Adjustment Data Validation (RADV)—2015

CMS may require health plans to perform RADV audits at any time. In an RADV audit, the health plan has just 45 days to send CMS "one best medical record" that substantiates all submitted reporting.

Health Effectiveness Data and Information Set (HEDIS)—1Q thru 2Q 2015

HEDIS audits review a subsection of the health plan group with a focus on specific measures, such as diabetes monitoring. Medicare uses HEDIS data to rank health plan performance (STAR Ratings); CMS can penalize payers for decreasing quality scores. Providers also benefit from HEDIS performance rankings because they can be used to gauge the quality of health plans during contract negotiations and as part of accountable care organization (ACO) arrangements. Like the risk adjustment audits mentioned above, HEDIS audits can benefit both sides.

DRG Payment Integrity Reviews—ongoing through year

These audits check to make sure cases are properly coded and sequenced, and that billed information matches the patient record. It is a comprehensive review of hospital claims that have been submitted to plans for payment. As ICD-10 approaches, the number of DRG audits will likely increase.

Care and Quality Improvement Plan Audits—ongoing through year

These audits, which also are ongoing throughout the year, target records of patients at a high risk for certain diseases. The goal is to use findings from the review to get members into physician offices and clinics for preventive care before their conditions progress and require hospital admission.

Outcomes Measures—Five-Star Program (Medicare Advantage)

This is an evolutionary audit program for health plans. CMS and the National Committee for Quality Assurance (NCQA) measure the quality of health plans. Health plans that demonstrate year-after-year improvement in patient experience, reduction in patient complaints, and sustained achievement of quality measures receive a better performance score. The Five-Star Program started as a broad process, but is now more focused on specific disease conditions and patient types. Plans must show continual improvement to earn the five-star rating.

Commercial Risk Adjustments—part of the new wave of audit requests

Mentioned above, commercial risk adjustment requests are new; in fact, the first filing date ever is this year on April 30. Commercial plans typically cover patients through age 64, while Medicare Advantage covers those 65 and older. The commercial plan with the healthier population will have to transfer payment funds to the plan with the sicker population.

Don't forget RAC: New Changes Announced

With stated goals to lessen provider burden, increase transparency, and enhance oversight, CMS will begin implementing RAC modifications, some of which could help HIM teams. These include:

- Instructing recovery auditors to allow 30 days for each discussion period, and to confirm receipt within three days of providers' discussion requests.
- Placing limits on additional documentation requests (ADRs).
- Refusing auditor contingency fees until the second level of appeals is exhausted.
- Restricting RACs' patient status reviews to six months, assuming that the provider submits its claim within three months of date of service.

These changes, and others to enhance program oversight and transparency, will be effective with each new contract awarded under the program.Due to multiple contractual disputes, however, CMS has delayed the full final establishment of the new RAC regions. And these aren't the only recent changes in governmental audits.

The Plan's Side: Top 10 Documentation Request Pain Points

1. Provider relationships
2. Determining the correct provider location to send requests
3. Improving chart retrieval rates
4. Reducing turnaround time
5. Chart copy fees
6. Familiarity with EMR systems
7. Eliminating paper charts
8. Provider understanding of review types
9. HIPAA compliance
10. Administrative expenses

HHS Shifting Medicare Payments from Quantity to Quality

According to an announcement made in January, HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as ACOs, by the end of 2016. Further, HHS wants to tie 50 percent of payments to these models by the end of 2018.

HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs.

This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payments.

Keys to Success: Proper Planning, Communication, Vigilance

The sheer volume of newly insured patients has forced the ramp-up of third party commercial audits; adding quicksand to the already confusing payer-provider communication quagmire. It is the responsibility of both sides to ensure the payer-provider relationship remains on solid ground, ultimately for the benefit of patients.

In order to juggle all the various audits, providers must often ask for additional information and education from the requesting contractor, payer, or plan. Health plans base next contracts on current audit cases. Be certain your team knows what is in them. Also budget for additional ROI staff to accommodate an increasing volume of audit requests.

Through successful communication—explaining the centralization process to the HIM team, conducting education with staff, and ensuring all key players know the ABC's of audits—HIM leaders can reduce their organization's audit burden.

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