Auditing and Monitoring--Elements of HIM Compliance

by Gloryanne Bryant, ART, CCS

Auditing and monitoring are two important components of a compliance plan. The author answers the most frequently asked questions about audits. In addition, find out how to get started—and what to do with the results.

Compliance—it's more than a buzzword. Establishing compliance in healthcare is in the best interest of providers and a smart business practice as well. Implementing a compliance program or plan can bring providers improved data quality, improved coding and billing accuracy, identify potential areas of risk, and reduce healthcare fraud and waste. Compliance programs should be designed to promote prevention, detection, and resolution in areas of conduct. For effective healthcare compliance, every program should, at a minimum, contain the key elements that are recommended by the OIG in its Compliance Program Guidance for Hospitals.[1]

This article focuses on one of the OIG's elements for a successful compliance plan—auditing and monitoring. These activities are key to viewing internal operations, identifying potential risk areas, and assessing educational areas for further focus.

Frequently Asked Questions About Audits

What healthcare settings need auditing and monitoring for compliance?

All settings—including physician offices, home health, long term care, laboratory and ancillary outpatient, emergency rooms, outpatient surgery, observation stays, and inpatient care—can benefit from auditing and monitoring. Size, volume, and scope will depend on each facility or organization. It is also recommended that auditing and monitoring processes include all payers, not just Medicare and Medicaid.

What does a formal internal auditing and monitoring process involve?

A formal auditing and monitoring process includes the roles and objectives of the audits, risk assessment, an auditing plan, testing with identification of weaknesses, reporting, and feedback with corrective actions when problems are identified. The audit process should be in writing and must be included in overall HIM compliance program policies and procedures. The auditing and monitoring process also should include thorough and regular reporting to senior hospital or corporate officers. Audit reports should also include suspected noncompliance areas as well as targets and identified problems.

Who should perform the audits and conduct monitoring?

The persons performing and conducting audits should be familiar with the function, processes, and guidelines of coding and documentation. This individual should have an extensive coding background and knowledge of HIM departmental functions. A credentialed RRA or ART should be required; the addition of a CCS or CCS-P certification should be strongly recommended. You may also want to utilize AHIMA's coding competencies as a guide. These competencies, which can be found at www.ahima.org, establish guidelines for several different coding skill sets. Often it is recommended that the auditor have at least five years of hospital coding experience. Extensive knowledge of reimbursement systems and federal, state, and payer-specific regulations and policies is also necessary. An auditor/monitor may come from within your own department or healthcare system or from outside; a combination of both internal staff and external staff is also possible. Ask for references if the individual is from an outside consulting firm or contracted service. In addition, verify that this individual has maintained continuing education in the HIM field.

How frequently should these processes take place?

Regular and periodic monitoring and audits need to be established within HIM functions, with emphasis on coding and the coding process. Although the OIG does not give specific numbers for this, it is clear that prospective and retrospective audits will decrease the chance of coding or billing errors and decrease your areas of risk. Monthly audits may need to be conducted initially to determine a baseline. If significant issues are identified, daily pre-bill reviews may be warranted in addition to retrospective audits.

You should address the following questions:

- Will you use a compliance software system that reviews records daily prior to billing?
- Will you conduct reviews with internal staff once per quarter or use outside coding compliance specialists on an annual basis? (Another option is to use a combination of these mechanisms.)

In the physician setting, often an initial baseline review will select 10 to 15 records in areas such as:

- evaluation and management
- physician presence (PATH)
- most commonly performed procedures

Sample size should be based on overall volume and on the results of previous reviews. Some retrospective reviews are conducted at 100 percent of all discharges within a given month. Other retrospective reviews select 10 or 15 percent of the average number of monthly or yearly discharges. And still other auditing and monitoring programs will stipulate that a minimum number of records be reviewed each month (e.g., 60 discharges, 50 outpatient surgeries, or 50 ancillary outpatients). Consider what will work best in your organization and still provide a good sampling of your patient type and patient volumes. The audit size should prove to be statistically valid and reliable.

How can we prepare to perform an audit?

It's important to develop audit tools to be utilized during the audit. Create or develop audit forms for both pre-billing and retrospective reviews (a paper trail). A rebilling log and a list of reviewed records (samples are available in *HIM Compliance: A Model Program for Healthcare Organizations*, published by AHIMA) are also helpful. Always notify the department and staff of the impending review and the process of the audit. Remember to utilize the appropriate resource materials, and be sure you are using the official coding resources from the correct time period of the review.

You can prepare internally for your own review by utilizing internal data and reports. When requesting or preparing a data report for an internal review/audit, consider the following elements to be included in the data report:

- medical record number
- account/billing number
- date of service or discharge
- physician identifier
- DRG assigned (inpatient)
- ICD-9-CM codes
- CPT-4 codes
- disposition status or codes
- carrier or payer identifier
- total charges
- length of stay (LOS)—inpatient
- patient type identifier

These elements can assist the auditor or reviewer in simplifying the selection process by identifying LOS and high-charge problems that also have a low acuity and severity in DRG selection. This is helpful for a selective review versus a random record selection review. In addition, a report from your own data system for the retrospective auditing can be generated or records can be selected from the payers' remittance advice (RA), usually available within the business office or patient accounting departments. Although the retrospective review process includes additional paperwork for the resubmission of claims and additional review by the peer review organization (PRO), these audits are still a useful tool in identifying errors and uncovering patterns and trends.

When selecting an automated compliance software audit system, consider the system's edit process. Most compliance software systems allow for both pre-billing and retrospective record processing. A compliance audit software system can assist in daily monitoring of coding prior to billing in a timely manner and using fewer resources. Investigate a software audit system that will include code edits, clinical edits, user-defined edits, and resource edits. Ensure that that the system includes all official coding guidelines and rules. Worksheets for cases that have an edit flag should be generated from the system to provide a paper trail and tracking. Report writing processes can be used to develop additional tracking and trending data as well as topics for an educational focus. Find out if the software system can produce statistical reports and graphs. Ask the vendor if the report writer function allows for the following types of reports to be created:

- reports by DRG and/or MDC
- reports comparing your final DRG selection to MedPar norms
- tracking by coder
- tracking by physician
- non/CC versus CC reports
- edit types report
- financial variances by DRG
- change rates and other statistics
- other MedPar data comparisons

What should be audited and monitored?

Using information from the manual audit process or a software compliance system, establish the areas, items, types of records, and DRGs to be reviewed in further detail. Again, remember that a compliance program must be tailored to fit the needs and the size of an organization. Using the target areas of the OIG would be one area to audit and monitor. These target areas are listed in the HHS/Fiscal Year 1999 Work Plan—HCFA, which can be found at http://www.hhs.gov/progorg/oig. In addition, a trend analysis can help identify specific practices and create a baseline for the audits. The work plan, which reviews the OIG's 1999 target areas in detail, provides additional areas in which to focus.

Analyzing Audit Findings

Once the audit is complete, gather the related documents and review and compile the results. Be sure to review this compilation with the compliance officer and other individuals involved in the coding process. Include in your findings statistics of the total variance rates, the types of variances, and problem areas identified. Look at the timeliness and completeness of the record at the time of coding as an issue. Also, identify any patterns specific to a physician and particular body system or specialty (e.g., orthopedics or the respiratory system). Commonly found coding errors include:

- coding of diagnosis and/or procedures that are supported in the physician documentation
- data entry errors in the abstracting or billing system
- assigning an inappropriate fifth digit on a diagnosis code
- incorrect selection of the principal diagnosis
- incorrect sequencing selection for the principal diagnosis
- not coding all documented diagnoses (and CCs) or procedures
- failure to verify conflicting or contrasting physician documentation

The analysis should also include a mechanism to identify (when possible) the causes behind the coding variance. Some common causes include:

- failure to review the entire record
- incomplete record at the time of coding
- incorrect coding advice or instructions
- insufficient coding education
- lack of knowledge of disease process and/or procedure techniques
- lack of outdated or limited coding and clinical resources
- misunderstanding of coding rules and guidelines

Results, Feedback, and Corrective Action

All auditing and monitoring activities, responses, and follow-up should be fully documented. Results and findings should be summarized in a timely manner. Recommendations for corrective measures should be communicated to the department involved, the compliance office, administration, and possibly the organization board. An audit summary report should include the development of revised procedural guidelines to prevent future occurrences. Identify and outline all key issues with the recommended corrective action to be taken. Include a time frame for the corrective action and any rebilling to be completed.

When overpayments have occurred, you must process the corrected claim even if the time frame for resubmission has expired. Monitor the rebilling through a "rebill log" sheet. Follow up with the business office for completion of the rebilling process and corrected payments. Document in the summary report any recommendations for additional education as well as physician documentation noncompliance issues.

Re-audits may need to be conducted in certain risk areas. These should be conducted in a reasonable period of time to assess the effectiveness of education and corrective action. Performance improvement efforts should be conducted in areas identified to be out of compliance. Feedback should also be provided to the identified problem areas.

Corrective action(s) should follow the overall compliance program outline when violations are identified. In some areas, it may be difficult to determine if a trend is evident or if actions were intentional. However, whether an honest mistake was made or potential fraud was committed, the error should be reported as part of the audit summary. Corrective action should always be prompt. Follow-up audits should be conducted to assure that corrective action is successful.

The ability to develop auditing and monitoring systems to identify actual and potential risks is beneficial to the self-assessment process. These processes can also contribute to the investigation of reports of noncompliance and to monitoring the effectiveness of overall compliance program. In all of these endeavors, the ethics and principles of health information management allow its practitioners the ability and tools to achieve positive outcomes as we face healthcare compliance challenges.

Notes

1. The OIG identifies these key elements: standards of conduct with written policies and procedures, designation of a chief compliance officer, education and training, communication, response and enforcement, auditing and monitoring, and investigation and remediation.

References

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helpful auditing and monitoring hints

In October 1998, AHIMA published *Health Information Management Compliance: A Model Program for Healthcare Organizations*, which offers these suggestions for auditing and monitoring:

- Compare diagnosis and procedure codes against the record documentation, if coded prior to record completion
- Compare diagnosis and procedure codes for overall accuracy and consistency
- Compare E & M code assignment with the required components of the reported code with the record documentation to ensure code level accuracy
- Verify CPT code assignment when multiples are used to verify that they are not components of a larger comprehensive procedure that could be described with a single code
- Evaluate claims denials related to code and DRG changes from the fiscal intermediary, peer review organization, and private payers
- Investigate a mechanism to compare the diagnosis and procedure codes assigned by the physician's office and the codes from the facility for the same encounter
- Perform periodic chart-to-bill audits
- Perform trend analysis of practice patterns. Look for significant changes in the organization's case mix or coding practices. Look at DRGs that show substantial increases in the number of cases assigned to them. Compare DRG distribution, ranked by volume, over a three-year period
- Monitor "with CC" and "without CC" pairs or OIG target DRGs (e.g., DRG 089/079, 320/416, and 015/014)
- CPT codes assigned through the charge description master (CDM)

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