Building a Clinical Audit Process

by Vera Rulon, RHIT, CCS, and Lorraine Tully, RHIT

Editor's note: This is the second-prize winner in AHIMA's 1999 Best Practices Award Program.

For Oxford Health Plans, a new clinical audit process became a way to address claims submission issues and save money. Here's how HIM professionals came to the fore as this program was built from the ground up.

How can a healthcare organization successfully identify claims submission issues and actively address them? For one organization, the answer was a clinical audit initiative. Developing a clinical audit program can yield cost savings, improve data quality, make business processes more efficient and help an organization better measure its results.

Oxford Health Plans, a managed care organization based in Connecticut, recently tackled this project. In implementing a clinical audit function, HIM professionals were able to come to the fore and leverage their unique knowledge. In building a process, collecting data, and building communication with staff, HIM professionals helped make the project a success.

Opportunity Knocks

Our story begins when Oxford saw the need for focused inpatient claims auditing, specifically DRG reviews. A credentialed coder was hired in January 1993. The first year realized $1,700,000 in savings (based on an average of 400,000 members). Clinical audits expanded beyond DRG reviews to utilization and charge-based audits.

In successive years, however, as all-payer prospective payment systems were phased out in the northeast, fewer DRG reviews were required. Contracting focused on per diem and case rate strategy. Because of this, yearly savings began to dwindle.

Further, the company's inpatient utilization Medicare medical loss ratio (MLR)—the proportion of premium spent on medical services versus administrative costs—was climbing, showing significant increases year after year. In response, Oxford's management requested that a business plan be created to address the alignment of clinically related audits and reviews performed company-wide.

The result of the preliminary analysis revealed that audits were redundant, not done at all, or incomplete. Those that were performed were not measured consistently, if at all.

An assessment of the current status of audits company-wide was performed. The result? Inpatient clinical reviews in the areas of DRGs, case rates, claims payment, and utilization reviews were no longer being performed.

As the organization studied the topic, it became clear that it was missing out on some of the potential fiscal and organizational benefits of audits in areas beyond DRG review, such as:

- utilization reviews (levels of care, length of stay)
- charge-based audits
- global case rate audits (i.e., are we paying for something included in the global rate?)
- medical necessity (appropriate application of per diem rates)
- professional practice pattern analysis
- quality management reviews

It's worth noting that although most managed care organizations have a need for such a function, implementations vary in size and scale. Interestingly, as a rule, the function is usually performed by RNs rather than HIM professionals.

It was time to launch an audit program. But how should we begin?

Input, Process, Output

The first step was understanding what we wanted to accomplish. Oxford's major goals for developing a clinical audit function were:

- ***plug gaps with new audits*** where none currently existed
- ***coordinate efforts across multiple departments***
- ***eliminate redundancy*** and ***achieve savings*** lost within current processes
- ***improve data quality*** by targeting providers submitting data to us
- consistently ***measure results*** and perform ***continuous quality improvement***

As we worked to develop a model for the clinical audit function, we used an "input-process-output" approach. This made it, in the long term, amenable to an automated systems approach. The approach can be broken down this way:

Input occurs pre-adjudication, focusing on information submitted by the provider. Data inputs include:

- required fields—has the provider submitted all required fields on claim forms (HCFA-1500, UB-92)?
- correct codes—have ICD-9-CM and CPT-4/HCPCs codes been used appropriately to correctly identify condition/service provided?
- correct groupings—does the information provided "group" to an appropriate diagnostic or procedural category (DRG, ASC group, etc.)?
- correct fee—is the provider billing with the correct fee (e.g., DRG rate)?
- new fee—is a claim being submitted for a service for which we have no fee?

Process occurs during claim adjudication: what are we doing to identify data submission inconsistencies?

As part of this exercise, we performed an evaluation and inventory through an extensive interview process, identifying who was performing these audits company-wide. We concluded that there were many gaps in review types, and communication was quite poor. There was no accountability process or feedback loop to correct deficiencies and improve the quality of data.

Output occurs post-adjudication. The identified results of the clinical audit process are:

Identified output: Improper coding
Examples: DRG analysis, UB-92 versus contract, case rates (are they identified correctly?), bed type versus diagnosis (i.e., tertiary care), CPT-4 coding

Identified output: Over/under utilization
Examples: Length of stay outliers, cost outliers, levels of care

Identified output: Contract efficacy
Examples: Global rates, case mix analysis (i.e., facility's case mix reflected in contracted rates?), bed type versus per diem rate

Identified output: Quality review
Examples: Appropriate setting (i.e., inpatient versus outpatient), complications/comorbidities

Identified output: Appeals
Examples: Medical necessity, improper procedure, fee inadequacy

Many of the issues identified caused problems. Too much or too little money was paid. Redundancies caused disgruntlement. Because little was being measured, there were few tangible results. And little was being done to correct repeated problems.

How were we going to get our arms around the scope of the problem and further improve the way we do business?

We decided to proceed as follows:

- create a clinical audit process task force
- perform a pilot study (post-pay) of inpatient claims
- establish an inpatient audit unit that would review specific case types (based on results of pilot study) on a pre-pay basis

As part of the clinical audit business plan, we assessed technologies in terms of their ability to support clinical audits. Six applications in use at the time were identified as potentially able to support clinical auditing. Of the technologies assessed, a DRG grouper was selected as the main supporter of this new function.

In addition, two applications were identified as future enhancements: inpatient audit queues (to automate the screening process) and a diagnosis versus procedure appropriateness identifier.

Goals for Implementation

Senior management defined the global goals that the audit function should meet. These included:

- **decrease** the MLR by achieving savings through DRG, charge-based, and utilization reviews
- **identify** opportunities in improving processes (i.e., contract efficacy, payment policy, etc.)
- **improve** data quality via identification of provider data submission inconsistencies (i.e., revenue codes)
- **build** interdepartmental integration through a clinical audit process committee
- **improve** the provider service relationship through correct coding initiatives and clinically sound record review
- **improve** member service relationship by ensuring that claims are paid correctly
- **reduce** administrative expense in the long term through implementation of front-end edits to reduce claims turnaround time

The overall implementation was coordinated by Vera Rulon, RHIT, CCS, then manager of clinical informatics at Oxford Health Plans, with significant support from Lorraine Tully, RHIT, then project manager of clinical informatics.

Building a Process

Step one: The Task Force

The first step was to create a clinical audit process task force, led by an HIM professional, to facilitate sharing of knowledge of the status and processes in the clinical review arena company-wide. Other task force members included representatives from the claims issue resolutions, medical management appeals, fraud and abuse, claims audit, inpatient claims processing, physician reimbursement, actuarial, quality management, medical affairs, and clinical informatics departments.

The task force was charged with the following objectives:

- identify what to audit
- establish a process flow (clinical audit process flow chart)
- develop metrics/measures
- create a clinical audit tracker

Although the task force achieved many things, there were many roadblocks to be skirted in creating and managing the group. (See "Managing the Task Force.")

The task force met four times in late 1997 and early 1998. Although metrics were never developed (these became the responsibility of each individual department), there were two significant accomplishments:

- the task force raised awareness of a company-wide problem with clinically related reviews, as identified in the assessment phase of building the clinical audit business plan. Thanks to the thoroughness of the plan, this was done with

specific examples, making it easier for people to buy into the concept

- the group developed a matrix that identified all audits being performed, who was performing them, at which stage of the adjudication process they occurred, and who was responsible for follow-up on outputs

Step Two: The Pilot Audit

Next, senior management agreed that we needed to perform a pilot audit. We decided to do the pilot on a post-pay basis to keep from slowing the claims process.

Two affiliated facilities were selected for review because their contract was about to be renegotiated and because they had a high volume of Oxford patients. The contract itself had an inordinate amount of DRG case rates, many more than an average facility. In addition, an earlier evaluation of Medicare HMO enrollees' inpatient claims costs identified a potential abuse of tertiary care revenue codes. As these facilities both had separate rates for standard medical/surgery beds versus tertiary care (ICU/CCU/etc.), it was decided that the pilot would focus on these two types of reviews.

Because Oxford did not collect revenue codes electronically, claims were screened manually. The criteria were based on bed types that were an ICU/CCU per diem rate for the entire stay that was not supported by either the clinical picture based on the diagnosis or the medical management certification process. All DRG case rates were selected for review.

Medicare members' inpatient claims were reviewed for 1996 and 1997 through September. Two full-time employees (FTEs) took approximately two months for the manual claims process, reviewing for potential DRG changes, per diem rates, length of stay, levels of care readmissions, and development of a spreadsheet for chart review. Based on the findings, an on-site chart review was performed on 626 charts in a span of two weeks.

Step Three: The Inpatient Review Unit

Finally, we created an impatient clinical review unit. This happened quickly, although it has not grown as quickly as we would have liked due to technological limitations. The dynamics of the process were based on resource needs. Current staff members had other responsibilities, but we had no volume projections yet to justify new hires.

Based on the results of the pilot program, a pre-pay audit process was necessary to assure that claims were paid correctly the first time, because retrospective review caused much reversing and reprocessing of claims. Because we lacked IT support, however, we implemented a manual solution of paper-based requests for review.

Processors were directed to suspend payment for claims meeting the following criteria: admitted and discharged from ICU/CCU (clearly defined using specific tertiary care revenue codes), with the standard UB-92 discharge status code of "01 = to home."

Because of resource constraints, clinical informatics staff performed the clinical audit function along with their usual day-to-day responsibilities, including Tully, who acted as project manager. A project manager came on board in August 1998. Soon after, two additional staff members were hired. In addition, two clinical informaticists focused on clinical audit.

The number of FTEs dedicated to clinical audit was derived through analysis of historical volumes of claims reviewed. Projections were made based on implementation of new criteria, thereby increasing the number of claims referred for review.

As the process was developed, several issues surfaced (see "Hurdles to Implementation").

Tracking Success

Although the main goal of clinical auditing was to create a quality improvement process, the best way to achieve buy-in from senior management was to focus on savings. The plan was to produce savings reports immediately and build an efficient system for tracking quality improvement in the longer term. (See "Savings Report for 1998.") In 1998, it was determined that we had saved more than $2 million.

Few resources were expended to achieve these savings. Travel to area hospitals was limited. Our total expenses equaled $5,908. Compared to a total savings of $2,108,000, it was surely a huge return on investment.

We had achieved much to date in the area of measuring improvement. Our automated tracking system now also allows for the collection of detailed items of interest for future reporting capability, which completes the quality improvement cycle:

- savings types—DRG, revenue code review, utilization, medical necessity, etc.
- quality outcomes—e.g., who was the issue referred to for follow up and what was the outcome?
- volume of claims referred for review
- types of criteria applied for referral of quality issues

There were other results as well. For instance, we improved our authorization process. Clinical audit review of tertiary beds has provided valuable feedback to case management. Clinical audit staff members were able to educate case managers regarding medical necessity assessment in conjunction with reimbursement. Case managers have improved their documentation so that claims did not need to be suspended for clinical audit, and claims were paid correctly the first time.

Our provider data submission has improved. Several hospitals have changed their charge masters after an audit identified inappropriate use of certain revenue codes. Specifically, step-down units and telemetry beds were coded as "ICU-other" and "CCU-other" respectively, thereby being reimbursed as an ICU or CCU bed when patients weren't really in those units.

We sharpened the process for transfers to alternate levels of care. Clinical audits revealed that utilization in both acute and alternate settings needed to be improved, because of the extensive cost for alternate care settings for post-hospital care (e.g., acute to skilled to outpatient rehab to home care). At the same time as the discharge planning issues came to light, a more tightly managed utilization model was included in that part of the process.

In order to integrate the clinical review process, the clinical claims review and medical management appeals departments were merged. The new group works closely with the clinical audit team. It was acknowledged that clinical reviews become intertwined across the continuum of care and therefore all types must be integrated (not necessarily organizationally) wherever possible. See "Long Term Directions," for an illustration of our future goals.

Many departments benefited from the implementation of the clinical audit function, including:

- contracting—through better defined and standardized contracts that allow negotiating to center around fiscal issues rather than clinical service definition
- medical management—through feedback to case management in areas of utilization patterns on specific cases and improving medical necessity documentation as it relates to certification process
- payment policy—through identification of policies that need refinement or definition with improvement of policy codification
- quality management—through records that are reviewed for dual purposes, eliminating redundancy
- claims adjudication—through clinical audits becoming a resource for claims personnel with regard to coding and related contract issues

Most significantly, HIM professionals benefited from this project by raising their profile and showcasing their skills. The project raised awareness of the HIM profession at Oxford, allowing HIM professionals to use their knowledge and apply it in a nontraditional environment. In addition, improved relations with nursing staff have created an integrated environment where HIM is recognized as a medical science and peer to other clinical professions.

Indeed, HIM professionals have become so vocal through this process that they have become the experts and "go-to" department in areas of claims processing, medical management, contracting, and member services. In doing so, HIM professionals have become part of an interdivisional team approach and a critical link to Oxford's quality improvement process.

Managing the Task force

Issue	Description	Follow-up
Buy-in	Medical management (MM) appeals representatives had difficulty pinpointing their role in the clinical	MM appeals eventually became part of a larger claims review/appeals department supporting (in the longer

	audit process. However, they continued to maintain a relationship with the clinical informatics department.	term) the global effort. Unfortunately, this re-organization was imposed on them.
Process	A subcommittee was formed to develop a clinical audit process flow	The subcommittee never completed the process flow. The focus was on professional claims with a goal to identify savings on a pre-pay basis. The process development was put on hold, since there were too many legal and ethical issues, e.g., changing CPT-4 codes submitted by individual providers. Inpatient clinical audit process was addressed in the development of the inpatient unit

Savings Report for 1998

Steps	How It Worked	$ Saved
Retrospective reviews	On-site medical record review on a retrospective basis (claims have already been paid). Includes pilot audit	$408,000
Pre-pay reviews	Claims are screened, records reviewed, and agreement reached with facility prior to check going out the door. (One criteria only was applied: tertiary care, discharged home = 1545 claims with savings)	$1,700,000
	Total 1998:	$2,108,000

Hurdles to Implementation

Process	Method	Hurdles
Communication channel with claims personnel	An inpatient claims forum is used to discuss clinical sudit criteria	• Claims personnel lack clinical understanding • Rotating participants: never sure who has received the information and who hasn't
Criteria implementation	Claims processors manually channel claims to clinical audit based on specific criteria provided them through the forum	• Claims personnel lack clinical understanding • No automated edit checks to assure criteria is applied accurately • Incomplete data collection precludes ability to automate criteria
The process	Claims processors fill out a "service request" based on above criteria	• Training issues: form filled out correctly • Paper-based channeling is error-prone
Tracking	Short term: spreadsheet Long term: SAS-based tracking system	• Non-standardized data entry

	(called MedTrack) was created to provide real-time tracking	
Measuring success	The spreadsheet and later MedTrack serve as the basis for measuring savings and volume	• Inconsistent data collection leads to incorrect savings results
Filing system	A filing system was developed containing correspondence and medical records by case number (as assigned by the tracking mechanism)	• Staff took longer than expected to create filing system due to resource constraints

Managing the Task Force Graphs (PDF)

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Article citation:
Rulon, Vera, and Lorraine Tully. "Building a Clinical Audit Process." *Journal of AHIMA* 71, no.2 (2000): 55-60.
