Coping with Government Audits

Save to myBoK

by Mary Butler

The HIM Problem: Medicare Auditor Scrutiny of Inpatient Claims

This spring, the Centers for Medicare and Medicaid Services (CMS) issued its "two midnight rule" which was intended to define and clarify what Medicare considers to be criteria justifying an inpatient stay. The rule requires physicians to certify, supported by documentation, why a patient needs to be admitted for an inpatient stay rather than an observation stay. CMS relies heavily on contract auditors that look closely at insurance and Medicare claims in order to detect and overpayments. Known as recovery audit contractors (RACs), Medicare administrative contractors (MACs), these auditors work closely with health information management (HIM) professionals during an audit to verify that claims and clinical documentation are adequate for billed services. Providers can appeal auditors' decisions, but it can be a lengthy, labor intensive process, requiring strong knowledge of healthcare revenue cycle and clinical documentation improvement.

The HIM Problem Solver

Jordan Viehman, MHA, RHIA, Government Audit Coordinator, Cone Health. Viehman manages all Medicare and Medicaid audit activity for Cone Health's 1,100 bed system.

How does the "two midnight rule" impact HIM professionals, and how does it impact CDI specialists?

Viehman: CMS's "two midnight rule" was a game changer for our profession. There has been so much upset and unrest among the provider community with the overwhelming amount of audits that have caused increased pressure and financial constraints. CMS's response to that upset was the two midnight rule. For the first time in history, Medicare gave a definition for an inpatient stay. What is key in this legislation is that Medicare has emphasized the importance of the physician's decision-making. Prior to this legislation, their clinical judgment was scrutinized and questioned. Now, however, the patient's story and the physician's decision-making is at the center—which is what it should have been all along. There is an increased emphasis on documentation in the two midnight rule. Our CDI specialists are vital to help capture that patient's story to ensure our physicians are telling it completely and in Medicare-friendly terms.

How does your HIM background improve your ability to help Cone Health respond to audits?

Viehman: Having an HIM background has really given me an added advantage in my work with government audits. I have a unique perspective that most healthcare professionals don't get to witness. I get to see the patient's entire story from beginning to end. Most healthcare professionals are on one side or the other. An HIM background gives me an added advantage that is all encompassing. I'm able to read a patient's medical record and understand the patient's illness and course of treatment and then apply that knowledge on the back-end.

There is a lot of tension between HIM professionals and RACs—how do you manage the tension? Briefly outline the tension and why it's there.

Viehman: In all honesty, I think that there is a lot of tension between healthcare professionals and CMS in general. It's not just the RACs that have wreaked havoc on health systems and providers. In fact, I'd say there has been more activity from the MACs that has only escalated that tension.

I try to be as open-minded and understanding as I can when I show up to work each day. I remind myself that there is a rhyme and reason for everything. The reason why CMS started these audits was because there was fraud and abuse in the

system. It's unfortunate that there are people who are out there and felt it was okay to capitalize and make a profit off of a system that was meant to help people.

However, there is also a great deal to be said about these audits, including the frequency, duration, and quality. Keep in mind that there are hospitals who have closed their doors because of these audits. There are systems who have laid off employees because they are paying overpayments to Medicare and can't afford to pay salaries. Without some type of quality control on these audits to ensure that what is being audited is not only appropriate but denied appropriately—and not met with an 90 percent overturn appeal rate—we will continue to have this air of discord.

Currently, I've been involved in collaborating with our MAC and government officials to educate them on the difficulties providers face due to these audits as well as providing them with statistical data of the impact. There has been open and engaged discussions on both sides to strategize ways to improve what is currently broken. It's going to take a lot more communication and adjusted expectations, but the first step is acknowledging it.

What role do HIM professionals play in an audit?

Viehman: With any audit, whether it is a RAC, MAC, comprehensive error rate testing (CERT), zone program integrity contractors (ZPIC), etc. the first step is to provide the medical record. As an HIM professional, our job is to be the keeper of that medical record. It is so important for the HIM department to control the release of the record. Two important factors are required: a complete clinical picture and well trained HIM professionals who can help obtain that complete clinical picture. In today's audit world, there isn't room for errors. Every step counts and every step in the process has a monetary value.

How did you come to work in government audits?

Viehman: I started working for Cone Health three years ago when the RAC program just started to heat up. I had recently graduated with my master health administration) and moved to North Carolina. I hadn't yet taken my RHIA exam and honestly, hadn't given it much thought. When I realized I was going to be managing a RAC program for a health system with over 1000 beds, I did what any sane person would do- made a 4-foot by 4-foot whiteboard.

After expanding from managing not only RACs, but now, all government audits for Medicare and Medicaid, I've realized that my RHIA has really been an assets. I'm able to effectively audit, analyze, and release medical records; track thousands of requests, denials and appeals; and educate key stakeholders on how to minimize our risk, because of my RHIA.

How can HIM professionals best prepare for a RAC audit? What steps can they take from a CDI standpoint to prevent excessive two-midnight rule scrutiny?

Viehman: My best advice is to start at the beginning. In order to do that, analyze what your current target areas are for audits.

Do a comprehensive review of all of the denials on hand to figure out if there is a pattern. Are there an overwhelming number of denials due to a specific DRG, provider, location, reasoning etc.? Once the areas of concern or risk have been identified, don't look back.

Shift your focus from a reactive approach to a proactive approach. Keep in constant connection with not only your RAC's activities, but other RAC activities. The same is said for other MAC jurisdictions. Chances are that if there is one target area in one location, you can expect to see it pop up in your location.

Once you've switched your approach from reactive to proactive, begin to strengthen your processes. The two best lines of defense are your CDI specialist and your UR program. Look at their processes and day to day work.

When I first began I spent a few days shadowing both programs. Shadowing is a great way to look at what you are doing well and what can be done better.

Next, I'd recommend setting up education sessions with your physicians.

Pay attention to the time the patient first received care and remind your physicians to take that into account. If the patient had care start in the ER at 11:59 pm, and the physician sees the patient at 12:01 am, that patient has already had one midnight's worth of care.

Encourage the physicians to use that timing to their advantage. Will the patient be here another night? If yes, write the order right then and there. If no, place the patient in observation and re-evaluate a bit later. Re-evaluation for those observation cases is key. I can't stress it enough.

I've been fortunate to have an amazing relationship with our CDI program. We did some co-education sessions with our physicians and it was a big hit. It really drove the point home for those physicians the importance of the documentation.

I always say providers need to spell it out in the record. If it isn't written in the record, then it didn't occur. Ensure that the patient's story can be told concisely from beginning to end. If I am reading a record and I have questions or can't follow how the patient got from point A to point B, then chances are an auditor won't be able to follow it and it will be denied. It's important to ensure that the physician documents the patient's full picture including comorbidities, the risk that the patient may face if not receiving inpatient services, and possible adverse events. I also suggest, if possible, tie in any nationally known clinical measures or evidence-based practices.

We have an observation report that is run and sent out each morning. Any patient that is on that report with over one-day length of stay is reviewed as soon as possible. The goal is that we touch every Medicare observation patient and review for level of care every day.

What current legislative activities are in the works to address the stress on providers? Do you think provider concerns are being heard by CMS?

Viehman: There has been a lot of talk at the national level looking at the ways these audits are being carried out. I was fortunate enough to participate in some discussions in Washington, DC, and was able to tell key legislators the provider's story. I know that the House Ways and Means Health Subcommittee held a hearing on the issues with the Medicare program, specifically related to the audits.

There has been testimony by the chief administrative law judge before the US House Committee on Oversight and Government Reform on the appeal crisis. I think the fact that we have Washington's attention now is a big step. If you asked me this question a year ago, I would tell you that the concerns of providers aren't being heard. Now, however, I feel that there has been a shift in the tides. Providers are being asked what can be done better and are being given the opportunity to be involved in making these process changes.

What is the current status of RAC and other contract auditing activity?

Viehman: The RAC program was suspended until the contracts were re-awarded. However, I just heard that the RACs will resume their work this month with a limited review. Per CMS spokesperson Aaron Albright, "In order to fulfill our statutory requirement to identify and correct improper payments in the Medicare program, we are allowing a limited number of reviews to be restarted by our existing Recovery Auditors while these contract contests are fully resolved."

Original source:
Butler, Mary. "Coping with Government Audits" (Journal of AHIMA), August 2014.
