The Art of the Self-Audit

Robin Ingalls-Fitzgerald, CCS, CPC, FCS, CEDC, CEMC
CEO/President
August 15, 2021

Medical Management and Reimbursement Specialists, LLC

MRS
YOUR REVENUE CYCLE PARTNER

CtHiMA
AHIMA Affiliate
Connecticut Health Information Management Association

“Knowing yourself is the beginning of all wisdom.”

~Aristotle

EPIC Inspirational Quotes

Today's objectives…

- Understand the value of self audits
- Identify high risk coding areas for both inpatients and outpatients
- Learn how to create and maintain a dynamic, constructive self-auditing process

What is a self audit?

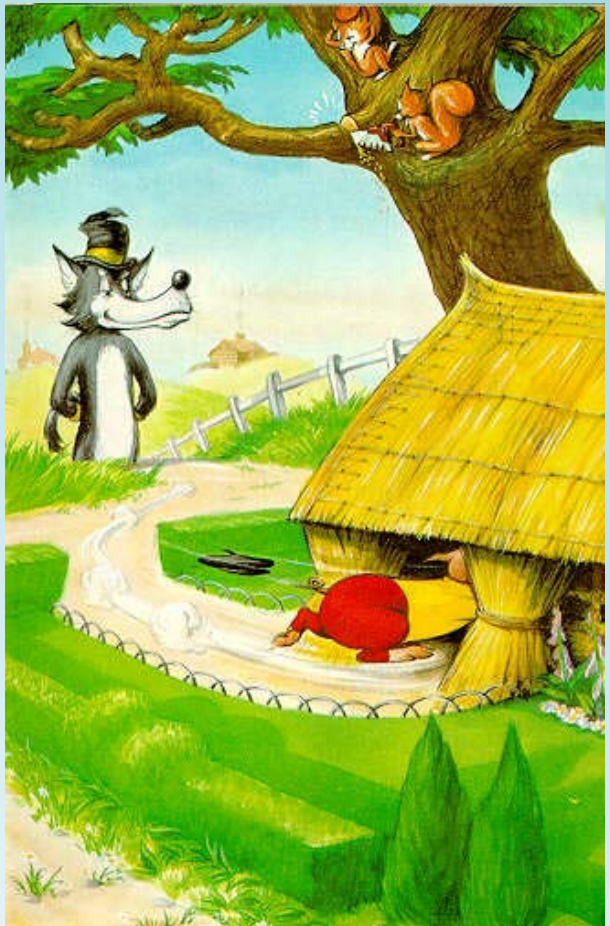
A self audit is a methodical review of your current coding practices to ensure that you comply with established coding and billing rules and regulations.

Self auditing steps:

- Select cases
- Review selected cases
- Report findings
- Provide coder and provider feedback and education
- Rebill when appropriate
- Self-report if required

Why it's important

Know your strengths and weaknesses before external auditors knock on your door!



With external audits on the rise, you will be better prepared if you audit your coding staff internally with either your coding manager/educator or a coding consultant.

What Self Audits Can Achieve

Reviewing your coding, billing and documentation processes allows you to:

- Identify improper payments, including missed billing opportunities
- Discover areas in need of improved patient care and satisfaction
- Target training and educational needs for your coding staff and other key revenue cycle team members (providers, billers, CDI staff)
- Create a vigorous culture of compliance within your organization

Self-Knowledge is the Key

Auditing ensures an accurate database that supports:

- Accurate case mix index and reimbursement
- Accurate reflection of risk of mortality/severity of illness measures
- Medical necessity of services rendered
- Patient admission status and correct place of service
- Resource consumption and length of stay
- Improved profiling and scorecards (e.g. PEPPER, PQRS, Healthgrades)
- Contract negotiations
- Decreased claims rejections and denials
- Adherence to compliance regulations

OIG Required!

"It's incumbent upon a health system's corporate officers and managers to provide ethical leadership to the organization and to assure that adequate systems are in place to facilitate ethical and legal conduct."

- Office of Inspector General

"adequate systems" = monitoring your current practices, identifying and addressing problem areas

OIG Recommendation

The OIG recommends that a facility or practice begin with a baseline audit.

It should:

- Cover at least one full quarter (3 months)
- Include a random selection of 5-10 Medicare/Medicaid charts for each provider who receives financial reimbursement from CMS

Office of Inspector General (OIG) Mission:

To protect the integrity of HHS Programs through a nation-wide network of audits, investigations, and inspections conducted by:

- Immediate Office of Inspector General
- Office of Audit Services
- Office of Evaluation and Inspections
- Office of Management and Policy
- Office of Investigations
- Office of Counsel to the Inspector General

OIG Work Plan

Prioritizes and conducts audits on identified high risk HHS program areas

Now in 2nd year of OIG's new approach to publicizing and managing its work plan

NOT a static document:

- OIG publishes a continuously updated list of items on its Active Work Plan page.
- Searchable by month of listing, responsible agency (CMD or FDA), title and report number

Adjustments are made throughout the year to meet priorities and respond to new/emerging issues

Monitoring this list can help keep you out of trouble!

OIG Enforcement Actions

Here's a sample of the 2019 enforcement actions from the OIG:

- **25 Southern California Defendants Face Federal Charges Alleging Fraud Schemes that Cost Health Care Programs Millions of Dollars**

  A local health care fraud enforcement action has resulted in federal charges against of 25 Southern California defendants for their alleged involvement in healthcare fraud schemes that fraudulently sought over $150 million from the Medicare and Medicaid programs, as well as private insurers and union health benefit plans. The charges target billing Medicare, Medicaid and other health care plans for services, testing and prescriptions that were ***not medically necessary*** or not actually provided to beneficiaries.

- **Prime Healthcare Services and CEO, Dr. Prem Reddy, to Pay $1.25 Million to Settle False Claims Act Allegations**

  Prime Healthcare Services, Inc. ("Prime") and Prime's Founder and Chief Executive Officer, have agreed to pay the United States $1.25 million to settle allegations they knowingly submitted false claims to Medicare including billing for more expensive patient diagnoses than the patients had (the latter practice known as "***up-coding***").

- **Medicare Advantage Provider and Physician to Pay $5 Million to Settle False Claims Act Allegations**

  Beaver Medical Group L.P. (Beaver) and one of its physicians, have agreed to pay a total of $5,039,180 to resolve allegations that they ***reported invalid diagnoses*** to Medicare Advantage plans and thereby caused those plans to receive inflated payments from Medicare, the Justice Department announced.

Here is a list of compliance resources that are available on the OIG website.

I've included the URL in the Links and Resources slide at the end of this presentation.

Self-auditing is a key component of your OIG-mandated compliance program

Of the 7 Compliance Program elements recommended by the OIG, 5 of them are addressed by a strong self-auditing process:

- Education
- Auditing and Monitoring
- Reporting and Investigations
- Response and Prevention
- Enforcement and Discipline

2019-2020 OIG Targets

- Assessing inpatient hospital billing for Medicare Beneficiaries
- Follow-up review on inpatient claims subject to the post-acute-care transfer policy
- Observation hospital care
- Physician billing of Critical Care E&M Services
- Part B payments for outpatient cardiac and pulmonary rehab

This is just a sample listing, there are 300 more!

Inpatient coding risks

Frequently audited DRGs (high-dollar, error-prone)

207- Resp system dx with vent support 96+ hours

247- PTCA w/ drug eluting stent

313- Chest pain

460- Spinal fusion excluding cervical

469- Major joint replacement w/ MCC

871- Sepsis with MCC without vent

853- Infectious disease with OR procedure

Inpatient cc/mcc risks

A single CC/MCC diagnosis is a red flag that begs to be audited:

- Encephalopathy
- CHF
- Malnutrition
- Acute/chronic respiratory failure
- Acute tubular necrosis
- Sepsis/Severe sepsis with organ dysfunction

Inpatient discharge disposition

"Discharge Disposition" is the code assigned to represent where the patient went when discharged from the acute care hospital.

Can affect reimbursement under the "Transfer DRG" rule

Resource: See Medicare Claims Processing Manual (100-04) Chapter 3.

Provider query/CDI risks

The intent of provider queries is to clarify and improve the quality of documentation in the medical record. Queries are a common tool in the inpatient setting and growing in the outpatient setting as well. Risks include:

Lack of written policy

Having financial goals as the center of your query process

Focusing only on Medicare rather than all payers

Failure to regularly audit query process for:

- Appropriate queries
- Non-leading
- Over querying
- Missed queries

Charge Description Master (CDM)

Failure to update codes regularly, resulting in outdated, incorrect or missing codes

Codes that are both hard coded and coded by HIM coders that may result in duplicate charges, hitting edits in your billing department and requiring rework.

Hospital outpatient clinics

Modifiers are a huge risk:

Modifier -25 not justified on the E&M service, lack of documentation

Modifier -57 (decision for surgery) automatically attached to a preop H&P visit

Modifier -59/XU overuse, used to override CCI edit

Injection and infusion coding

Problematic for ED's, oncology/chemo clinics, other outpatient clinic settings

Nursing documentation often leaves out or is ambiguous about key information such as infusion site, medication infused, start and stop times.

Coding and charge rules are complicated

E&M coding

Professional E&M codes convey the provider's patient care efforts based on documentation and medical decision making. E&M codes are used (and misused!) in multiple settings:

- ED
- Inpatient hospital
- Clinic and urgent care
- Provider office
- Nursing home
- Home visits

HCC Risks

CMS uses a Hierarchical Condition Category (HCC) risk adjustment model to calculate risk scores in Medicare Beneficiaries enrolled in Medicare Advantage plans.

Higher HCC categories represent higher predicted healthcare costs, resulting in higher risk scores. The assigned HCC score is adjusted annually for each patient.

Frequent coding errors include:

Chronic conditions not documented as chronic in the medical record/not documented annually

Lack of specificity in documentation and/or code assignment

Required linking language, causal relationship or manifestation codes are missing

Getting Started

1. Build the framework

Identify your goals: Start simple, e.g. identifying improper payments. Develop a roadmap that allows you to advance to more complicated goals such ad validation of provider documentation.

Internal policies and procedures: Use your roadmap to create policies and procedures that address coding quality and consistency as well as your auditing plan - frequency, methodologies, reporting, follow-up and education. Include a process that allows a coder or provider to dispute auditor findings

Audit oversight: Determine who is accountable for specific roles in your organization. Include HIM, coding and billing leadership. The audit director should be someone actively involved with your Compliance Committee and revenue cycle.

2. Who ya gonna call?

Consultant vs Internal Staff

Consultant	Internal Auditor
• No ties to internal staff • High level of expertise • Provides objectivity free of internal influences • Can be expensive	• No outside costs • Sometimes difficult to find the needed expertise in-house • Staff may not be receptive to a peer finding their errors • May have other workload that needs coverage while audit is under way.

3. Auditing frequency

OIG recommends quarterly audits.

This timeframe works well to:

- Identify current problems before they become major headaches
- Ensure pertinent training and education to resolve errors
- Provide focus for follow up auditing

4. Sampling Methodology: What will you audit?

Consider focusing on problem-prone, high-risk and high-volume areas for the biggest return on your investment.

Determine sample size – What percentage of charts will you review?

A good rule of thumb is 2% of inpatient encounters and 1.25% of outpatient and professional encounters

Think about:

- Targeted DRGs – recent denials, previous payer issues
- Specific payers vs all payers
- Outpatient surgical cases
- ED visits
- Infusion clinic visits
- OIG “hit list”

A word about RAT-Stats…

RAT-Stats (Regional Advanced Techniques Statistics) is a statistical software used by CMS and the OIG to assist in random sampling for audits

Available to providers to download for free to assist with claims selection for self review.

Ensures a valid sample that is in compliance with OIG guidelines.

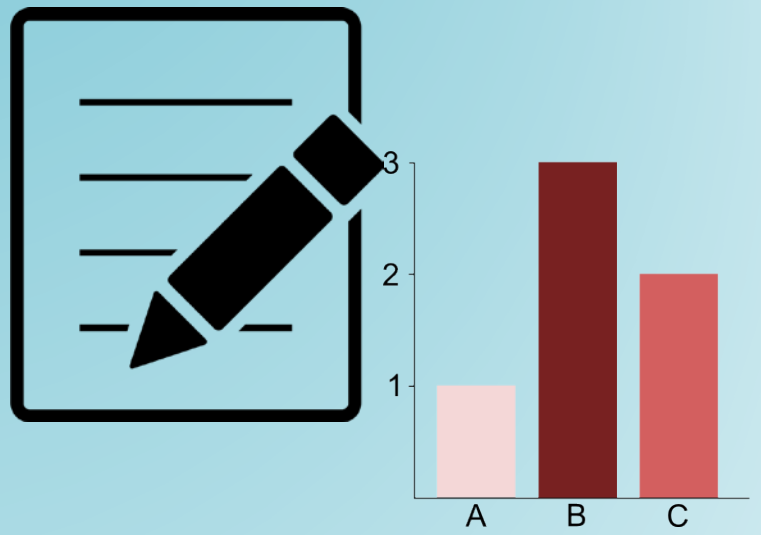
OIG training videos are posted on Youtube

Link to OIG webpage is on slide 33.

5. Set your pass-rate requirement

The pass-rate threshold for government payers is 95% so this should be yours.

Report Your Findings



Your final report should include all your findings:

the good, the bad and the ugly!

Tailor your report to the type of audit performed and

to your audience: Your C-Suite report will not look like your coder report

Include a financial impact analysis for the issues you have identified.

e.g. missed query opportunities that have the potential to improve revenue.

Include recommendations for improvement and your corrective action plan

Recommendations

Develop a Corrective Action Plan with timeline

- ✓ Educate
- ✓ Rebill
  - Log and track your rebills to completion
- ✓ Re-audit

Conclusion

Accurate consistent coding is an ongoing process not a destination. The benefits of creating and maintaining a strong self-auditing program are many:

- Accurate reimbursement
- Accurate data and reporting
- Coder education and development
- Improved provider documentation
- Reduced rework and rebilling
- Overall increased compliance

Helpful Links and Resources

https://oig.hhs.gov/compliance/compliance-resource-portal/

https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-MLN5862089.pdf

http://bok.ahima.org/doc?oid=91927#.WayGHrKGPIU

Center for Medicare and Medicaid Services. 2018. *Publication 100-08 - Medicare Program Integrity Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html

Office of Inspector General - U.S. Department of Health & Human Services. 2013. *Provider Self-Disclosure Protocol*. https://oig.hhs.gov/compliance/self-disclosure-info/protocol.asp

https://oig.hhs.gov/compliance/rat-stats/index.asp

Quality Nightmares by MasterControl

"That's how the clinical team decides which regulations they will follow."

QUESTIONSNS

Give yourselves a round of applause!

Medical Management and Reimbursement Specialists, LLC

PO Box 486

Bristol, NH 03222

603-237-1360

www.mrsnh.com

robin@mrsnh.com