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Advance planning can ease the pain of an audit

Hospitals that go through the risk analysis process before an audit will find themselves in a better position when the record requests arrive

Chuck Green (/news/author/2621)
(/news/author/2621)

Larry Hegland, MD, is less than impressed with the data that the U.S. government provides to hospitals preparing for audits, like those tied to Medicare's Recovery Audit Contractors (RAC) program.

The Center for Medicare & Medicaid Services furnishes guidelines designed to help hospitals develop programs to prevent RAC (/directory/rac) audits. But they tend to provide general guidance that may not relate to actual RAC audits, he noted.

Hegland, who is the system medical director for Recovery Audit and Appeal Services at Ministry Health Care in north-central Wisconsin, part of Ascension Health, said these documents "basically list every conceivable target under the sun. They generally don't help much."

Hospitals need to be prepared because while CMS paused the audit program in March, it said in August that a new round of recovery auditor contracts would be awarded before the end of 2014.

"PEPPER can be a good starting point for examining data and identifying the areas where you should focus in preparing for an audit," said Ralph Wuebker, MD, chief medical officer of Executive Health Resources, referring to the CMS's comparative data report PEPPER: The Program for Evaluating Payment Patterns Electronic Report which consists of 29 high-risk audit categories and is delivered to all U.S. healthcare facilities.

Marsha Epps, associate product manager at MedAssets, suggests that hospitals assessing their risk of audit prepare a risk analysis of their billing practices. Monitoring denied claims will help identify billing issues and provide data to

assist in developing corrective actions needed to avoid improper payments.

Additionally, based on the RAC contractors' areas of focus, hospitals can conduct a preemptive review to identity where risk might exist, said Epps.

[See also: CMS slows down RAC activity in advance of new auditor contracts (/news/cms-slows-down-rac-activity-advance-new-auditor-contracts)**.]**

One example is whether the hospital is paying adequate attention to the two-midnight rule. Under the rule, an admission is assumed to be appropriate for a Medicare Part A payment if a physician expects a patient's treatment to require a stay in the hospital over two midnights and admits him or her under that assumption.

"If patient care was initiated at 12:01 a.m. and a patient stayed over an additional midnight and then was released; in essence, two days later, the hospital won't qualify for reimbursement (/directory/reimbursement) under the 2014 IPPS," Wuebker explained. "It's must be two midnights (with few exceptions). In terms of how that data plays into preparing for an audit, the two midnight rule has some key parameters around it in terms of when the clock starts and the physician's expectation versus how long that patient stayed."

Whatever the case, Hegland said his facility, Ministry Health Care, bases its audit preparation on its own historical information to attempt to identify areas of concern and also conducts preventive education for staff members. However, when reviewing any set of RAC audits, targets don't abide by a "particular rhyme or reason," making the process more challenging. Consequently, when alerted to an upcoming audit, "we evaluate every case, using people like our coding and clinical experts."

On another front, Hegland said the institution tracks its database with the Compliance 360 database. "When an audit arrives, we load every case into (Compliance 360) and track all timelines in the database (since you're required to meet) numerous timelines and failure means your money's taken back."

Hospitals and other medical facilities should devise internal metrics to follow, beyond just an observation rate, added Wuebker.

Furthermore, hospitals must establish a central location to efficiently accommodate audit requests and any audit related communication, said Epps. "We've often seen record requests sent to one address, and demand letters to another. The best practice includes establishing ownership of audit communication and a clearly defined workflow. Cross-departmental collaboration is essential as well so that deadline dates are met."

Mike Semel, president and chief compliance officer of Semel Consulting, says that when a member of his team asks a hospital or medical practice employee where something's located, "they're regularly told someone else has it. Problem is, no one has prepared them for an audit, and sometimes they can't find a critical document."

According to Hegland, "the best practice probably is dedicated resources, (especially) since the audit process can be difficult, highly detailed and nuanced. You need people who perform the task exclusively and know how to analyze clinical records, prepare appeal letters and (make) arguments."

Just as importantly, you must be positioned to learn from an audit, said Hegland. "Coding and billing is incredibly complex. If you see a completely correct hospital bill, you're holding a miracle on paper."

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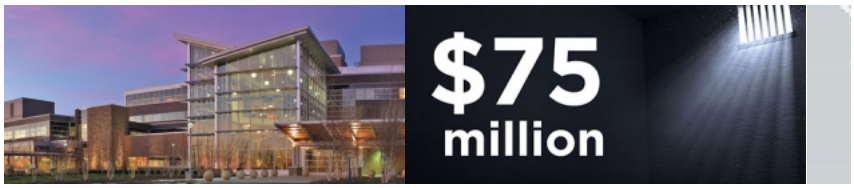

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