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Claims Processing Ongoing Monitoring and Auditing: Improves Revenue and Prevents Costly Errors

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Important Questions Compliance Officers Should Be Asking

The Medicare administrative contractors (MACs) continue to question claims. The zone program integrity contractors (ZPICs) seek pattern errors suggesting fraud and abuse. The recovery audit contractors (RACs) operate under great incentives to find instances of improper payment. The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) auditors look for questioned costs, and their investigators, along with the U.S. Department of Justice (DOJ), seek patterns suggesting fraudulent billing. All are looking at all facets of claim submissions to detect coding errors and documentation for medical necessity.

The risk from these audits will only increase as hospitals complete the transition to ICD-10, which will complicate the issues of coding accuracy with its requirements of new codes and greater specificity in documentation. Their reviews, data analysis, and mining grow in intensity and sophistication. Ongoing monitoring and auditing is the means that can meet this challenge. It is also one of the seven critical elements of a compliance program identified by the OIG "critical to a successful compliance program."[1]

There are many benefits to having effective ongoing monitoring and auditing of claims processing, including helping to ensure mistakes are caught before claims are submitted and providing a basis for improving coding and billing accuracy, thereby lessening a hospital's exposure to payer audits and enabling the hospital to capture revenue to which it is entitled. The biggest benefit is ensuring the hospital knows more about its business than the government. The question is how to do it properly.[2]

ONGOING MONITORING

Monitoring aims to ensure that policies and procedures are in place and are being followed. This is a program manager's responsibility and should be part of his or her daily routine. Program managers are the ones most familiar with their own operations and should be charged with (a) identifying risk areas of their responsibility; (b) developing appropriate internal controls, policies, and procedures; and (c) monitoring them to ensure they are being followed. To do this, program managers must keep track of changes in rules and regulations; translate those changes into policies and procedures that act as internal controls; train their staff on the written guidance; and verify whether they are accurately carrying out their responsibilities under the rule.

The last portion of this equation involves having a quality assurance program (QAP) for claims processing that includes quality control reviews (QRCs). QRCs are nothing more than drawing randomly a number of claims in process for "real time" testing for errors before submission for payment. Any errors should result in an educational contact with the person responsible for them. Errors should be tracked so as to identify any emerging patterns by coder, diagnosis-related group (DRG), physician, et cetera. Coders then could be educated on why the denial is occurring and how to prevent its recurrence. If a pattern of error or denials emerges for a coder or physician, it should result in retraining or some other action. If a pattern develops by DRG, then the matter should be investigated as to the cause.

In its compliance guidance, the OIG advises conducting assessments to gain "as part of benchmarking analyses that becomes a baseline." The OIG gave one example of "a baseline level includ(ing) the frequency and percentile levels of various diagnosis codes and the increased billing of complications and co-morbidities."[3] As such an important part of monitoring is maintaining trending information to help identify root causes of denials, such as clinical documentation and compliance with medical necessity. Data obtained through ongoing monitoring can be used to raise staff awareness of steps to take to avoid errors leading to denials. Such data can be used, for example, to develop educational initiatives for coders aimed at promoting high-quality coding and avoiding costs of denial processing, appeals, and resubmissions. It also can be used to "benchmark" improvements in error reduction.

Drilling down on data reveals precise details, such as the number of coding errors made on a specific DRG. These details can be broken down across the hospital, by facility, or by coder. The data might show an unusually high percentage of denials in a specific clinical category, indicating a need for additional instruction for the entire team. Or it might show repeated denials linked to an individual coder's skill set. In some cases, it might indicate problems with physician documentation or legibility. The findings can be used to develop focused educational programs to improve coding and billing accuracy and limit audit exposure. Monitoring can not only measure compliance and accuracy; it can improve cash flow and limited exposure of payor audits.

ONGOING AUDITING

Ongoing auditing needs to be performed by parties independent of those operations.[4] It can be done by the compliance office, internal audit, external auditor, outside consultants, or any combination thereof. Whereas monitoring is a daily effort, auditing is periodic, normally annually. Monitoring is the key to avoid liabilities, for if problems are identified after a long period of control failure through annual audits, significant liabilities may already be on the books.

Auditing aims to verify that the program managers are meeting their monitoring obligations and to validate that the results of the monitoring have had the desired outcome. Auditing may transcend

the one program, in that coding accuracy is a shared responsibility that may involve other areas, including physicians, nursing, IT, patient accounting, and medical records. All those managers should be actively engaged in monitoring their own areas of responsibility.

Appropriate audit attention to all of these areas can contribute to better communication across functions. To be effective, auditing should follow a formal tracking mechanism for trending analysis that includes examining denial rates. The audit should establish quality check rules to avoid such erroneous coding practices by performing an up-front quality check on all claims that fit the "commonly denied" profile. There should be random checking of all codes and coders to pinpoint where coders are having quality problems and denials are more frequent. This can start by using data to establish indicators to highlight areas where problems are most likely to appear, such as the:

■ number of appeals won or lost;
■ risks posed by denials in terms of dollars that might be lost;
■ dollar amount that the organization expects to recover from correcting errors; and
■ dollar amount that the organization has recovered in the past.

21 QUESTIONS COMPLIANCE OFFICERS SHOULD ASK[5]

Ongoing monitoring is a program manager's responsibility, not the compliance officer's, and ongoing auditing is something in which the compliance officer may or may not be directly involved. What he or she should be doing is making sure that program managers are engaged in effective ongoing monitoring of the type described herein and that periodic independent reviews/audits are performed to verify that program managers are doing this effectively — and validate the outcome. The following 21 questions are the type that compliance officers should be asking:

1. How effective is communication that exists between departments affecting claims submissions?
2. Is there an effective method to identify risk areas for which they are responsible?
3. Is there a process to keep track of regulatory and rule changes affecting their operation?
4. Have controls been established for all regulatory issues relating to billing and coding?
5. How are coders being kept aware of changes in rules and regulations?
6. How is the staff being trained on the changes in policies and procedures?
7. Do internal controls, policies, and procedures address changes in rules and regulations?
8. Are policies and procedures scheduled for review and updated regularly?
9. Are coders being tested to see if they are following the written guidance correctly?
10. Are they verifying that coders are accurately carrying out their responsibilities under the rules?
11. Are identified weaknesses remedied quickly by control changes, education, and other corrective actions?
12. Is there immediate, follow-up testing when control deficiencies have been remedied?
13. Do they have a QAP that includes frequent online testing (QRCs)?
14. Are they making educational contacts every time an error has been identified?
15. Where patterns of errors are identified, do they have refresher training for coders?
16. Are all errors tracked so as to identify any emerging patterns by coder, DRG, physician, et cetera?
17. If a pattern of error develops by DRG, is it investigated as to the cause?
18. Do they maintain trending data on error rates by DRG, coder, and physician?
19. Is there an annual audit plan to review billing and coding?

20. Do the audits address how well monitoring is taking place?
21. Do audits validate billing accuracy to reduce error rates, protect revenue, and guard against liabilities?

Footnotes:

1. "OIG Compliance Guidance for Hospitals" oig.hhs.gov/authorities/docs/cpghosp.pdf.

2. "Billing monitoring: Weakest link or greatest strength?" Cornelia Dorfschmid, *HCCA Compliance Today*.

3. *Id.*, footnote 51.

4. "Auditing and Monitoring: How to Get It Done," Steven Forman, November-December 2012, *Journal of Health Care Compliance*.

5. For more details on the subject, see www.compliance.com/category/auditing-monitoring.