In The Eyes of The Auditor…

William L. Malm, ND CMAS CRCR
Ernie de los Santos, MBA SSA

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Objectives

- Identify Types of Audits
- The Audit Process
- ID Key Documentation Elements
- External/Other Documents
- Consistency

TYPES OF AUDITS

Governmental

- OIG
- RAC
- CERT
- MAC
- ZPIC
- Supplemental Medical Review Contractor

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf

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Commercial & Managed Care

- Line Item
- Medical Necessity
- Authorization
- HEDIS
- High Dollar
- “Medicare Like” DRG Validation
- RADV – Risk Adjustment Validation (Payor)

http://www.healthcarefinancenews.com/blog/6-top-healthcare-audit-types

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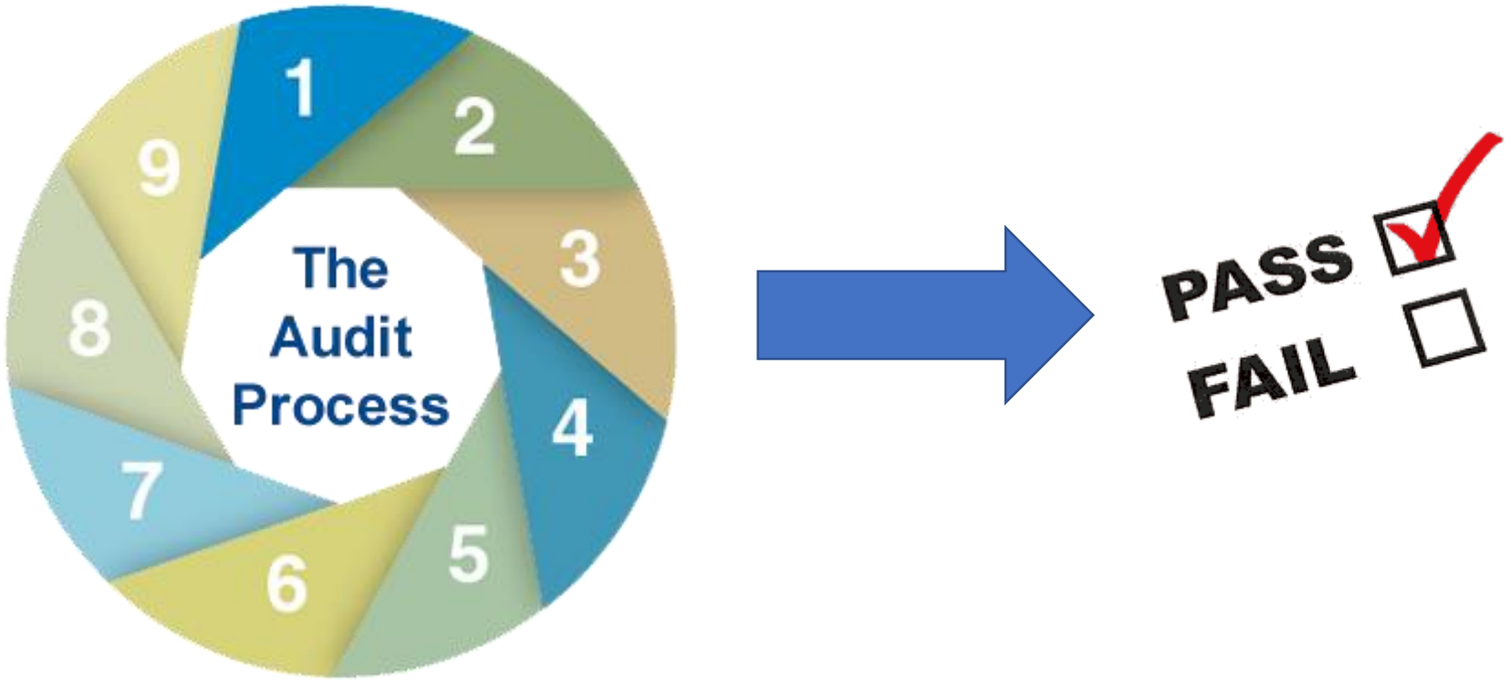
THE AUDIT PROCESS



NHS Healthcare

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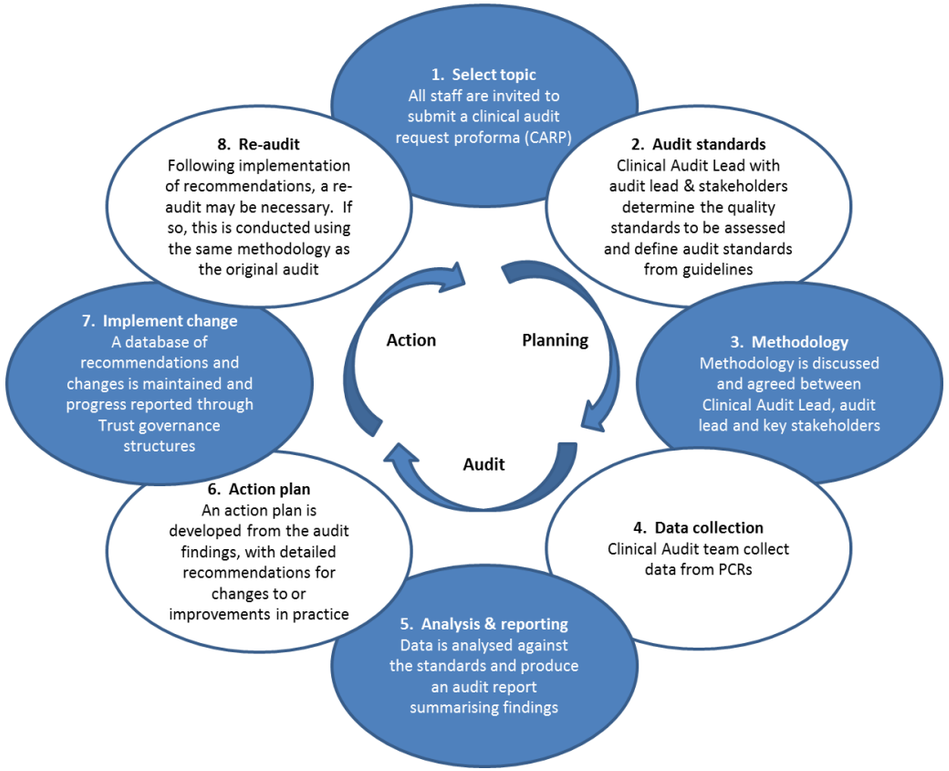

Accounting Cycle

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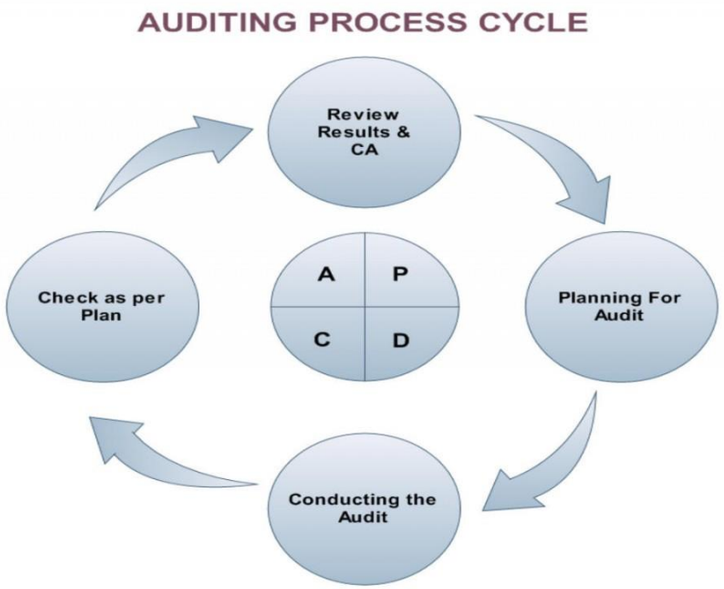

ID KEY DOCUMENTATION ELEMENTS

Key Elements

- Identifying key elements is critical to successful documentation
- A denial can occur *before* service is rendered:
  - Verification of coverage
  - Authorisation(s) – (remember some IP require auth)
  - Operating / Attending/Facility – NPI numbers
  - Prevent basic errors – does the CPT or ICD-10 match the authorisation ?
  - Patient Access errors are frequently the first step of a potential denial and easily caught in claim download to payor!

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Data = Selection:
What Picture Does the Claim Paint ?

- Auditors really only want to see claims that are selected due to a data aberrancy or prepared “routine” analysis
- After meeting all the authorisation and claim completeness the claim will be scrubbed against “Big Data.”
  - Outliers – usually Dollars / High Dollar Account
  - Pharmaceuticals – High Dollar / FDA Investigational
  - Higher level procedures coded outside the norm within the community – Example only submitting 99215 or 99285
  - Excessive units of service
  - Violations of LCD / NCD
  - Medical Necessity (admit as inpatient for less than 2 midnights)
  - Provider is deemed high cost and lower quality based on peer group

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Medical Record Should Read Like A Book

- Auditors look for the “story” and whether it is plausible
- A book has a beginning (examination / evaluation) a plot (the clinical process) and an ending (result of the clinical process)
  - Auditors do not like surprise endings – something that just appears at the end but never mentioned previously (example sepsis appears in discharge summary but no clinical documentation of sepsis prior to the discharge summary)
  - The plot can be the outline of the problem list and how the clinical process aligns with the stated goals in the problem list
  - If problem is not being addressed by plan, how was the plan of care changed ?

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Did Your EMR create “War & Peace”

- EMR when printed can create hundreds if not thousands of pages of documentation that are confusing to follow. (EMR dump = a raw data dump)
- When providing an EMR that prints pages not necessarily important to the audit it is essential that some sort of summary be provided to the auditor
- When paper charts were in play there was an admission summary, daily progress note and discharge summary – try to make it like the paper version.
  - Some EMR will print one vital sign per sheet or replicate the labs each day from admission to discharge – this is distracting and can create adverse audit results

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The Problem List – A critical element

- The auditor must see which problems are active, chronic and active, chronic and inactive. This will become more important as we move toward risk based reimbursement
  - Cannot code from problem list but it allows an auditor unfamiliar with the case to easily see what the provider was managing and the thought process
    - Every good book has an outline

Emergency and Admitting Documentation

- Sets the plan in motion
  - Presenting symptoms
  - Prior health history, how prior hospitalisations have progressed – readmissions or extended recovery ?
  - Identification of active, inactive and contributory concerns
  - Summation that creates the plan of care – what is the medical decision process – the 5 W's need to be identified at this stage and at every progress note thereafter
  - Key documentation requirement – what is the risk to sending the patient to a lower level of care or home ?

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THE 5 Ws FOR DOCUMENTATION/AUDITING

What are we treating?

- Diagnosis
- Procedure (if relevant)

Where is treatment needed?

- Inpatient
- Outpatient
  - Observation
  - Surgery

Why is treatment needed?

- Why is this diagnosis acutely requiring attention
- Relationship to chronicity
- References to requiring testing, drugs, or other interventions
- References in variation from baseline to current state
- Potential for adverse outcome

HOW are we treating it?

- What are we actively doing requiring our level of care
- Implications if not performed

When do you think they'll get better?

- Expectation for stay
- Plan for discharge

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Recovery Analytics
Committed To Your Success

EXTERNAL/OTHER DOCUMENTS

Daily Progress Notes

- This is where the plan, progress toward goal, alterations in the plan and clinical decisions must be documented.
- Must be in clear language and easy to understand
- Timeframes for discharge or return must be incorporated into the plan as well as the risk to the patient for not pursuing the plan
- EMR templating can cause significant disruption in this messaging with “physician preferred templating” that is not consistent across an enterprise or even a service line

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Daily Progress Notes

- Auditors will look for templating:
  - Cut and paste
  - Progress notes that repeat themselves
  - Data that pulls automatically from prior portions of the record and not current to the date of service
  - Errors that occur from page to page
  - Conflicting notes between providers
  - Comments that permeate such as “Following With You” but no real involvement of the specialist when they should have signed off
- Templating creates significant issues if not enterprise wide and service line specific – all the cardiologists should depend on the same method for documenting if possible

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Daily Progress Notes

- Progress notes that do not address the plan of care
  - New clinical approach not previously discussed and not part of the current plan or care or an amended plan of care
    - Treatment of an unrelated issue not previously documented. Example: Surgical removal of gallbladder but while under anesthesia decided to remove 3 cysts on leg
  - Different providers addressing the plan in divergent documentation
  - Template does not address or allow the plan to be addressed
  - Dates and times – do they make sense ? Sunday at 3am progress note without any reason for the patient to be evaluated – is this something auto-generated ?
  - Auditors look to try to put it into some sort of format such as the older S.O.A.P documentation – Subjective – Objective – Assessment and Plan
  - With a SOAP format the elements for successful documentation are present and easy to understand by the auditor

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Provider Orders

- Orders are an essential element of the medical record
  - Provide evidence of the plan
  - Diagnostics and Therapeutics are driven by plan
- Auditors are going to look and see if the orders demonstrate:
  - Medical necessity if outpatient
  - Are reasonable in light of the plan of care (versus custodial)
  - Completed by the necessary Nursing service or ancillary providers (Respiratory etc...)

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Provider Orders

- Auditors will also look at proxy and verbal orders – did they have the right co-signature within the designated time frame
- Look for services rendered that were not based on an order
  - Example: Respiratory may see the patient 3x / day and charge an assessment but the only provider order is for oxygen prn. Example of ancillary induced orders not supported by the provider
    - In a line item audit these would be removed as charges – no valid order for medically necessary services

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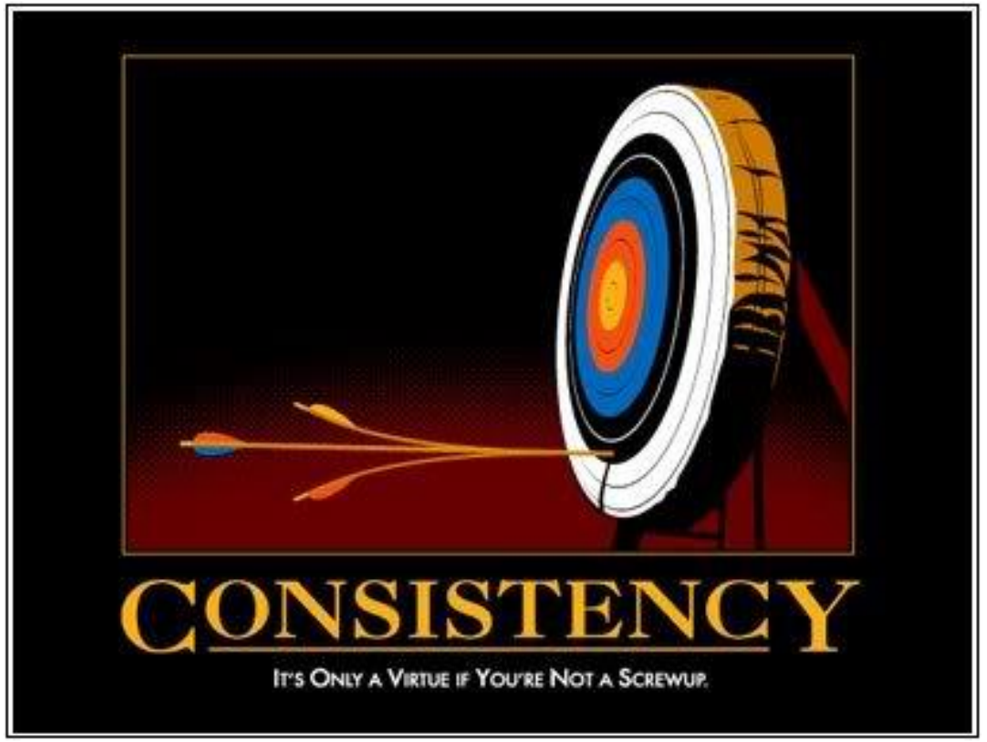
CONSISTENCY



Timely Provision of Services

- Auditors will look at the severity of illness stated in the admitting and progress notes and look for any delay of treatment
  - Delay of treatment over a weekend
  - Delay of treatment over a holiday
  - Look for delay to meet the schedule of a specific provider when the description of the illness is such that immediate care / urgent care should be rendered
  - Holding a patient when the service cannot be provided within the facility – delay transfer
  - If there is a noted delay of service then the auditor will be confronted with a disparity between the description of illness and services rendered
    - Could they have been provided in a lesser status?
    - Could another physician / provider have been approached?

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Progress toward Goal

- Plan of care must have a clearly stated goal
- Goal must be objective
  - Dry weight to be 100 kg
  - Respiratory rate within 20-24 / min
  - Heart rate decreased to less than 110 per minute
- Subjective measures can be in the goal
  - Patient states no further shortness of breath
  - Patient denies further dizziness
- Subjective and Objective notation should be present to some degree to document progress toward stated goal in every progress notes

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Progress toward Goal

- There are occasions when the patient is not progressing toward the goal
  - Auditors will expect to see some sort of statement about the progress being slower than expected or not attained
  - What did the provider do to change the plan?
  - Is there a new more realistic goal?
  - Does it change the timeframe for treatment (especially if an inpatient – will it delay discharge)
  - Does it change the need for post-discharge services (home care, SNF, LTAC…)
  - New goal must be specific and documentation on how the plan will be adopted to fit the new outcome

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Discharge Plan

- Discharge planning is expected to start with admission for commercial plans
- Providers have provided the plan and daily progress toward the plan but there must be evidence of a discharge plan
  - Discharge plans that are delayed or unattainable thereby delaying discharge will most likely be denied

ONE LAST FACTOR

Virtually No One Has Enough Time

- How much time do your Coders & Billers spend per claim?
- How much time does an Auditor have to audit?
- Automation and Data Analytics are “helpful” at either end

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Good Luck with All Your Audits!

William L. Malm, ND CMAS CRCR
Health Revenue Integrity Services
malm.williaml@gmail.com

Ernie de los Santos, MBA SSA
Appeal Academy
erniedls@appealacademy.com

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