

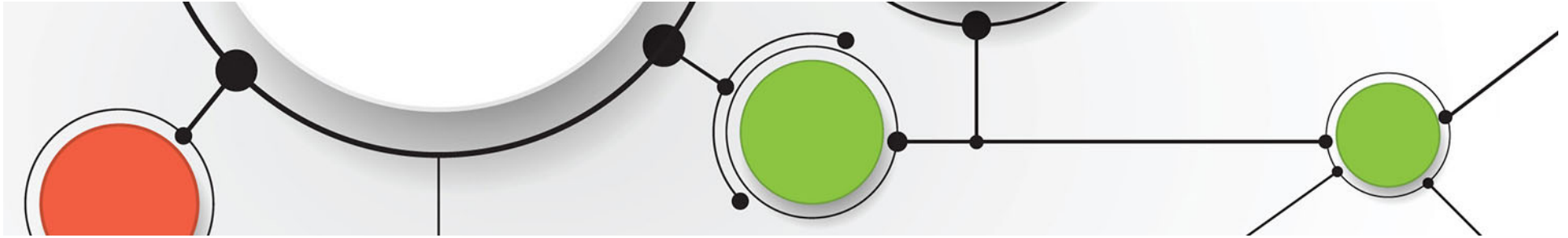


Managing the Revenue Cycle with Revenue Integrity Audits



Western Reserve Chapter

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Agenda

- Purpose and benefits of Revenue Integrity Audits
- Audit Scope
- Audit Components
- Examples of what to look for
- What to do with audit results



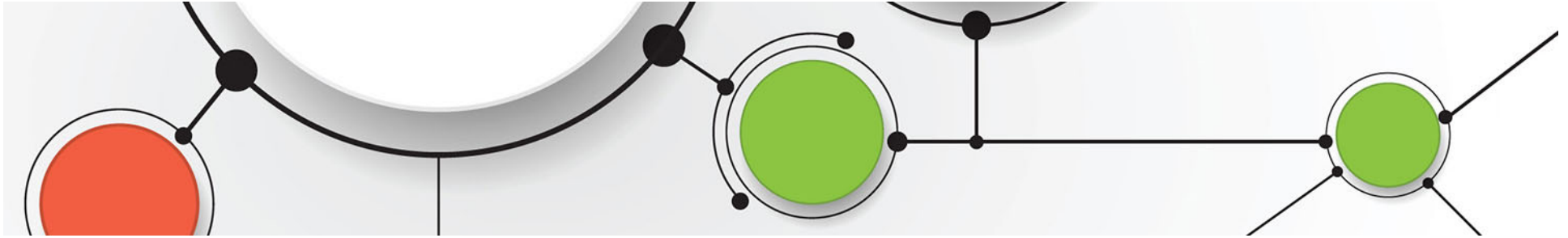
Audit Purpose

- To ensure the **completeness, appropriateness** and **accuracy** of charges captured in all clinical areas
- Did you charge for everything that you should have?
- Are all charges which were captured appropriate?
- Do the charges that were billed accurately represent the services that were performed, and that are ordered and documented in the medical record?



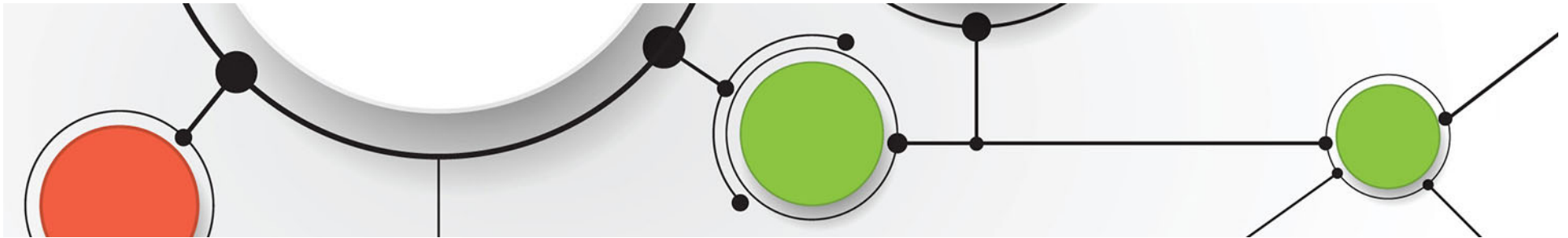
Potential Risks to Identify

- Missed charges
- Incorrect or inappropriate charges
- Missing or insufficient orders or documentation
- Incorrect billing units, modifiers, or other billing codes
- Incorrect reimbursement or denials



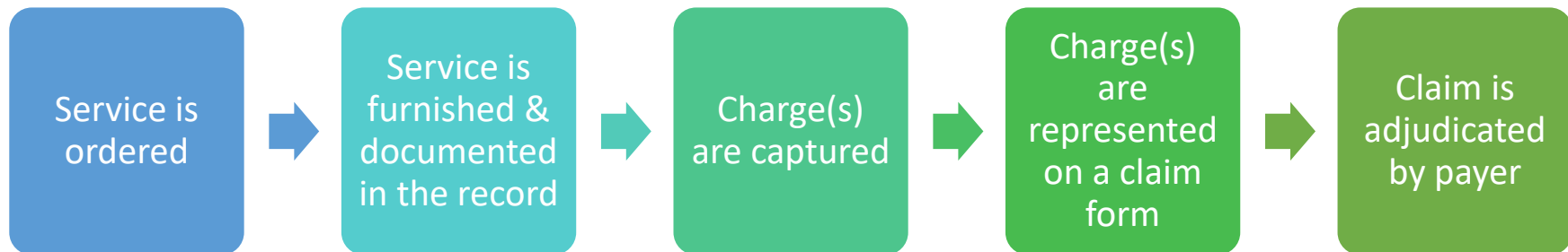
Potential Opportunities to Identify

- Increased charge capture (increased revenue)
- Reduction in denials/claim edits
- Mitigation of compliance risks

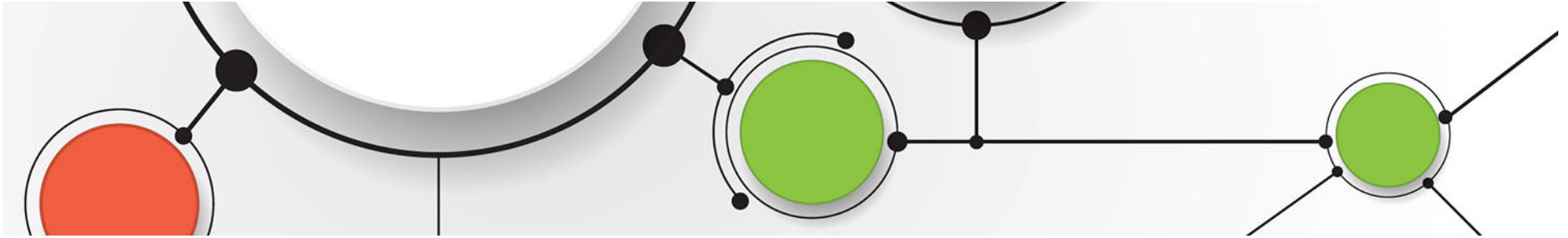


Audit Scope

- A comprehensive Revenue Integrity Audit examines a complete encounter from the point of physician order to adjudication of a claim by an insurer

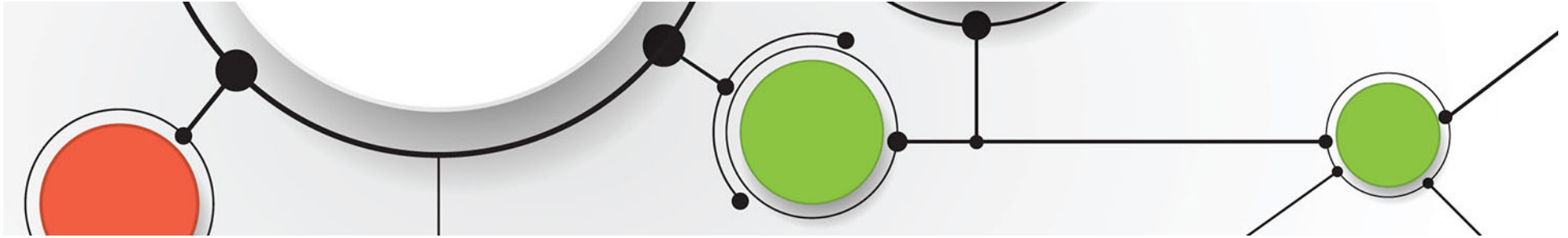


- Each of these five components of an encounter are reviewed in an audit – errors can happen at any one (or more) of these stages



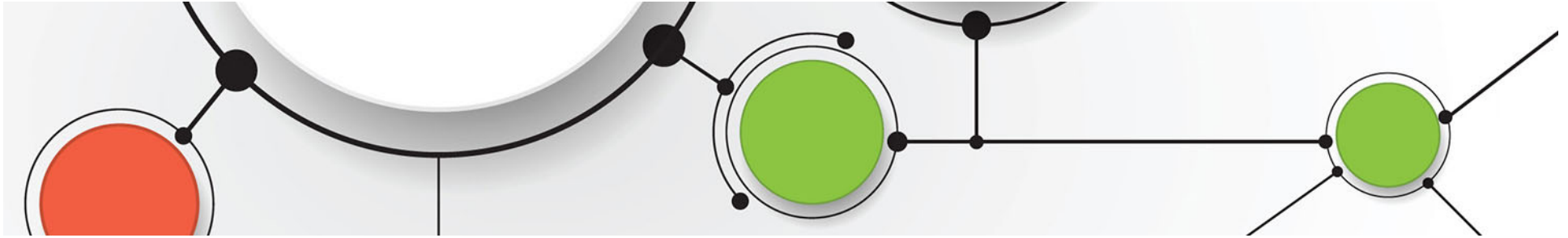
Audit Components

1. Orders – ensure that all services were furnished in conjunction with valid orders
2. Medical record documentation – ensure that all services are appropriately documented in the medical record
3. Charge capture – ensure that all charges for items and services furnished were captured, and those that were captured are appropriate
4. Claim forms – ensure that claim form(s) are generated correctly
5. Third party adjudication – ensure that the claim was correctly reimbursed



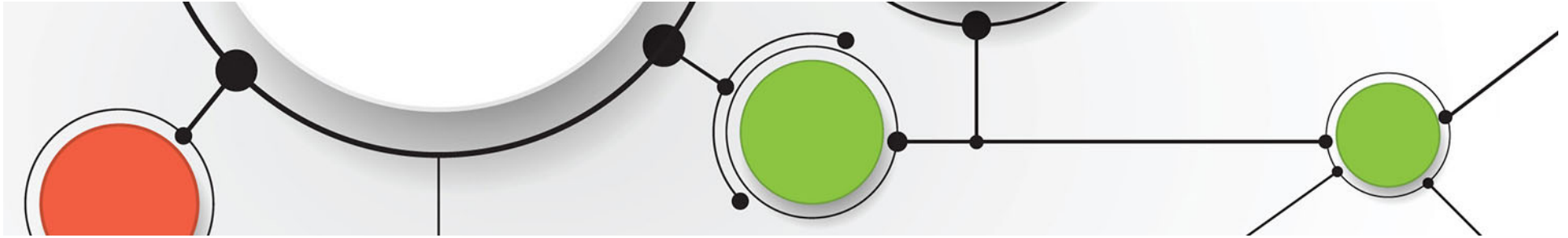
Orders

- The driver of all charges is a valid order
- Orders may be delivered via the following forms of communication:
 - A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed
 - An electronically generated/signed order
 - A verbal order by the treating physician/practitioner which is subsequently authenticated in the medical record



Orders – Things to Look For

- Is it signed and dated?
 - Signature not required on orders for laboratory tests paid via CLFS or pathology services
 - If the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating physician that he/she intended the clinical diagnostic test be performed
- If a signature is missing from an order auditors are instructed to disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received)



Orders – Things to Look For

- Is the signature legible?
- If not, is there a signature log?
 - Provider or organization may also submit attestation statement
 - Illegible signature over a typed/printed name meets requirements



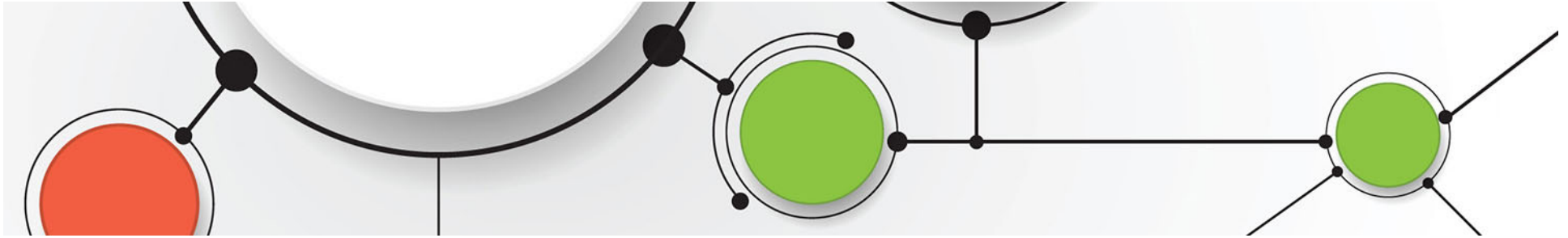
Orders – Things to Look For

- Does the order support the test performed and reported on claim?
 - Description of service/CPT
 - Example: Audit once resulted in recouped payment for CBCs w/ auto diff when order only stated CBC
 - Diagnosis/reason for testing
 - Medical necessity
- Was diagnostic test changed/different?
 - If so, is this supported?
 - Should not perform unordered test until new order is obtained



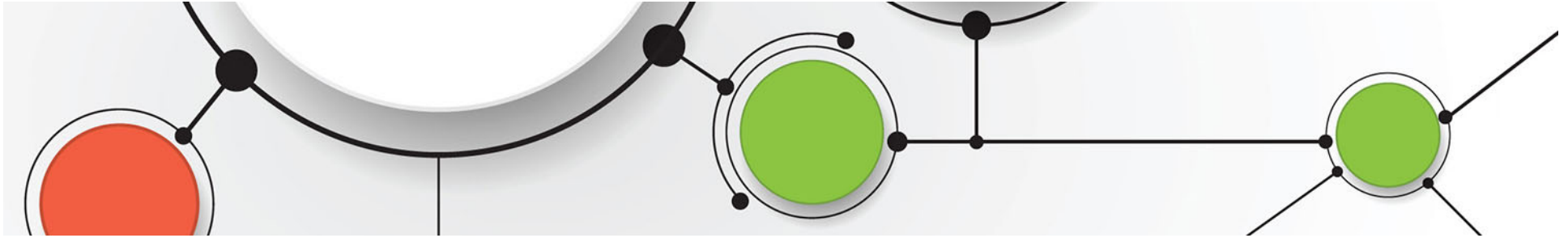
Orders - Example Problem Areas

- Observation
 - Observation time cannot begin until an order is made (e.g., “place patient in observation status”)
- Fetal Non-stress Tests - “OB Triage”
 - Sometimes patients are connected to a fetal monitor automatically upon arrival – in order to bill for an NST, there must be a proper order, documentation, medical necessity, etc.
- POC Testing
 - Tests must be backed by order or approved protocol
- Screening versus diagnostic tests
 - Is correct charge being generated based on the intent of the order?



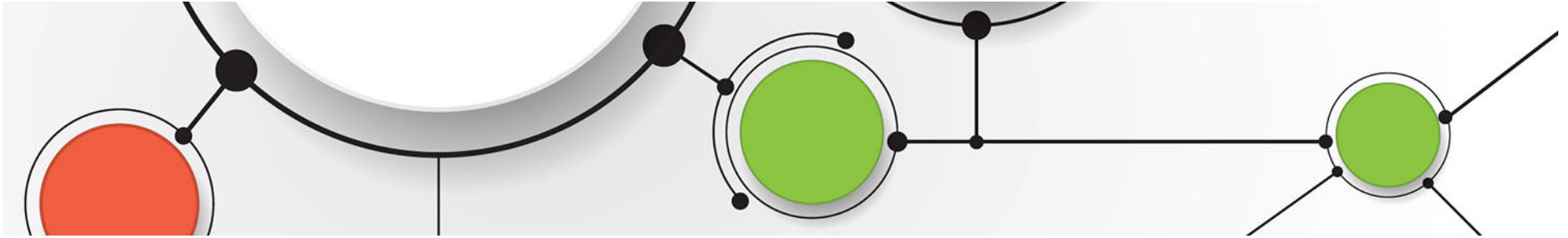
Medical Record Documentation

- “If it isn’t documented, it wasn’t done”
- Where is the documentation kept?
 - EHR, paper chart, external system (e.g. PACS, TraceView, iHeal), combination of each?
 - Ensure that auditor is provided with, or has access to complete record



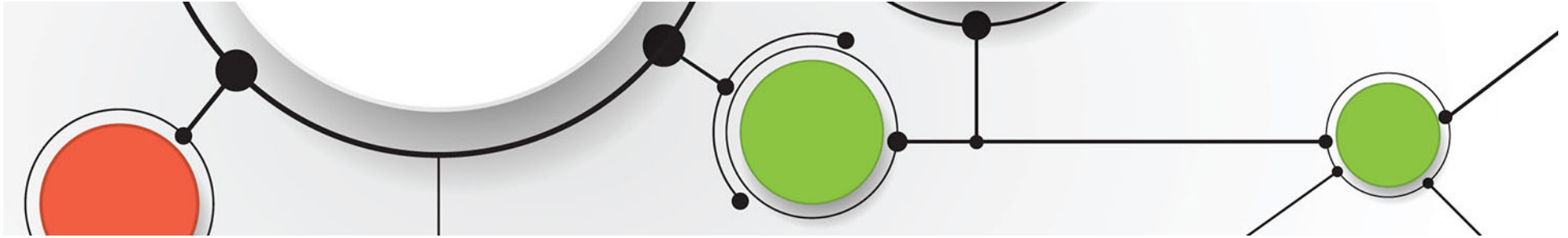
Medical Record Documentation

- Is every charge that is reported supported by documentation in the record?
- Does documentation support additional charges which are not reported?
 - Written reports/test results
 - Progress notes - physician and nursing
 - Physician interpretations
 - MAR



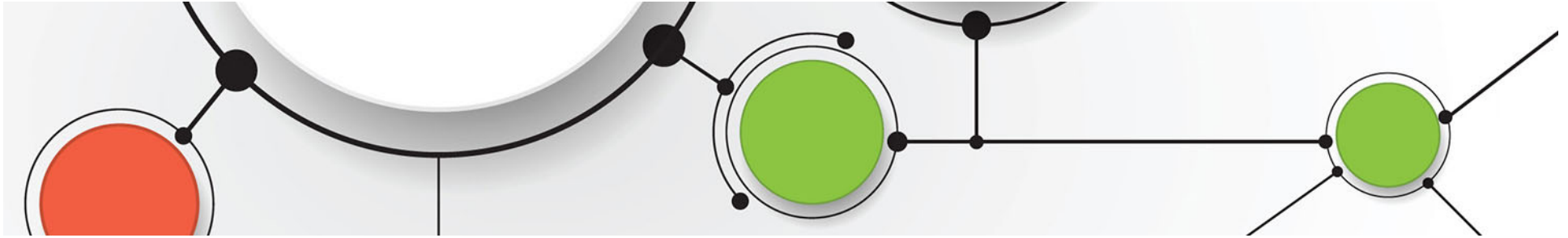
Medical Records – Things to Look For

- Service-specific requirements - Auditor should be familiarized with documentation requirements for the specific type of encounter being reviewed. For example, if reviewing:
 - CT scan encounters – know that CTA procedures must include documentation of 3D rendering
 - Rehab encounters – understand requirements for documented plan of care, certifications, etc.
 - Drug administration services – know what must be documented to support hydration versus infusion versus push, etc.
 - Time-based services – ensure that time is clearly documented, and units are calculated appropriately



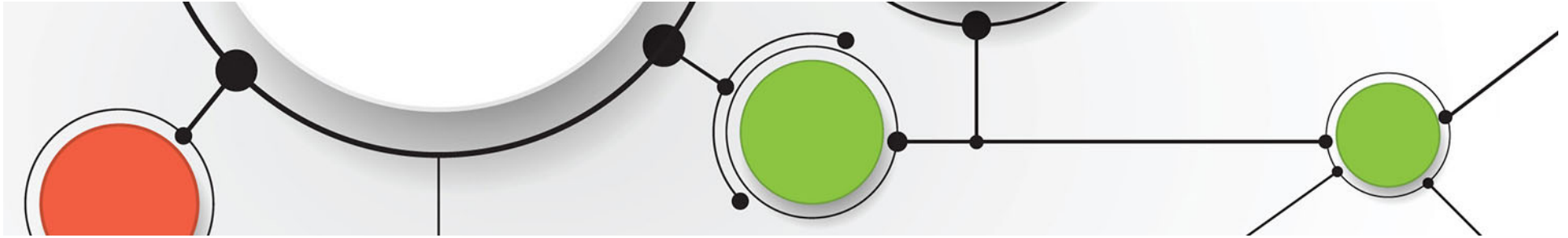
Medical Records – Example Problem Areas

- Infusion start/stop times
 - Facilities frequently have difficulties with nurses or other staff not always documenting start/stop times of drug administration services
- Limited versus complete ultrasound exams
 - CPT guidelines specify what must be documented to constitute a complete versus limited exam – make sure each required element is documented - e.g., abdominal (76700) and retroperitoneal (76770) ultrasounds
 - From the AMA CPT code book:
 - A complete ultrasound examination of the abdomen consists of real time scans of the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava including any demonstrated abdominal abnormality
 - If any required elements are not documented, a limited exam should be reported



Medical Records – Example Problem Areas

- Contrast exams
 - If contrast exam is ordered/billed, does the written report indicate that contrast was used, and if so, how much?
- Visit charges (e.g., G0463) reported with procedures without supporting documentation
 - Visit must be separate and distinct from procedure(s) and supported by documentation



Charge Capture

- What is charge capture?
 - Ensuring that each patient encounter is charged completely and compliantly for all services, supplies, and pharmaceuticals used
- Very complex process
 - Multiple types of patient encounters
 - Many different departments and locations
 - Unique coverage and billing requirements
 - Variety of information systems



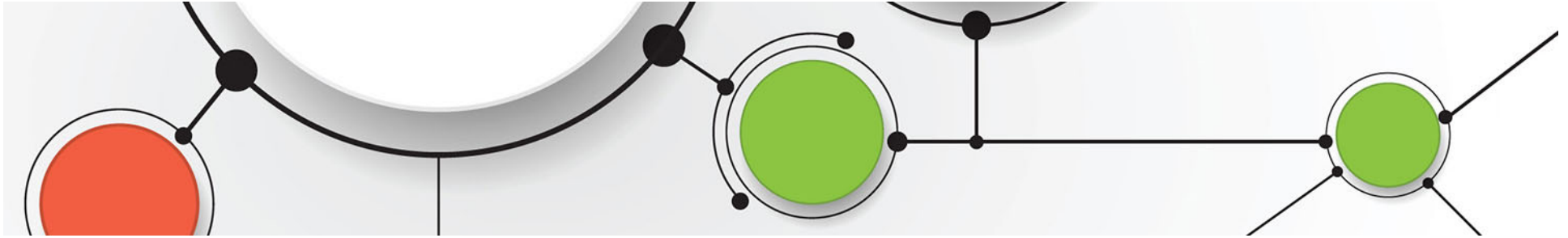
Charge Capture – How Are Charges Captured?

- Order entry (ordered/resulted)
- Upon EHR documentation
- Manual entry by specified staff (and backup person if staff is out?)
- HIM/coding
- Patient accounts? (hopefully not!)



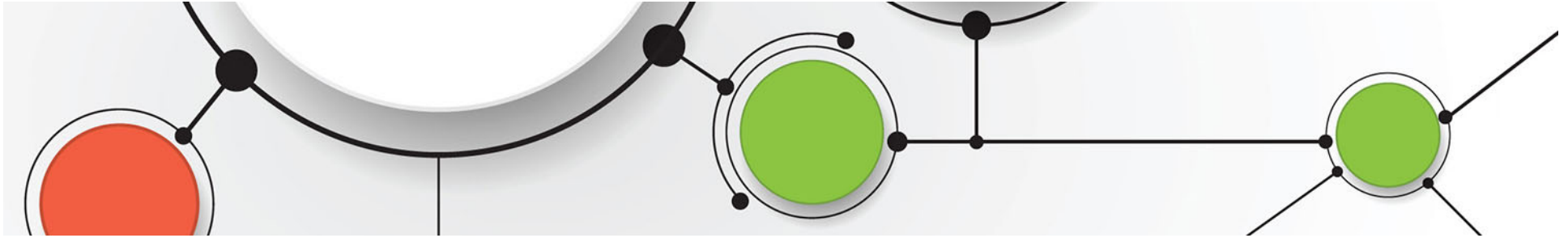
Charge Capture – How Are Charges Captured?

- During a single patient encounter, many different hospital departments and associated personnel might contribute to providing and charging for services and supplies
- Do all parties understand the complexities of charge capture?
 - Nurses?
 - Ancillary staff?
 - Coders?
 - Billers?
- Audits can help identify when additional training/education is needed



Charge Capture – Things to Look For

- Changes in practices – any of these could trigger the need for an audit
 - New staff
 - Properly trained in policies and procedures?
 - New providers
 - Correctly credentialed?
 - New systems
 - Do orders/charges/claims flow as expected?
 - New equipment
 - Any impact on how things are billed? e.g., non-NEMA compliant CT scanners
 - New locations
 - Correct reporting of address, place of service codes, PO/PN modifiers?
 - New services
 - Are new services being properly captured, billed and reimbursed?



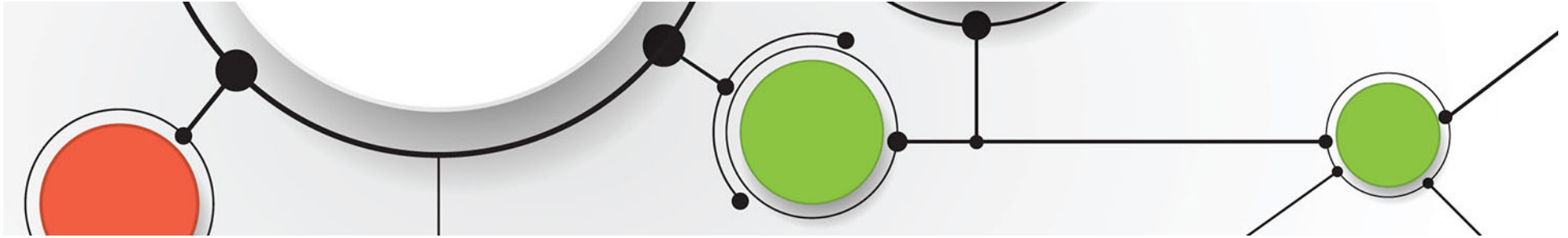
Charge Capture – Things to Look For

- Focus on charge capture concerns applicable to certain types of encounters. For example:
 - If auditing Cardiac Cath encounters, look to ensure that all implants and devices are captured (e.g., catheters, pacemakers, etc.)
 - If auditing Diagnostic Imaging encounters, look for capture of contrast material or radiopharmaceuticals and correct reporting of units
 - If auditing Endoscopy procedures, ensure that separately reportable procedures are captured (e.g., polypectomy and biopsy of different lesions)



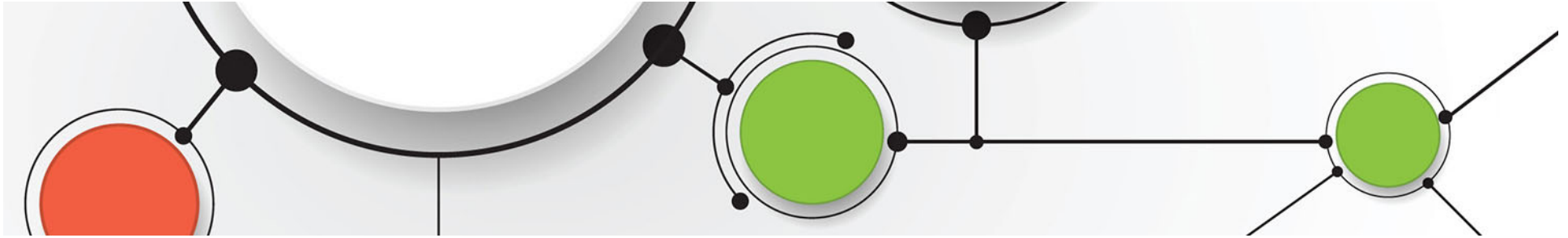
Charge Capture – Example Problem Areas

- Nurse-performed services
 - Are these all being charged for? Example – bladder scans (frequently missed charge due to no well-defined charge capture process)
- Unbundling
 - Departments sometimes generate charges which are inherent components of other services (e.g., drug administration related to procedures, EKGs performed with cardioversion, post catheter placement chest x-ray, etc.)
- Outdated charge sheets
 - Charge sheets should be reviewed regularly and dated
- Charges captured via documentation
 - Are staff aware that items being selected in the EHR are generating charges?



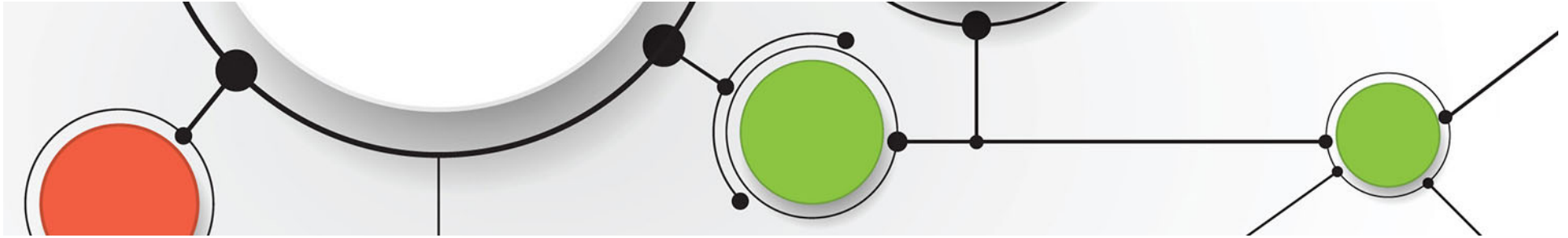
Charge Capture – Example Problem Areas

- Drug administration
 - Mistakes are often made due to complexity of coding hierarchy (e.g., not capturing pre-chemotherapy meds, not correctly reporting additional sequential infusions, etc.)
- Imaging guidance
 - Was it captured? If so, is it separately reportable?



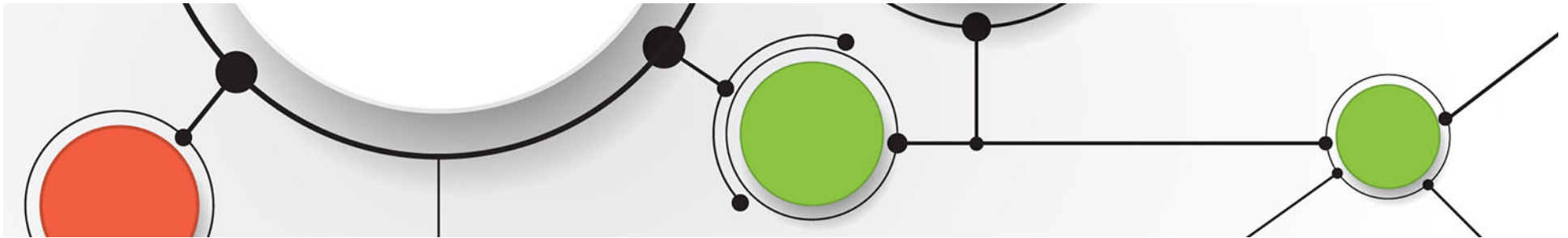
Claim Forms

- Every data element reported on claim forms should be validated
- CPT/HCPCS codes
 - Do they match the services documented?
 - If not, is it a charge capture or a CDM issue?
 - Keep an eye out for CPT/HCPCS codes that have recently been revised
 - Be mindful of differing codes required by different payers (e.g., HCPCS codes for contrast echo exams required by Medicare)
- Revenue Codes
 - Are they specific to the item/service/location?
 - Example: Are implanted devices reported with revenue code 278?
 - Payer specific (e.g., revenue code determines contracted rate)



Claim Forms

- Billing Units
 - Are services being properly reported in units defined by HCPCS descriptions (per ml, per 5 mg, per 15 minutes, per specimen, etc.)
 - If not, is it an issue with charge capture, multipliers/conversion factors, etc.?
- Occurrence/Value/Condition or Other Billing Codes
 - Are they accurately reporting correct information?
 - Do the billers, coders, or other staff understand their meaning and when/how they should be reported?



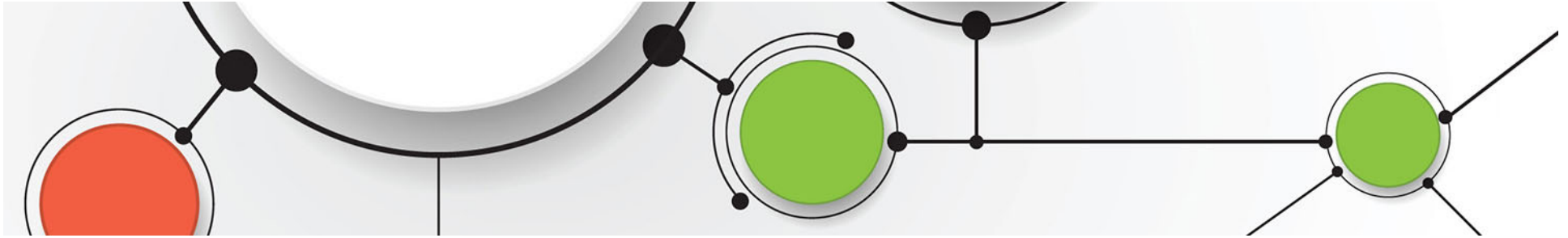
Claim Forms

- Service Dates
 - Are they accurately reported?
- Modifiers
 - Where are they coming from?
 - Hard-coded or soft-coded?
 - Should only be hard-coded if applicable 100% of the time
 - Staff that add modifiers must understand their significance
 - Every modifier reported should be validated as accurate
 - Modifiers such as 25, 59, 91 and the X-EPSU modifiers (XE, XP, XS, XU) are frequently misused



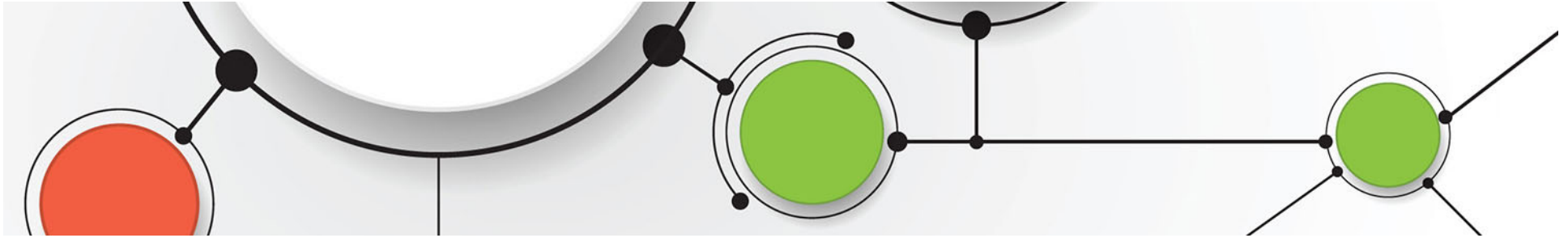
Claim Forms

- Include review of itemized bill
- Can reveal additional findings not seen on claim form
 - E.g., claim form shows 10 drugs reported under RC 250 on Medicare OP claim, but review of itemized bill shows two of them are self-administered drugs, which should not be bundled under this RC
- Compare charges on itemized bill to charges on claim form to look for:
 - Matching services and charge amounts (charges may appear correct on itemized bill, but not translate correctly to claim form)
 - Potential incorrect rolling together of charges which might otherwise be separately payable line items



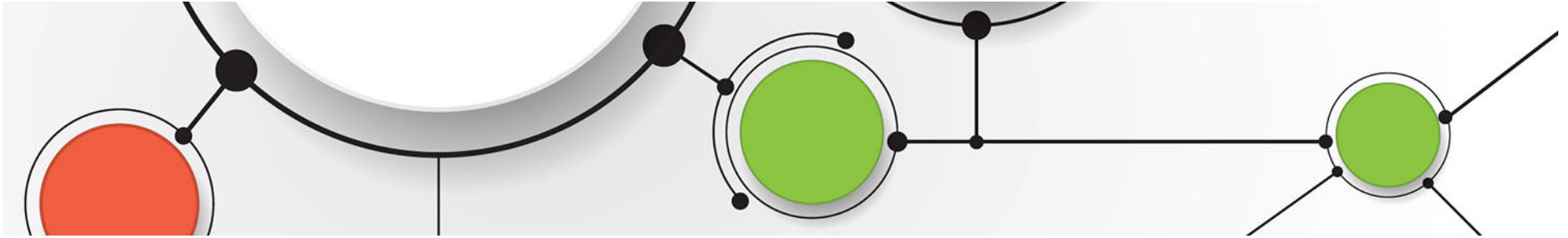
Third Party Adjudication

- The final audit component is to determine if the claim was paid appropriately
- Denials - Where do they stem from? Front end? CDM? Coding?
- NCCI and MUE edits
 - Medically appropriate scenarios, or due to incorrect charging?
 - Research causes and correct at the source
- Trends with particular providers?



Keeping Up with Payer Guidelines

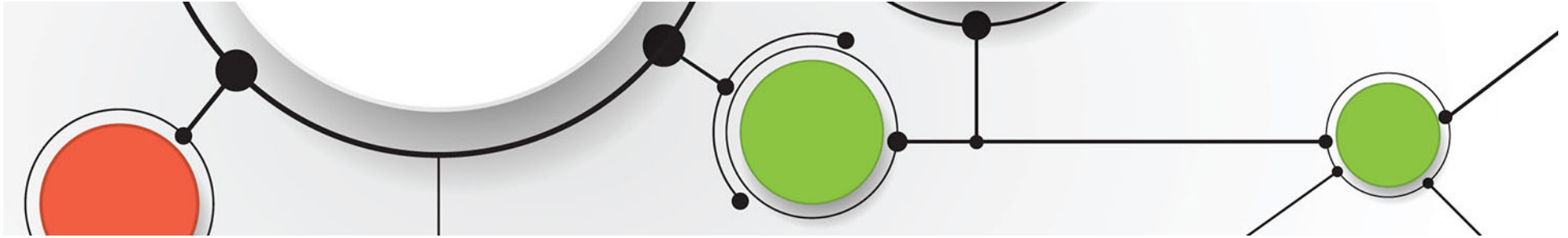
- Auditor should be familiar with payer-specific guidelines
- For example:
 - Drug waste (JW modifier)
 - Provider-based billing (PO/PN modifiers)
 - 340B (JG/TB modifiers)



Payment Reconciliation

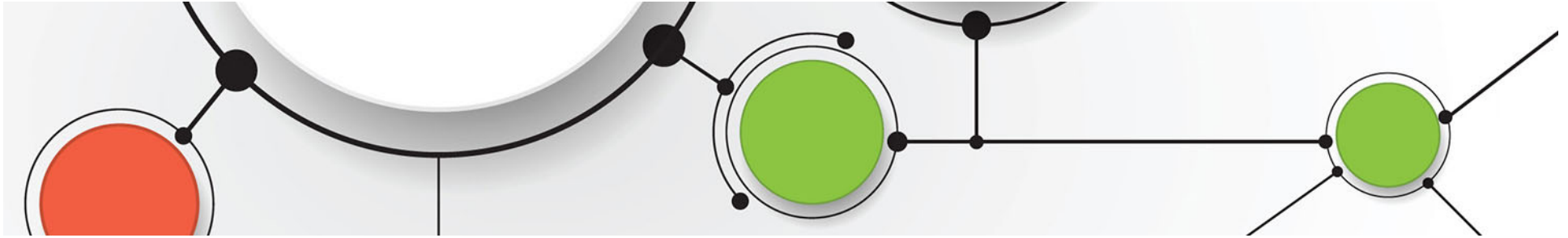
- Review remittance advice to uncover potential payment errors
 - Fee schedules versus case rates (e.g., payment driven by CPT code versus revenue code)
 - Did the claim pay as expected?
- Underpayments, overpayments
- Review payer's average PAF to specific claims
- Review service line accounts and look for low PAF
- Review contract language and confirm claim has processed correctly

Go after the money \$\$\$!



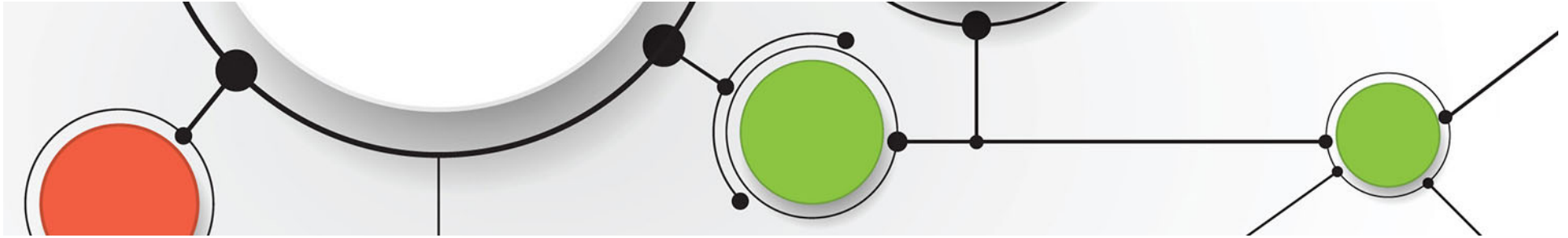
What to Do With Audit Results

- Trace all findings back to the source (CDM, charge capture, coding, etc.)
- Engage clinical departments in the process
- Open communication of audit results
 - The good and the bad
 - Share information
- Track and trend



What to Do With Audit Results

- Implement daily reconciliation process – catch issues up front
- Did every patient receive their charges for services performed?
- Ensure reconciliation process is appropriate (looking at correct data, more than just “one registration = one charge”)



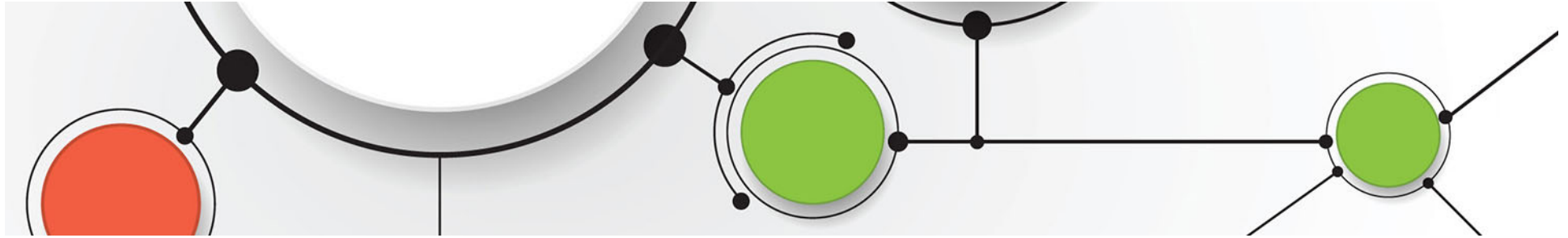
Frequency of Audits

- Audit frequency depends on the size of the department, the number of services furnished, and the accuracy of audit results
- Audits should be performed more frequently for departments that have higher percentage of errors identified
- Frequency of audits can be reduced when departments consistently report high accuracy rates



Conclusion

- Healthcare charge capture and reimbursement are very complex
- There are many areas throughout the process where deficiencies can occur
- Many times these problems are masked, and can be uncovered by routine performance of audits
- Revenue Integrity Audits help uncover opportunities to maximize reimbursement, and mitigate compliance risks



Questions?

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