Health Care Auditing Strategies

Practical Tips For Auditing And Monitoring

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Use these four easy steps for physician documentation

Although you can expect physicians to maintain complete medical record documentation, you must inspect records to ensure that they have done so and that the documentation is effective, says **Michael O'Connell, MHA, FACMPE, CHE,** vice president of professional and physician services at Huron Hospital in East Cleveland, OH.

Providers don't learn about documentation or coding in medical school, says **Annette Goldwyn, CPC,** compliance officer for Island Coast Pediatrics in Fort Myers, FL. You need to verify medical record

compliance with government regulations, managed care contracts, and your organization's billing and compliance policies.

To verify that documentation is clearly organized and appropriately reflects the services provided, audit physician records, says O'Connell.

The following audit will serve as a valuable educational tool: It will help physicians and staff to better understand documentation requirements and monitor improvement.

Simple plan helps hospitals audit 3-day payment window compliance

Your hospital might be missing out on reimbursement if it unnecessarily bundles services that occur within three days of an inpatient admission.

Medicare's three-day payment window requires that each hospital's inpatient reimbursement claim include a list of preadmission services that were furnished to the patient within three days of the admission.

In February 1998, the Centers for Medicare & Medicaid Services (CMS) made the following revisions to

the three-day window rule:
• The rule applies only to non-diagnostic preadmission services when there is an exact match of all digits between the inpatient stay and the ICD-9-CM principal diagnosis code assigned for the preadmission service.

• Services furnished by skilled nursing facilities, home health agencies, and hospices do not have to meet the three-day rule provision.

It took CMS five years—

Physician documentation   < p. 1

Audit steps

1. **Choose a sample.** Select 25–30 charts from each physician, says O'Connell. Use your organization's computer system to identify patients seen during a particular time period and the common procedural terminology (CPT) codes assigned for those visits. From this list, randomly choose every tenth patient.

Also consider the following when selecting a sample:

❏ Get some variety. Include a range of visit types in the sample, says O'Connell. Choose the sample based on the following practice-specific guidelines:

• For family practice physicians: Audit new and established patients, hospital and nursing home patients, and office surgeries

• For medical specialists: Audit office and hospital consultations and hospital surgeries

❏ Keep it current. Auditing prospectively allows you to fix a problem before the practice bills for the visit and it allows you to teach the provider, says Goldwyn.

"We audit two charts per day from each of our centers," says Goldwyn. "We alert the provider when we find [that they've chosen] a level of care that doesn't meet the documentation requirements for that level."

The provider can then complete the necessary documentation to bill that level or the auditor can lower the level and reiterate to physicians the importance of complete documentation.

2. **Gather necessary documents.** Obtain the following as needed, say O'Connell and Goldwyn:

❏ Chart notes

❏ Physician orders

❏ Signed charge tickets (superbill or encounter form)

❏ Billing report for the visit, including any

Four pediatric documentation tips

Pediatric practices have unique legal concerns. In addition to reviewing the general documentation requirements for physician practices, consider the following tips for pediatric audits:

1. Document the name of the responsible adult for each visit. If both parents were present, document specifics about any disagreements related to the child's care and treatment, says **Annette Goldwyn, CPC,** compliance officer for Island Coast Pediatrics in Fort Myers, FL.

2. Pediatricians tend to undercode, so keep an eye out for that. Consider setting up an electronic mailbox where physicians can send any questions or documentation concerns to coders. "Before we instituted this, providers would often code a level-3 [evaluation and management code] for fear of over-coding," says Goldwyn. "Now we can show them whether their documentation supports the level they think they deserve."

3. Compare the documentation of any well visits with sick visits coded for the same day. Ensure that sick visits were properly and separately documented, says Goldwyn.

4. Review any procedures performed the same day as an office visit (e.g., earwax removal, wart removal). Ensure that procedures are documented correctly, including how the provider performed them and how well patients tolerated them, says Goldwyn. ∎

modifiers assigned

❏ Patient history form

❏ Problem list and medication list

❏ Prescription orders

❏ Diagnostic tests ordered and their results

3. Review documentation. Always verify the following documentation criteria, says O'Connell:

❏ Handwritten notes (that they are legible, or that documentation has been dictated)

❏ Physician uses appropriate, acceptable abbreviations

❏ Physician uses the SOAP format—by including subjective, objective, assessment, and plan criteria

❏ Documentation supports a review of systems, even when the physician noted no problems in a system (e.g., examined eyes with no noted problems)

❏ Notes are dated and signed to show when the service was performed and who performed it

❏ Mid-level provider and medical resident documentation is appropriate

❏ Documentation includes services provided by physician staff (e.g., blood draw ordered by physician and performed by the staff member noted in the record)

Sample pediatric record audit

Prov. #	Chart# Date of service						
History (HX)	Chief complaint (CC)/history	99211	99212	99213	99214	99215	Suggestions/notes
	Specific problem focused HX	X	X				
	Exp. HX of mult. Sys./1+ problem			X			
	Detailed review with pertinent past family social history (PFS) HX/4 problems				X		
	Comp. rev. of all sys. w/complete PFS HX/4 prob					X	
	Examination						
	Problem focused	N/A	X				
	Expanded problem organ/2+ systems			X			
	Detailed problem organ, System, and 5+ systems				X		
	Complete multisystem exam, and 8+ systems					X	
Med dec	Medical decision-making						
	Minimal complications and/or data/1+ diagnosis (DX)	N/A	X				
	Low complications and/or data/1+ DX			X			
	Moderate amt. of comp. and/or data/2+ DX				X		
	Mod. to high risk complications and ext. data/2+ DX					X	
Circle	*Note: Counseling, time documented is 50% or more*	min	low	low	mod	mod	
Time>	*"may" justify higher level.* Normal visit times:	5	10	15	25	40	
Audit	Billing audit						
Y N	Does CC address all being presented?						
Y N	Was history of present illness appropriately documented by provider?						
Y N	Was review of systems appropriately documented?						
Y N	Does above documentation requirements support evaluation and management code?						
Y N	Does documentation support DX code?						
Y N	Was method of procedure explained and documented?						
Y N	Were all procedural/other type services coded by provider?						
Y N	Were proper diagnostic interpretations given? (e.g., pulse oximetry)						
$	Total of charges captured						
Y N	If sick visit coded in addition to well, was separate eval and tx documented?						
Y N	Timely response from provider?						

Source: Annette Goldwyn, CPC, compliance officer at Island Coast Pediatrics in Fort Myers, FL.

Physician documentation

4. **Consider specialty-specific audit areas.** Focus audits on the services provided by the practice, says O'Connell. Consider the following guidelines:

- **Pediatric audits:** Focus on appropriate use of evaluation and management (E&M) code levels. See the box on p. 3 for more information on pediatric audits.

- **Surgeon audits:** Focus on appropriate use of documentation of surgeries and the use of modifiers. Also ensure that surgeons clearly document their approach to the surgery and the levels of service, as well as size, scope, specificity, and details of the service provided.

- **Emergency physicians:** Focus on adequate documentation, the use of a final diagnosis in notes, and the presence of the physician's signature. ■

Expert advice on auditing documentation

As you review physician documentation, consider the following tips:

✓ Choose the charts for the audit yourself. Staff may select charts that have better documentation, which could skew the results, says **Michael O'Connell, MHA, FACMPE, CHE,** vice president of professional and physician services at Huron Hospital in East Cleveland, OH.

✓ Prospectively audit so the data is fresh in the physician's mind. This allows the practice to change the bill before sending it to the carrier, says O'Connell.

✓ Watch for too many level-3 evaluation and management (E/M) visits and too few level-4 visits, says **Annette Goldwyn, CPC,** compliance officer for Island Coast Pediatrics in Fort Myers, FL. This will be evident in a top-heavy bell curve when you evaluate the percentage of E/M codes.

✓ Ensure that documentation supports all findings and recommendations, says O'Connell. "If there is no supporting documentation, indicate the difference between the facts and personal opinion."

✓ Document all meetings with physicians, even those held over the phone. Always document what you discussed, the date of the discussion, the physician you spoke to, and the information you provided. ■

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Three-day window

until February 2003—to update all of its manuals and claims processing systems to reflect this change.

However, many hospitals did not update their editing systems because they were not aware of the change, says **Cheryl Rice,** corporate compliance, coding, and reimbursement analyst for Catholic Healthcare Partners, a Cincinnati-based health system.

Hospitals must now identify any inappropriately bundled claims and reprocess claims that Medicare denied due to incorrect coding, says Rice. "CMS has indicated that it is the facility's responsibility to identify claims for repayment."

Types of payment errors

The three-day rule dictates which services hospitals can include on inpatient v. outpatient claims, says Rice. "An error in the three-day rule can create a 'ripple

> **"CMS has indicated that it is the facility's responsibility to identify claims for repayment."**
>
> **—Cheryl Rice**

effect' in all aspects of reimbursement and payment, from both the Medicare payer and beneficiary perspective."

For example, if hospitals do not place services on the appropriate type of claim, they could reduce their overall prospective payment system payment and calculate and collect incorrect patient coinsurance or deductibles, says Rice.

"Placing services on the wrong type of claim can ultimately result in incorrect coverage benefits being extended or denied to patients."

Perform an audit

To ensure that it correctly bundles services that fall within Medicare's three-day payment window, perform an audit of your organizations' claims editing system suggests **Gloryanne Bryant, RHIT, CCS,** director of coding compliance and HIM for Catholic Healthcare West in San Francisco.

Use the following steps to validate compliance with Medicare's three-day payment window:

1. Review your hospitals internal information system. Determine whether your internal coding and billing systems have electronic edits that screen for related patient accounts by diagnoses and date of service, says Rice.

Determine whether the software automatically combines any services provided within three days of an inpatient stay, regardless of the type or reason for the service, says Bryant. You don't need to include certain services, such as nondiagnostic services, on the inpatient claim.

2. Check whether the hospital uses occurrence span code 74. If it does, determine how the hospital uses this code, says Rice. Talk to the health information management (HIM) department for

Illustration by David Harbaugh
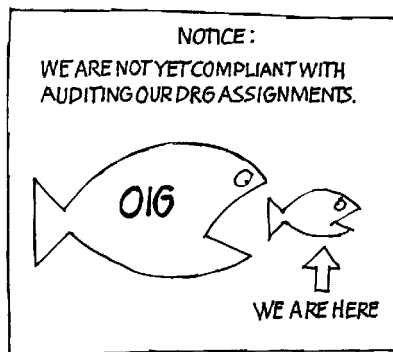
Three-day window

more information.

Providers can bill repetitive Part B services when occurrence span code 74 is present. This will define periods of inpatient care or the day of ambulatory surgery, when either occurs during a monthly billing period. Ensure compliance with the following rules for using this code:

- Use occurrence span code 74 to identify a period of time during the billing cycle that is not included in the charges billed on the claim

- Complete the service date filed on the UB-92 for the services billed on a repetitive Part B claim

- Do not bill a claim with occurrence span code 74 if the intermediary has rejected a claim type 13X or 14X because the beneficiary has an inpatient claim with overlapping dates, unless it is appropriate

- Investigate the overlapping dates and, if applicable, include the charges on the inpatient claim

- Do not use occurrence span code 74 to force the claim to be paid

3. **Review whether the internal claims editing system is set up correctly for billing monthly repetitive services** (commonly known as "series" billing), says Rice.

TIP: PM-A-03-013 and PM A-03-008 outline specific services and UB-92 revenue codes subject to repetitive services billing, such as respiratory therapy, physical therapy, occupational therapy, cardiac rehab, home health, etc.

4. **Identify cases that involve preadmission services, inpatient admissions, and repetitive services.** Determine whether your system is properly addressing the services from start to finish, says Rice.

Get this information from the common working file, which shows all outpatient services the patient used and the corresponding ICD-9 code for those services, says Bryant.

5. **Review claims.** Choose 50–100 Medicare patients who had services within three days of an inpatient admission, says Bryant.

Review the claims for the following high-risk areas:
- Claims with multiple bill type changes.
- Patterns in the type of claims (e.g., labs, cardiac rehab, physical therapy).
- Too many edits, or too few. "Too much swing in either direction is a problem," says Bryant.

6. **Verify the proper assignment of the date of service for testing, therapies, and interventions.** Identify how the system assigns a date of service for hospital services, says Rice.

7. **Prepare an inservice. Include registrars, billers working with these claims, and clinical staff who provide these services.** Teach them how to properly check for repetitive service accounts and how to properly place and screen for changes, says Rice. ■

For more information

Visit the following Web sites for further background on the three-day payment window rules.

PM A-03-008 issued on February 3, 2003: *www.cms.hhs.gov/manuals/pm_trans/A03008.pdf*

PM-A-03-013 issued on February 14, 2003: *www.cms.hhs.gov/manuals/pm_trans/A03013.pdf*

Occurrence span code 74: *www.cms.hhs.gov/manuals/pm_trans/R1892A3.pdf* ■

Sample Medicare three-day window billing audit

1. Obtain a list of Medicare outpatient accounts for the month prior to the audit period. If the audit period is January, select accounts from December.

2. Determine the audit sample size to be 30 accounts or total account volume if <30.

3. The total account volume (500) divided by the audit period of December (month 12)=41.6 or 42.

4. Enter the patient's account number in column 2 of the audit tool.

5. Enter the admission date for each patient in column 3 of the audit tool.

6. Perform a manual/automated search for each patient to identify any outpatient services within three days of admission.

7. Identify whether the patient had outpatient tests/services in the three days prior to admission enter "Y," "N," or "NA" in column 6 of the audit tool.

8. Determine whether the system 72-hour flag identified an overlap visit? Enter "Y," "N," or "NA" in column 5 of the audit tool.

9. Identify whether the registration staff recorded the current and previous account # assigned on the 72-hour log. Enter "Y," "N," or "NA" in column 6 of the audit tool.

10. Determine whether the log information was forwarded to the business office and the appropriate outpatient charges were combined with the inpatient claim.

11. To determine the compliance % count the number of accounts that had overlap services that were not combined/total # of accounts reviewed. ■

No.	Account #	Date of Admission	Did the patient have any outpatient tests/services in the 3 days prior to admission? (Y/N/NA)	Did the system 72-hr flag identify this overlap visit? (Y/N/NA)	Did the registration staff record the current & previously assigned account numbers on the 72-hour log? (Y/N/NA)	Was the log information forwarded to the business office for the appropriate outpatient charges to be combined with the inpatient claim? (Y/N/NA)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Compliance % = Total # of appropriately combined or N/A accounts/total # of accounts reviewed			__/__ =			

Source: Andi Bosshart, RHIA, vice president and corporate compliance officer for Community Health Systems in Brentwood, TN. Reprinted with permission.

Four simple steps to audit cardiac-cath billing

The financial stakes are high for billing and coding of cardiac catheterization (cath) services.

"It's a high-dollar and sometimes high-quantity procedural item," says **Bret Bissey, CHE, CMPE,** chief compliance and privacy officer at Deborah Heart and Lung Center in Brown Mills, NJ. Bissey urges periodic reviews.

Healthcare facilities, including physician practices and hospitals, should review any services frequently performed and frequently submitted to government payers, says **Jennie Campbell, CPC, CCS-P,** a consultant with Pershing Yoakley and Associates, in Knoxville, TN. "Cardiac cath services often meet both of these criteria for cardiology groups."

Audit objective

Audit cardiac cath billing to ensure that your organization is documenting, billing, and coding accurately, says Bissey. Review medical record documentation to ensure that your facility or group's cardiac cath documentation complies with both government regulations and the organization's internal standards.

A review of cardiac cath billing should include validation of common procedural terminology (CPT) coding, review of ICD-9 coding, and verification of the date of service and provider of the service, says Campbell.

Audit steps

Use these steps to audit cardiac cath billing:

1. **Select a sample.** For a focused review, use a statistically valid or stratified random sample, says Bissey.

"We recommend selecting a sample of charts based on coding patterns, including a mix of all services and procedures performed by the facility," says Campbell.

> **"We have worked with cardiology practices involved in Medicare audits focused on this issue and we know it's an area targeted by certain carriers for review."**
>
> —*Jennie Campbell*

"In some cases, a true random sample can be helpful, and may be required, especially if the physician group operates under a corporate integrity agreement."

2. **Gather documents.** The cardiac cath report should include all medical record documentation necessary for the review, says Campbell. If you still have questions after reviewing this report, obtain the flow sheet from the cath lab to validate additional procedures, such as renal angiography.

Also consider reviewing the following documents as part of your audit, says Bissey:

❑ Procedure or catheterization report

❑ Charge ticket

❑ Invoices (1500/UB-92) produced for the service

❑ For a retrospective review, examine the Explanation of Benefits received from the insurance carrier

3. **Review chart documentation.** Use the following steps to review the medical record, says Bissey:

❑ Verify that the procedure is documented

❑ Review all documentation of the procedure

❑ Identify the reason for the procedure to validate medical necessity

❑ Verify that the results of the catheterizations are included in the medical record

❑ Verify that the ICD-9 coding is accurate

❑ Verify that the CPT coding is accurate

❑ Verify that the chart follows the Physicians' at Teaching Hospitals (PATH) documentation guidelines

❑ Verify that the signature of the physician who

performed the service is included

4. Identify inappropriate bundling. Inappropriate bundling and billing for additional medically necessary procedures are common problems for cardiac cath billing, says Campbell. "Reviewers should pay close attention to the location of catheter placement and potential billing for multiple procedures."

For example, facilities may bill for renal angiography after meeting certain medical necessity criteria, says Campbell. If the facility does not meet these criteria, the Medicare carrier won't consider the renal angiography medically necessary and the facility would need to obtain an advance beneficiary notice to bill Medicare. "We have worked with cardiology practices involved in Medicare audits focused on this issue, and we know it's an area targeted by certain carriers for review," says Campbell.

5. Modifiers. Validate that the appropriate modifiers have been used, to ensure appropriate reimbursement, says Bissey. ∎

Assess documentation of stent procedures

The Office of Inspector General (OIG) has placed coronary artery stent claims high on its list of areas to examine in 2004. According to its 2004 *Work Plan,* the OIG will determine whether these services are medically necessary and supported by adequate documentation.

Bret Bissey, CHE, CMPE, chief compliance and privacy officer at Deborah Heart and Lung Center in Brown Mills, NJ, says, "It is logical that the OIG is looking at stent procedures. The introduction of this type of technology appears to result in some very positive outcomes for patients, but at the same time, it's very expensive."

The OIG will investigate the following questions:
- How do providers use coronary artery stent technology?
- What is appropriate from a medical necessity standpoint?

Audit advice
"Take a look at what procedure codes you're using because that's the first place the OIG will look during an audit," says **James Kopf,** president of operations at Healthcare Oversight, a consulting firm based in New York City.

Kopf advises facilities to conduct an internal coding audit that focuses on stents. Use the following tips as you perform this audit:

- Determine how often you use and bill stent codes. If the facility uses stent codes frequently, investigators will look to see why you're billing them so often. You need to know why and have documentation to prove it.

- Compare your data to other hospital figures. Fiscal intermediaries for the Centers for Medicare & Medicaid Services have the information to help you determine whether your numbers fall above or below national averages.

U of M plans
Theodore Sanford, Jr., MD, associate chair for education and program director at the University of Michigan's Department of Anesthesiology in Ann Arbor, says his facility will investigate how many cardiac procedures it has done over a period of time.

"This would then lead us to see whether there is a high volume of stents being performed at our institution, and then we'll get into medical necessity auditing," Sanford says. "Presently, we are looking [at trends in] our physicians' coding and looking for high volumes."

High-volume procedures are suspect when a physician performs only high-reimbursement cases and just a few small-cost procedures, he adds. ∎

Mental health: Audit therapy notes for accuracy

Audit your organization's mental health documentation to verify that all services provided are medically necessary, billed correctly, rendered by qualified personnel, and properly documented.

Auditing mental health billing will help you solve any billing system errors and ensure billing accuracy, says **Quinten Buechner, MS, MDiv, CPC, CHCO,** president of ProActive Consultants in Cumberland, WI. "It is important that what you bill and the frequency of the services you provide are correct so you don't get any surprises from the government."

Performing this audit will also help ensure that the organization is billing for all eligible services and obtaining the reimbursement it deserves, says Buechner.

Mental health coverage

Know the following before you audit:

- Generally, a patient must have a psychiatric illness/emotional or behavioral symptoms for Medicare to cover psychiatric procedures, such as individual and group psychotherapy.
- Symptoms, goals of therapy, and the patient's capacity to participate in and benefit from psychotherapy must be documented in the patient's medical record.
- Medicare covers psychological testing when it aids in determining a patient's diagnosis and therapeutic planning.
- The patient's medical record must indicate the presence or symptoms of mental illness and document specific psychological tests performed, number of hours of testing, scoring, and interpretation of test results.

Audit steps

Use these tips to audit mental health billing:

1. **Select a sample.** Choose the sample based on the number and type of services your organization performs, says Buechner. "If your organization performs a variety of mental health services,

review a few records from each different service the practice bills," he says. Or use the RAT-STATS system to choose a sample using the government's sampling method. Go to the Office of Inspector General's Web site *http://oig.hhs.gov/* for more information on RAT-STATS.

2. **Obtain billing and documentation criteria.** Obtain your most common payer's documentation criteria for each mental health code, says **Cindy Schroeder, LPN, BS, CPC, CPC-H,** a billing compliance analyst at MeritCare Health System in Fargo, ND. Put them in a structured outline.

TIP: In addition to information from local Medicare carriers, organizations can find documentation criteria in the American Medical Association's Common Procedural Terminology book and on the Web sites of the American Psychiatric Association and the American Psychological Association.

3. **Include others in the audit.** Once you have the billing criteria outlined, gather a group of key staff members, says Schroeder. This could include other auditors, the compliance officer, the manager of psychiatric services, and a staff psychiatrist.

4. **Decide which billing criteria to audit against.** The team should decide which billing rules the facility will use during the audit, says Schroeder.

"We have taken the team approach in order to include all aspects of maintaining compliant mental health services," she says. "We follow Medicare's rules for all payers. This helps us support and justify the medical necessity of the visits."

5. **Review documentation for accuracy and completeness.** The AMA's current procedural terminology (CPT) codes usually include only vague documentation requirements. For example, says Schroeder, code 90806 requires the following: "Individual psychotherapy, insight oriented, behavior modifying, and/or supportive; in an office or outpatient facility, approximately 45–50." Using

this information, a provider might incorrectly document the following statement in the medical record: "50 minutes of supportive therapy was provided."

However, this isn't sufficient for billing. Document the most compliance information possible, says Schroeder. Some payers, such as Medicare, publicize what you should include in a therapy note.

TIP: The Health Insurance Portability and Accountability Act of 1996 places restrictions on mental health notes. Review only the minimum amount of information necessary during the audit (e.g.,

information available to the payer, not confidential information).

6. **Review common problem areas.** Ensure that the therapist is documenting the therapeutic alliance between the practitioner and the client, says Buechner. "The diagnosis interview should include an evaluation of how well the practitioner thinks their alliance is going to fare, and whether he or she thinks the client is able and willing to work with the practitioner."

Also ensure that the therapist documents the progress made in each therapy note, he says. ■

Sample mental health audit program

Evaluate the completeness of the medical record documentation for intake and psychotherapy services, as well as overall quality, by reviewing the following:

Intake/interview (90801/90802)
Determine whether documentation supports the following:
❏ Present illness/history
❏ Mental status exam
❏ Patient psychiatric history
❏ Patient medical history
❏ Patient family psychiatric history
❏ Patient's level of risk
❏ Short- and long-term goals and treatment strategies
❏ Intake notes include an assessment of psychosocial and environmental stressors

Psychotherapy services (90904–90829)
Determine whether documentation supports the following:
❏ Patient's symptoms as related to the patient's diagnosis
❏ Patient's behavioral insight
❏ Technique/type of therapy used
❏ Level of risk
❏ How the patient is responding to therapy as related to the diagnosis and goals/treatment strategy
❏ Time spent with the patient in therapy
❏ Rationale and medical need for continued treatments

Group/family therapy (90846-90857)
Determine whether documentation supports the following:

❏ Group session was held
❏ Patient's personal dynamics, as related to the commonality of the group/diagnoses
❏ Group dynamics and emotional catharsis, as related to the commonality of the group/diagnoses
❏ Time spent in group therapy

General quality
Evaluate the quality of the documentation by verifying the following:
❏ Entry was inside an intact medical record specific to the patient
❏ Entry had a correct identification on every page
❏ Entry had a correct date of service
❏ Entry had a legal signature
❏ Entry was legible
❏ Entry had legal and acceptable alterations or corrections when applicable
❏ Entry was of legal entry (e.g., written in ink)
❏ Entry did not have JCAHO's dangerous abbreviations
❏ Entry had a current medication and allergy listing
❏ Entry had a diagnosis documented
❏ Entry had a return to clinic plan
❏ Entry had a pain scale assessment, when applicable
❏ Entry was dictated in a timely manner

Source: Cindy Schroeder, LPN, BS, CPC, CPC-H, a billing compliance analyst at MeritCare Health System in Fargo, ND. ■

Psychotherapy chart review checklist

Use this form as you audit psychotherapy medical records:

❍ 90804 outpatient psychotherapy   ❍ 90805 outpt psychotherapy with E/M
❍ 90806   ❍ 90807
❍ 90808   ❍ 90809

❍ 90816 inpt psychotherapy   ❍ 90817 inpt psychotherapy with E/M
❍ 90818   ❍ 90819
❍ 90819   ❍ 90822

The medical record documentation maintained by the provider must indicate the medical necessity of psychotherapy (individual, group, and family) including the following:

❏ **Psychiatric illness**—The presence of a psychiatric illness/the demonstration of emotional or behavioral symptoms sufficient to significantly alter baseline functions.

❏ **Time**—The time spent in each psychotherapy encounter.

❏ **Therapeutic intervention**—The documentation that therapeutic interventions, such as behavior modification, supportive interaction, and discussion of reality, were applied in an attempt to produce therapeutic change.

❏ **Patient participation capacity**—The patient's capacity to participate and benefit from psychotherapy.

❏ **Estimated treatment duration**—The estimated duration of treatment in terms of number of sessions required.

❏ **Goals of therapy, target symptoms, monitoring outcomes**

❏ **Patient participation and interaction**—The degree of patient participation and interaction with the group members and leader, etc.

❏ **Acute problem**—For an acute problem, there should be documentation that the treatment is expected to improve the health status or function of the patient.

❏ **Chronic problem**—For chronic problems, there must be documentation indicating that stabilization or maintenance of health status or function is expected.

Source: Gathered from Medicare documentation requirements. ■

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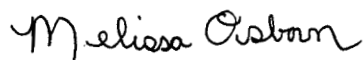
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Billing and coding audits made easy

Dear reader:

HCPro, Inc., is pleased to present this 12-page report to help you perform billing and coding audits. This special report will offer you advice from the experts on auditing for accuracy of ambulatory payment classification coding, diagnosis-related group coding, one-day stay billing, evaluation and management coding, and same-day readmissions billing.

This report will serve as a tool to help you put top-notch auditing programs in place. We look forward to continuing to provide you with timely, pertinent information and tools to aid in your compliance efforts.

Sincerely,

Melissa Osborn

Melissa Osborn, managing editor

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Why perform billing and coding audits?

When considering compliance auditing, most providers focus on the fact that it must be performed pursuant to federal government regulations. Instead, try to put auditing in a more positive light.

When presenting the concept of medical-record and coding audits to the administration, governing board, and others, present it as a process that will improve the organization, rather than as a chore it has to complete. To make this shift, offer the following 10 benefits of medical record and coding audits:

1. **Improved operational efficiency.** If performed correctly, audits should identify all types of errors and direct you to the root of any coding problems. Audits can also increase productivity. If employees see auditing as a normal part of their work process rather than as a function that threatens their jobs, they are more likely to perform with a higher degree of effectiveness and efficiency.

2. **Mitigated damages in the event of an investigation.** The government considers the existence of an effective compliance program to be a potential mitigating factor in the event of an investigation. The key word here is "effective." The auditing program must identify compliance concerns, create a feedback mechanism that prevents the same errors from recurring, and initiate repayment of any funds received in error.

3. **Additional protection against certain legal exposure.** An effective auditing program will likely uncover potential non-reimbursement related problems that could develop into legal issues, such as risk-management and quality-of-care issues. The organization will then be able to rectify these issues before they develop into full-blown legal exposure.

4. **Improved data quality overall.** If compliance auditing is performed appropriately, with the necessary feedback, education, and follow-up, it results in improved data quality. All data users have an interest in ensuring that data is reliable.

5. **More reliable data for reporting and research purposes.** Quality data are essential for reliable reporting and research. Government funds may be awarded to facilities based on certain reporting requirements. In addition, statistical reporting of healthcare data plays a role in the awarding of grants for research purposes.

6. **Improved relations between HIM/billing staff and physicians.** An effective audit will identify errors caused by physician documentation problems. Physicians responsible for poor documentation should be informed and educated on these issues, and receive regular feedback from health information management (HIM) staff.

7. **Correct reimbursement to the organization.** Audits should identify underpayments as well as overpayments. Because of the improved operational efficiencies that can result from auditing, many facilities have seen an increase in their overall revenue base.

8. **Better relations among all departments and functions involved in the reimbursement process.** Employees work better when they understand why they are doing what they are doing. It is also helpful if employees understand how individuals in other functions or departments affect their work processes—and how their own work processes affect others.

9. **Enhancement of auditing by current quality assurance/utilization review efforts.** Organizations should take stock of any functions that could enhance compliance auditing or be used in the compliance monitoring process before reinventing the wheel.

10. **A new public relations tool.** Developing a successful auditing system is something to be proud of. It's one more achievement your organization can use to attract new patients and ensure that patients receive the best quality of care. ∎

Editor's note: This article was adapted from the book Coding Compliance: A Practical Guide to the Audit Process. *Go to* www.hcmarketplace.com/Prod.cfm?id=106 *for more information on this book.*

APCs: Ensure accurate billing and coding

When much of your facility's billing depends on accurate and timely use of thousands of HCPCS/CPT codes that generate Ambulatory Payment Classification (APC) groups, you need to have a system in place to check your billing and coding department's work. Accurate and complete coding is the single most important element driving your success in the environment of APC reimbursement.

Conducting an APC audit is a great way to ensure that your organization identifies, monitors, and rectifies inappropriate billing practices, which will benefit your bottom line while simultaneously highlighting potential compliance issues, says **Jugna Shah, MPH,** president of Nimitt Consulting in St. Paul, MN.

Auditors should also conduct periodic follow-up audits to ensure that the organization has procedures in place to address issues regarding the quality and accuracy of the coding and billing process, said Janet Kucinski, RHIA, CCS, CCS-P, a senior consultant with Hospital Resource Management of Dallas.

Cover at least these main areas in your audit:
- Compliance with coding and claim development laws
- Policies that affect appropriate and efficient outpatient coding, including physician documentation and department processes
- APC reimbursement losses from improper or missing documentation and charge-capture problems

The audit

Review the HCPCS/CPT codes currently used by all departments performing APC-reimbursed services. Cases from any departments that don't pass Medicare outpatient code editor (OCE) edits can serve as your starting point for further analysis.

1 **Select cases.** Auditors can organize cases by department or other criteria and then, for further review, select a random sample of cases within each APC group. The sample does not need to be large: 100–150 cases is usually sufficient. "I suggest that you start by auditing with a random sample before starting

a focused audit," says Kucinski. "There may be a lot of opportunities to fix problems you're not aware of."

Consider relying on data and edits generated from the OCE to pinpoint areas where claims are showing up with problems on them. This is a more strategic, unbiased approach than attacking known problem areas, says Shah. Moreover, by starting with your highest volume of OCE edits, you have the opportunity to fix high-volume problem areas first. Shah stresses that the OCE can help you find your problems, and that the priority should be fixing them on the front end, rather than making quick fixes in the billing office.

2 **Gather your toolkit.** Gather the medical record and audit trail of codes assigned by the health information management (HIM) coding staff for each claim selected as part of your review. The printed coding summary from the HIM abstracting system or the encoding software makes the best audit trail, said Julia Palmer, MBA, RHIA, CCS, president of the division of Hospital Resource Management. Palmer and Kucinski spoke during an audioconference sponsored by HCPro, Inc.

For each record, Palmer suggested that you also pull the UB-92, the hospital itemized bill, and the detailed Medicare remittance advice that shows the CPT codes Medicare received for payment, how those codes were paid, the APC assignment for each, and any modifiers and units of services, said Palmer.

3 **Code review.** Once you have selected your sample and assembled your tools, review the codes your organization submitted to the fiscal intermediary on the UB-92 against the information on the medical record. Also compare medical record documentation with the following:
- Codes reported by HIM coding staff
- Codes reported via the chargemaster (itemized bill)
- Codes paid on Medicare remittance advice

When reviewing claims, focus on whether your organization included all relevant codes and documentation to support the codes billed, and correctly listed all modifiers. Include modifiers 25, 59, 52, 73, and 74 on your organization's compliance hit-list, says Shah.

Watch for potential human errors. Many organizations have not updated their HIM abstracting system to accept and transfer modifiers to the billing file. Doing so requires manual intervention by billing staff, inviting human error and omission.

Many organizations also do not appropriately assign modifiers for service areas with CPT and HCPCS codes that they submit via the chargemaster. Even worse, some HIM department's coding competes with chargemaster codes for the same procedures. When this happens, one or both codes can appear on the UB-92, says Palmer.

4 **Analysis.** Compare the revenue the facility would have received under "best practice" coding against the money it actually did receive. The difference is generally a reasonable measure of potential improvements available to the hospital. Keep track of increases and reductions in outpatient revenue associated with best-practice coding and billing.

It is important to recognize that the size of reductions made to Medicare reimbursement due to discovered over-coding is one measure of the compliance risk. Under-coding is also a risk and an opportunity—a risk from the compliance end, and an opportunity in terms of increasing revenue. One area to look for missed charges is in the Emergency Department, says Shah, where providers are still not capturing all the services they provide.

If you find a lot of errors through your audit, consider their magnitude and whether your organization can fix them internally. Determine whether errors are due to carelessness or lack of education. If they are, your organization may need to revamp its APC task force by broadening its role, adding new members or discarding old ones, and finding ways to make the tasks interesting, valuable to senior management, and rewarding for those participating, says Shah. ■

Essential audit toolkit

Gear up for your audit. No audit of Ambulatory Payment Classification (APC) coding is complete without the following:

- CPT code book
- HCPCS Level II code book
- Medical record
- Audit trail of codes assigned by HIM coding staff (e.g., pencil codes on face sheet, a coding summary printed from encoder software, etc.)
- UB-92
- Itemized bill
- Medicare remittance advice—detail remittance showing payment by APC, CPT code plus any modifiers, and units of service reported
- Hospital chargemaster
- List of high volume CPT procedures, like gastro-intestinal endoscopies
- List of high-dollar (charges or APC reimbursement) CPT procedures, like pacemakers, brachytherapy, or chemotherapy
- List of problem-prone CPT procedures by body system, such as the following, for the integumentary system:
  - Fine needle aspiration v. core needle biopsy
  - Wound repairs—simple v. intermediate v. complex
  - Excision of lesions—new rules for 2003
  - Adjacent tissue transfer—check whether wound repair was coded instead
  - Nail procedures—check whether excision of nail and nail matrix include amputation of distal tuft
- List of CPT code pairs:
  - "simple" v. "complicated" v. "complex"
  - "with" and "without"
  - "without anesthesia" and "requiring anesthesia"
- List of procedures paid at 150% when modifier -50 is appended to the CPT code ■

Source: Julia Palmer, MBA, RHIA, CCS, president of the health information management division of Health Resource Management in Dallas.

Audit for inaccurate DRG assignments

Diagnosis-related group (DRG) upcoding has been on the government's plate for the last eight years—and it probably won't go away. The government has collected hundreds of millions of dollars from U.S. hospitals for pneumonia DRG upcoding and other upcoding issues.

If that's not enough incentive to audit DRG assignment, consider this: On the inpatient side, incorrect coding can change your hospital's reimbursement by thousands of dollars, says **Jugna Shah, MPH,** president of Nimitt Consulting in St. Paul, MN. "It's worth your organization's time and money to perform this audit."

"Upcoding leaves the door open for investigations, while undercoding denies providers compensation they deserve," says **James Kopf,** senior vice president of Healthcare Oversight in New York City. "The fallout to undercoding is lower Medicare reimbursement rates in future years."

Organizations should audit DRG assignment to ensure that the patient's condition supports the diagnosis, says Shah. Hospitals should audit DRGs for two main reasons:

- To ensure that the organization is complying with all rules and regulations.

- To identify revenue opportunities. "Don't leave money on the table," says Shah. "You may find places where your organization has missed revenue or where you could improve processes."

TIP: "You need to walk the line very carefully to minimize compliance risk, while generating all the revenue that is due to your organization," says Shah.

Audit plan
Use the following tips to put together a DRG audit tool:

① **Assess your risks.** No organizational risk assessment is complete without addressing DRG assignment. This is critical for monitoring

compliance, says **Susan Parker, BSN, RN, LNCC, CCS,** a consultant with Parente Randolph, a national consulting firm with 15 offices in Pennsylvania.

"Pay close attention to the DRGs that the government targets as 'high risk' for fraud and abuse enforcement," she says.

② **Review target DRGs.** Begin by reviewing the DRGs of highest vulnerability: those targeted by the OIG or those considered "high risk" due to their variation from national norms, says Parker.

Focus your assessment on coding accuracy. Examine the following:

- Assignment of proper codes

- Appropriateness of the code sequencing

- Identification of all reportable diagnoses and procedures

③ **Compare DRG distribution.** Organizations should also compare their distribution of DRGs with and without complications and comorbidities (CCs), says Shah. "Most hospitals will see a normal distribution of complicated cases and normal cases. If all of your cases are complicated, there should be a good reason."

④ **Choose a sample.** Before selecting a sample, organizations must decide which patients they want to review.

If your organization hasn't audited DRG assignment recently, randomly select 20 inpatient medical records from each department, says Shah. Review each medical record and test it by assigning the case a diagnosis; then see whether the coder assigned the same diagnosis.

Organizations can also generate a report of their top 25 DRGs, either by volume or by Medicare payments. If your top DRGs include a lot of CCs, determine whether medical records support that data,

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says Shah. "Start with data, then let that help to focus where you look next."

5 **Review code use.** Analyze whether one code is being used more than the others in the sample. Also check for "standing orders" for coding (e.g., always bill an emergency department service at level four). Look for the sudden increase in use of one code, add-ons, and outlier payments, says Kopf. "This is what the contractors do."

6 **Review the medical record for clarity and completeness.** "Determine whether code assignments accurately reflect the services provided," says Parker.

Begin the claim review by examining the UB-92. "This will ensure that there are no glitches in the submission of ICD-9-CM codes and subsequent DRG assignment to the billing department," she says.

During your review, verify the principal diagnosis and secondary diagnosis, as well as the sequencing of diagnosis and procedure codes. Also verify the patient's age and discharge status, since these can affect DRG assignment, says Parker.

"When you review the medical record, you are basically looking for a story, with certain phrases," says Shah. "If complications arose, there would be a narrative description. There should always be a trail."

7 **Review coding safeguards.** Your organization's coding and documentation policies and procedures should address all of the pertinent federal and state statutes, regulations, and guidelines, says Parker.

Other safeguards against upcoding include the following:

- Reviews of high-risk DRGs.

- Reviews of the distribution of all DRGs that include CCs. "The medical record must verify that the treatment or length of stay were affected by the assigned CCs," says Parker.

Try to determine the cause of any variations through focused reviews, says Shah. "These will help to identify deviations, such as patterns in claims denials or areas where services are under-reimbursed. Organizations can address coding weaknesses through targeted education."

8 **Perform ongoing monitoring.** After completing your audit, review in a few months whether your organization effectively implemented the changes you recommended. Find out whether training and education was effective by comparing documentation in both a pre-audit record and a recent case that's similar, says Shah.

Use the Office of Inspector General's *Work Plans* to learn where the government is finding aberrant coding patterns, says Parker.

"Providers should monitor their code distribution in comparison to their peers' to identify aberrant coding patterns and to examine the reasons for those variations."

This type of monitoring can lead organizations to discover inappropriate coding patterns, Kopf says. "However, changes in coding distribution may also be due to changes in the services that your facility provides. It is important for providers to correct inappropriate coding and to be able to explain the reasons for differences." ∎

Illustration by Dave Harbaugh

"OIG says their next audit will concentrate on auditing DRG coding, and they expect to hit pay dirt."

Assess the appropriateness of one-day stays

Your organization may pride itself on caring for patients efficiently. However, if it is so efficient that it consistently discharges patients after only one day of inpatient admission, your organization may be inadvertently overbilling Medicare.

Perform an audit of one-day stays to verify that your organization admits patient under the appropriate status (inpatient v. observation).

Medicare pays more for an inpatient admission than it does for observations, says **Tammy Forgatch, BSN, RN,** nurse auditor supervisor for Southern Illinois Healthcare in Carbondale.

> ## "Admitting a patient for only one day brings up medical necessity and quality-of-care issues."
>
> *—Anthony Almeda*

"It is fraudulent to bill Medicare for an inpatient stay when the patient may have met observation criteria."

OIG focus area

The Office of Inspector General (OIG) has looked at this issue closely, according to its last three *Work Plans.* **Anthony Almeda, CPA,** senior internal auditor for Community Health Systems, Inc., in Brentwood, TN, says the OIG wants organizations to have adequate controls in place to detect inappropriate Medicare payments for one-day stays.

Although one-day stays aren't included in this year's OIG *Work Plan,* Almeda says hospitals should still find ways to ensure that they are appropriately billing these claims.

Also review one-day inpatient admissions for non-Medicare patients, says Almeda. "Admitting a patient for only one day brings up medical necessity and quality-of-care issues."

Review focuses

According to Forgatch, try verifying the following to determine whether a patient's status is appropriate:

- **Status on medical record** (i.e., physician order)—does it match the status on the billed claim?

- **Charges on the claim**—Are they consistent with patient status (no outpatient charges for an inpatient stay)?

- **Medical necessity of the stay**—Is it based on clinical criteria (e.g., Interqual)?

- **Stay**—Ensure that it wasn't just for patient or physician convenience.

Evaluate discharge criteria to make sure the organization did not discharge the patient too soon.

Also, consult with the utilization review nurse to determine whether the organization assigned an appropriate diagnosis code for this admission, or enlist a coder to evaluate the coding, says Almeda.

TIP: Use the steps on p. 9 to guide your one-day stay audit.

Monitoring one-day stays

If your organization doesn't have a policy for managing one-day stays, recommend one. A few months later, check whether the disciplines involved are following the policy, says Forgatch.

Audit a sample of inpatient claims in three months to verify whether applicable departments implemented all of your recommended changes.

Follow up

If the utilization-review department is evaluating Medicare inpatients according to appropriate criteria, the auditor could follow up by looking at the department's review methodology to determine whether it has a sound process for evaluating the medical necessity of Medicare admissions, says Almeda. ■

Step-by-step review of one-day stays

Auditing one-day stays is easy, with a little help from the experts.

Use the following steps when you audit one-day inpatient stays:

1. Enlist the help of your organization's utilization review department, says **Anthony Almeda, CPA,** senior internal auditor for Community Health Systems, Inc., in Brentwood, TN.

2. Pull any of your organization's policies on monitoring one-day stays, says **Tammy Forgatch, BSN, RN,** nurse auditor supervisor for Southern Illinois Healthcare, in Carbondale.

3. Find out how your organization's utilization review department is managing these patients, says Forgatch.

4. Obtain data from the hospital's accounts receivable system, says **Terri Allen, CIA,** a hospital internal audit director.

Collect the following information:

- Account balance
- Admit day
- Diagnosis related group (DRG) assigned
- Discharge date
- Discharge disposition code
- Financial class
- Hospital service
- Inpatient/outpatient indicator
- Last activity date
- Medical record
- Patient account
- Social Security number
- Total adjustments
- Total charges
- Total payments

5. Using ACL software, analyze a period of time (usually a year) by extracting all inpatients with a length of stay that is equal to zero or one.

6. Eliminate from your review any patients whose discharge disposition code indicates that he or she passed away or was transferred.

7. Select a random sample from each remaining group (zero-day stays and one-day stays).

8. Review the medical records. Determine whether the physician's order indicates that the hospital should have admitted the patient under inpatient status.

9. Review the nursing notes and the physician's order and notes to determine whether the DRG assigned is supported.

10. For accuracy, compare the discharge disposition code to the discharge-planning document.

11. Enlist a clinical coding specialist to review any charts that do not appear to support an inpatient admission. ∎

Evaluate your coding and documentation of E/M services

Tips for safer billing under the government's watchful eye

The government is on the hunt for services that do not meet medical necessity requirements—and the stakes are too high for your organization to ignore. Between October 2001 and March 2002, the federal government collected more than $780 million from healthcare providers accused of Medicare and Medicaid billing irregularities.

Make sure your organization is up to par before the Office of Inspector General (OIG) comes knocking. Audit your organization's evaluation and management (E/M) services documentation and coding to see whether they meet the OIG's standards. Start by performing these five steps:

1. **Perform a baseline audit to identify problem areas.** Review the billing report for the following patterns and practices:
   - Physicians who always assign the same level of E/M service
   - Unexpected codes (code categories, E/M levels, procedures, or modifiers).
   - Codes not being used that you would expect to see
   - Patterns that differ from national norms or from others in the group practice
   - Graph physician usage of the various codes, as compared to the national use of the codes for physicians in their specialties

2. **Determine the type of audit.** Choose whether to perform a focused review or a general review. Use these guidelines:
   - Focused review—assess a particular physician or specialty to identify any problematic codes to single out and review
   - General review—evaluate the current procedural terminology and code utilization report or analyze high-usage or high-payment codes

3. **Choose the sample.** Determine the size and scope based on the audit's purpose.
   - Statistically valid random sample—select 30 records per physician, or 5% of the total number of surgical cases for a three-month period

   - Smaller probe audit—choose five to 10 services per physician
   - Choose whether to review claims prospectively or retrospectively

4. **Review the medical records.**
   - Determine whether each medical record is complete and legible
   - Identify whether the following documentation is present:
     - Reason for the encounter
     - Relevant history
     - Physical exam
     - Prior diagnostic test results
     - Physician's assessment of the patient's condition, clinical impressions, or diagnosis
     - Treatment plan
     - Date and legible identity of the observer (physician, nurse, etc.)
     - Time (only a factor when counseling is 50% or more of the visit)
     - Documentation of the patient's progress, response to treatment, and changes in treatment or diagnosis

5. **Watch for common problem areas, such as**
   - disproportionate use of high-level E/M codes
   - lack of medical necessity documentation
   - physicians and coders using the wrong local medical review policies (e.g., using Part A guidelines instead of Part B)
   - physicians using hospital coding guidelines to perform office coding (the E/M guidelines are different for physician coding and hospital coding)
   - consultations—if the physician uses the words "referring" or "referred" in written correspondence with the requesting physician, the carrier can downcode the visit from a consultation to an inpatient or office visit ■

Sources: Ellen Arrington, RN, a clinical auditor for the North Shore Medical Center in Salem, MA, and Stacie Buck, RHIA, LHRM, president of HIM Associates, a consulting firm in North Palm Beach, FL.

Tips for auditing same-day readmissions

Your hospital may try to do its best to treat and discharge patients efficiently. But if you routinely discharge patients too soon and then readmit them later the same day, your policy may not pass muster with the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS).

Patients who are discharged earlier than necessary and then readmitted face potential medical risks. In addition, hospitals could be overbilling Medicare if they don't include the charges for the second inpatient stay on the original claim or they treat the situation as a transfer, says **Terri Allen, CIA,** a hospital audit director.

OIG's target areas

The OIG has been looking into same-day readmissions for years, says **Hank Vanderbeek, MPA, CIA, CFE,** a consultant and former auditor for the OIG's Office of Audit Services. The OIG looks for the following in its audits of same-day readmissions:

- Claims for a second patient admission when the patient was actually transferred to a non-acute care unit within the same hospital

- Whether the readmission claim should have been a continuation of the initial admission

- Premature discharges or incorrect discharges (e.g., the patient never left the hospital)

- Medical conditions that do not require a readmission after a discharge

Hospitals should conduct a prospective review of all same-day readmissions based on the OIG's review protocol, says Vanderbeek. They should also repay any overpayments they uncover. Auditors can select a probe sample of same-day readmissions from the prior 12–24 months to determine whether the hospital is correctly billing for these admissions.

Nine steps

Vanderbeek and Allen outline nine steps that auditors can follow for reviews of same-day readmissions:

Evaluate controls for same-day readmissions

Providers should use a system to monitor readmission rates by diagnosis and provider, as well as by clinical certification. Include this information in the overall utilization statistics. Hospitals can also use this information to identify opportunities for increased cost savings and inclusion of heavily used practitioners in the network, says Vanderbeek.

Examine the following areas to evaluate the controls on tracking/follow-up actions for hospital readmits:

- Whether anyone reviews claims for coding errors or readmission errors.

- What the internal audit department has done to ensure that the hospital prevents the errors the Office of Inspector General and Centers for Medicare & Medicaid Services identified.

- Whether there is a quality assurance indicator that includes reviewing all readmissions within 72 hours of discharge. "This is a key quality assurance indicator used in the Veterans Health Administration medical centers and hospital systems," says Vanderbeek.

- Whether the local intermediary or quality improvement organization is tracking readmissions for potential medical necessity and billing errors.

Lastly, don't get lulled into a false sense of security if your review shows that the controls are adequate. The adequacy of controls indicates only the extent of transaction testing needed to augment control review, says Vanderbeek. ∎

Auaiting tips

1. Determine whether there are any internal reviews, current or past, of readmissions. If the hospital reviewed readmissions, obtain and analyze the prior audit results, says Vanderbeek.

2. If your hospital has never audited readmissions, contact the fiscal intermediary (FI) and local quality improvement organization (QIO) to determine whether they are reviewing readmissions, says Vanderbeek.

3. Proceed with a review if the FI and QIO are not reviewing readmissions. Start by notifying management and applicable staff of the objective of your review. If the FI and QIO are reviewing your readmissions, decide whether their review of your hospital readmissions is sufficient, he says.

4. Obtain inpatient claims from the inhouse claims database or CMS' Standard Analytical File, which includes data on claims that have the same discharge date of service, subsequent date of service, and provider numbers.

   Allen obtains and analyzes patient accounts receivable information using Audit Command Language (ACL) software. This software produces reports of all patients with hospital stays of zero or one day and then attaches the discharge disposition code to each account, says Allen.

5. Research applicable federal and state regulations, quality assurance policies, local medical review policies, and codes associated with readmissions, says Vanderbeek.

6. Analyze discharge codes to determine to which location the patients were discharged between the initial admission and readmission, he says.

7. Review medical records to determine whether same-day, same-provider readmissions were billed correctly and were medically necessary, he says. Analyze the following as part of your medical record review:

   • Physician orders for admitting and discharging

   • Physician notes

   • Nurses notes

   • Discharge planning summary

   • Discharge coding record

8. Report findings to the audit committee and other appropriate internal managers.

9. Repay any overpayment identified through the review and issue a written report on the audit findings, says Vanderbeek. ■