AAHAM
American Association of Healthcare Administrative Management

MAPAM
Massachusetts Association Of Patient Account Management

Revenue Integrity Audits:
Why They Are So Important

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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 accurately represent the services that were performed and are documented in the medical record?

Audit Scope

- The audit should consist of a detailed review of:
- Chart documentation
- Charge capture
- Claim form(s) and itemized charges
- Third party remittance advice

Chart Documentation

- The driver of all charges is a valid physician order

Definition:

An “order” is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y).

Physician Order

- What to look for:
  - Is it signed and dated?
    - Signature not required on laboratory tests paid via CLFS
  - Telephone orders must be documented in physician chart and facility record
  - Does the order support the test performed and reported on claim?
    - Diagnosis/reason for testing
    - Medical necessity
  - Was diagnostic test changed/different? If so, is this supported?
- Example problem areas: OB Triage (NSTs), observation, POC testing, CBCs

Supporting Documentation

- Is every charge that is reported supported by documentation in the record?
  - Copy of requisition/order
  - Written reports/test results
  - Progress notes - physician and nursing
  - Physician interpretations
- Where is the documentation kept?
  - EHR, paper chart, external system (e.g. PACS, TraceView, iHeal), combination of each
- **“If it isn’t documented, it wasn’t done”**
- Example problem areas: Missing or invalid orders, infusion start/stop times, other timed services, vague notes/missing details, missing clinical significance/medical necessity

Charge Capture

- Can be a very complex process
- How are charges being captured?
  - Upon order/completion
  - Via manual charge entry
  - Upon documentation
  - Coding
  - Billers? – hopefully not
- Does each party understand their charge capture responsibilities? Audits can help identify when additional training/education is needed.
- Example problem areas: outdated charge tickets, lack of coverage, lack of training

Charge Capture

- Keep an eye open for:
- Change in practices
  - New staff
  - New providers
  - New system
  - New equipment
  - New location
  - New services
- Issues could exist with charging/mapping

Charge Capture

- Engage clinical departments in the process
- Open communication of audit results
  - The good and the bad
  - Share information
- Track and trend
- Daily reconciliation – 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”)

Claim Form/Itemized Charges

- What to look for:
- CPT/HCPCS assignment
  - Do they match the services documented?
- Billing units
  - Are services being properly reported in units defined by HCPCS descriptions (per ml, per 5 mg, per 15 minutes, per specimen, etc.)
  - Multipliers (usually Pharmacy, Laboratory)
- Missing charges
- Occurrence/Value/Condition Codes

Claim Form/Itemized Charges

- Service dates
- Rolling together charges
  - Potential to lose reimbursement by rolling together separately payable lines
- Unbundling
  - Inappropriately reporting services which are inherent components of other services
- Charge explosions/Panels
  - Radiology, Laboratory

Claim Form/Itemized Charges

- 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
  - Laboratory (59,91)
  - ED and Clinics (25, 59, 76)
  - Ancillary services (52, 59)
  - New X-EPSU modifiers (XE, XP, XS, XU)
    - Commonly used incorrectly

Claim Form/Itemized Charges

- Revenue code assignment
  - Reimbursement may be driven by these!
    - Fee schedule versus case rate, etc.
  - Be specific

    → e.g., 335 “Chemotherapy-IV” vs. 280 “Oncology”

Remittance Advice

- 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
- Medical necessity
  - Did the order support the service?
  - Were all diagnosis codes captured?
    - Signs/symptoms versus definitive results
    - Coded based on report or off of order
  - Trends with particular providers?
  - Is ancillary service coded prior to complete chart being coded?

Remittance Advice

- Prior authorization
  - Payer specific
    - Out of network provider
  - Service line specific
    - Chemotherapy
    - Advanced imaging
    - Level of care
  - Who is responsible for obtaining?
    - Written policy and procedure
- Frequency thresholds
  - e.g., preventive benefits (Annual wellness visits, mammograms, screening lab tests, etc.)

Payment Reconciliation

- Review remittance advice to uncover potential payment errors
- Underpayments
- 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 $$$!

Conclusion

- Errors can occur in any of the various stages of the revenue cycle
- Revenue Integrity Audits allow for identification of such errors which may otherwise go unnoticed
- Audits should be incorporated as a regular part of your facility's processes

Questions?

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