Get ready for RAC audits: Six tips to help you prepare

CMS recently ended the demonstration phase of its recovery audit contractor (RAC) program and began permanent, nationwide implementation. RACs, or independent contractors hired by CMS to ensure proper Medicare payments, are paid contingent upon finding over- and underpayments.

If your facility is not in one of the pilot states—New York, Florida, California, South Carolina, and Massachusetts—don’t relax yet. It only means you have some preparation time. And that time could make a significant difference to your RAC results, says Lynn Grieves, chief compliance officer at Memorial Care Medical Center in Huntington Beach, CA.

During the initial pilot project, Memorial Care Medical Center experienced RAC audits in four of its five hospitals. By the end of the process, the organization paid $9.5 million in lost revenue and appeals costs, says Grieves.

“This was a huge hit for us,” he says. “We thought we were prepared for the RAC, but dealing with the huge volume of activity was very difficult. We left hundreds of thousands of dollars on the table simply because we couldn’t meet the deadlines.”

Consider the following six tips to help you prepare for a RAC audit:

1. It’s an inevitable process. The RAC program proved to be cost-effective and beneficial from CMS’ perspective, despite protests from providers regarding problems with RACs and lack of agency oversight. So don’t expect it to go anywhere, says Jason Healy, a partner at Reed Smith in Washington, DC.

“The message to providers needs to be that [RAC] is for real, it will be rolled out, and you need to be prepared to respond,” he says.

In fact, you should spend less time focused on how to avoid a RAC audit and more time thinking about how to prepare for one, says Greg Radinsky, chief corporate compliance officer at New York–based North Shore Long Island Jewish Health System. “This program has been very successful for the government, and the best thing you can do is try to mitigate your liability by being proactive now,” he says.

2. Look for clues now. To prepare your organization for RAC scrutiny, look at target areas in the OIG Work Plan and examine which DRGs were targeted most during the demonstration phase of the rollout, says Judith Waltz, a partner at Foley & Lardner in San Francisco.

By focusing on active RAC areas, you can tailor your own internal audits and make sure your documentation and records are in good shape, she says.

“We thought we were prepared for the RAC, but dealing with the huge volume of activity was very difficult.”

—Lynn Grieves

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RAC

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Understandably, RACs went for the big dollar amounts, says Healy, and that meant inpatient hospital claims. They also put a lot of resources into proper DRG assignments and issues of medical necessity, adds Radinsky.

During the pilot phase, RACs in California focused on inpatient rehabilitation facilities (IRF), severely limiting which patients could receive care in an IRF versus a skilled nursing facility. Although CMS placed a hold on those IRF reviews, there is no way to be sure whether CMS will review IRFs again or whether the previous decisions will stand.

In California, RACs also honed in on one-day stays, says Waltz. “There have been issues about changes in payment for observation services,” she explains. “Medicare stopped paying for observation, so the OIG now thinks providers are admitting people as inpatients to get payment.”

3. Develop a detailed internal audit and risk assessment program. Confirming accurate documentation, billing, and coding are the best ways to ensure you’re ready for a RAC audit. So do plenty of billing and compliance training, says Healy. Internal education is also essential. You need to make sure everything is correctly recorded in your electronic medical records and that your claims represent the services and items provided. If there is a problem with the way clinicians are documenting, “that will be a big problem when the RACs come to look at claims data,” Healy says.

In addition, make sure you have an effective compliance program in place. If staff members understand compliance issues and how to report problems, it decreases payment errors and the chance that RACs will find any.

Another good auditing strategy is to compare past and current billing practices and look for any dramatic changes, says Robert Markette, a partner at Gilliland & Markette in Indianapolis. “It does help to look at the OIG Work Plan, but it’s also helpful to check records for radical changes in billing,” he explains.

A lot of RAC audits are automated and look for interruptions in patterns. “If you can find those ahead of time, you can be ready when they begin requesting records,” Markette says.

Thanks to a detailed database of benchmarks from the New York Hospital Association, establishing a comparative analysis at his facility was easier, says Radinsky. The analysis proved valuable because New York hospitals could focus on higher risk areas.

“The idea is just to keep track of data and see trends, just like any audit,” Radinsky says. “What you have to keep in mind too is there is a real learning curve. As you get used to more RAC audits, you’ll build better internal controls and determine the best ways to respond.”
A good RAC team also needs a strategy for scanning and managing the slew of paperwork generated by audits. After multiple appeals and resubmittal of documents, his facility was drowning in paper, says Grieves.

4. Once audited, move quickly. In the event of a RAC audit, be cooperative and respond quickly, says Healy. The way the program runs currently, RACs use software to analyze claims data. The RAC determines whether more information is needed. That means there are very few ways they can determine overpayments without requesting medical records, he says.

“Once they contact a provider for records, the provider needs to make that request known to the reimbursement department and the legal department right away,” Healy says. “How they respond early on will have an effect on their determination later.”

Another worry, Healy says, is the use of extrapolation—or statistical samples—in audits. It’s very controversial. If you get an overpayment notice that stems from statistical sampling, expect the appeals process to be complex. “A significant amount of both time and resources need to go into that kind of appeal,” he says.

5. Involve all areas. A solid internal auditing process requires coordination throughout the organization. Dealing with compliance and documentation issues in silos won’t get the job done efficiently. “Everyone—medical records, billing, clinical—has to be in the loop and work together for the program to work well,” says Grieves.

A rigorous, multidisciplinary approach that involves everyone is the best way to use resources and be successful in your compliance efforts, Radinsky says.

6. Spread the word about RAC experiences. Providers should share their stories with each other as much as possible.

“The recent status report from CMS is very one-sided and really doesn’t reflect the number of appeals,” says Grieves. RACs frequently meet with members of Congress, so providers should too.

“No one is against a normal auditing process, but the contingency-fee arrangement and lack of appropriate oversight are costly and problematic,” he says.

Providers should support RAC moratorium legislation to draw attention to these issues. You should also speak with government officials about any problems you encountered during your RAC auditing process.

“All we’re asking is that they take a closer look at the program,” Grieves says.

Need help with compliance?

The Healthcare Compliance Professional’s Guide to Policies and Procedures provides the easy-to-use policies and procedures you need to ensure your compliance program runs efficiently and smoothly.

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To order, call customer service at 800/650-6787 or e-mail customerservice@hcpro.com.
Time to prepare for present-on-admission investigation

CMS completed its phased implementation of the present-on-admission (POA) reporting requirements April 1. That means your POA auditing strategies need to be in place now to ensure proper reimbursement down the road.

The POA reporting initiative is part of a CMS program, mandated by the Deficit Reduction Act of 2005, that requires quality reporting aimed at ferreting out hospital-acquired conditions.

Under the program, all inpatient prospective payment system (IPPS) hospitals had to begin submitting POA information for all Medicare inpatient discharges October 1, 2007.

On January 1, CMS began processing all of the POA data and giving providers advice about which reporting problems needed to be addressed. Hospitals had a grace period from January 1 to March 31 to get comfortable with the new requirements, during which time CMS did not return claims.

However, beginning April 1, that grace period was over. Any claims that were submitted that did not have adequate POA coding for all primary, secondary, and E-code diagnoses were returned.

And once they’ve been returned, you’re stuck with the arduous task of correcting claims and resubmitting them.

That’s why having a clear understanding of the POA requirements and crafting an effective auditing strategy is so important, says Betty Bibbins, MD, FACOG, CHC, CPEHR, CPHIT, president and chief medical officer at DocuComp, LLC, in St. Clairsville, OH.

“This is something that is still brand-new. So we haven’t really seen a lot of audits yet. But hospitals should make sure they are as prepared as possible to capture data and show justification” for their claims, says Bibbins.

Eight preventable conditions

During the past year, CMS attempted to shift its payment processes from a passive to an active one, says Bibbins.

The agency is carefully examining patient care for evidence of quality, efficiency, and effectiveness.

Medicare only wants to pay for high-quality care. To do that, the agency identified eight events that should be avoided during the regular course of treatment in a hospital.

If these conditions are present when the patient is admitted to the hospital, Medicare will reimburse the hospital for treating them. If not, Bibbins says, “the hospital will be penalized.”

If you do not provide adequate documentation for any of the following conditions, CMS can determine the condition was the hospital’s fault and refuse to provide reimbursement. The conditions are:

1. Objects left in during surgery
2. Pressure ulcers
3. Catheter infections
4. Falls
5. Incompatible blood transfusions
6. Surgical site infections
7. Air embolisms
8. Catheter-induced urinary tract infections

For example, a patient admitted with pneumonia falls during his stay and fractures his hip.

If the patient had trouble walking at admission but no one documented it, Medicare says the fall was the facility’s fault and could refuse to pay for any extra treatment, says Bibbins.

“CMS is basically stating that if this patient had been given proper care at the beginning, this would not have happened,” she says.

CMS will likely add other preventable conditions, such as sepsis and staph infections, to the list in 2009, Bibbins adds.

Look for two more tips to flag present-on-admission problems in next month’s issue!
**Retrospective versus concurrent POA audits**

To audit POA concurrently, you should use a staff case manager or nurse to evaluate histories, physicals, and orders. This person should make sure the eventual diagnosis matches the information recorded, says Bibbins.

To conduct effective retrospective audits, providers should compare the admission with the final discharge summary to make sure the information in each report corresponds with the other.

“You need to look at both documents and ask, ‘How did this get on the discharge summary,’ ” Bibbins says.

**Document, document, document**

Rigorous attention to documentation will enable smooth audits later on, says Linda Martien, CPC, CPC-H, CPC-I, an RCM coding specialist at the National Healing Corporation in Boca Raton, FL.

“Documentation is the most important thing because it shows third-party payers that we’re providing the best care and it shows what conditions were present when the patient was admitted,” says Bibbins.

If a symptom is documented at the time of admission, and a diagnosis is not made until discharge, you may still meet that POA requirement, says Bibbins.

“This new POA requirement needs to be addressed on the clinical side because the onus of determining diagnosis should never be on nonclinical staff,” says Martien. “Usually, when a patient is admitted, the nurse does an intake or an admission assessment, and then the physician reviews [it]. POA coding needs to be built right into that clinical pathway.”

When clinicians document whether diagnoses were POA, they enter the POA code in either the UB-04 or an electronic claim, followed by one of four POA indicators:

1. **Y**—the diagnosis was POA
2. **N**—the diagnosis was not present
3. **U**—there was not enough documentation to determine whether the condition was POA
4. **W**—the provider was not able to determine whether the condition was POA

To make sure you address the issue sufficiently, create a clinical documentation improvement program within your facility, Bibbins says. (For information about the Association of Clinical Documentation Improvement Specialists, visit www.hcpro.com/acdis.)

“We might not feel like we have time to document as much as we should because care is so much more important, but we have to go back to the old adage, ‘It’s not done until the paperwork is done,’ ” Bibbins says.

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**Use in-house staff members to capture data and POA audits**

The best way to establish an effective present-on-admission (POA) compliance program is to create a clinical documentation improvement group. This group should incorporate everyone—coders, physicians, nurses, and other staff members—so they can work together to make sure clinicians capture data that convey the presence and severity of illnesses, says Betty Bibbins, MD, FACOG, CHC, CPEHR, CPHIT, president and chief medical officer at DocuComp, LLC, in St. Clairsville, OH.

If the documentation team members work within the hospital, they can be stationed right on the floor units, answering questions and demonstrating how to capture the right data in the records, she adds.

“Clinical documentation improvement teams are something that every single hospital needs,” says Bibbins. “Having that resource on-site means the staff members can be available as new POA changes come about and they can adjust the auditing strategy accordingly.”

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**Questions? Comments? Ideas?**

Contact Senior Managing Editor
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**E-mail mvarnavas@hcpro.com**
Sample policy and procedure form

HOTLINE AUDITING AND MONITORING

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**BACKGROUND**

One of the primary responsibilities of the compliance office is to ensure that the hotline operates in conformance with its objectives (see Hotline Policy). Periodic audits of the hotline operation will provide the organization assurances that the hotline is operating in conformance with established procedures.

**PURPOSE**

To ensure that the hotline is operating effectively through a process of periodic auditing and monitoring.

**POLICY**

1. The compliance officer has primary responsibility for the hotline operations and will therefore arrange for an independent review of the function at least annually to ensure adherence to established policy and procedures.

2. The report of independent review of the hotline function will be given to the executive compliance committee and the board of directors.

3. The compliance officer will take necessary steps to ensure all findings from the independent review are acted upon with appropriate corrective measures.

**PROCEDURES**

1. The compliance officer will arrange for periodic independent audits and/or reviews of all aspects of the hotline operation.
2. The audit or review will focus on ensuring the following:

- All calls are answered promptly during established hotline hours
- A pre-recorded message explaining the ground rules of the hotline is in place
- Callers are fully debriefed
- Callers are provided a report identification number
- Callers are not traceable (calls cannot be identified on the telephone bill)
- Call information is kept confidential
- Calls cannot be overheard or seen by the general population
- Record-retention policy is followed
- Records are maintained in a secure area
- Followup on call information is handled promptly and appropriately
- Call logs are maintained properly
- Non-retaliation/Non-retribution policy is followed
- Hotline is viewed by employees as a viable communications channel

3. The compliance officer will provide reports on the results of any hotline audits to the executive compliance committee that, in turn, will report to the board of directors.

4. The compliance officer will make recommendations to the executive compliance committee for any necessary changes to the hotline operation.

REFERENCES/CITATIONS

Top 10

Myths and misconceptions to refute about the changing role of compliance officers and auditors

In the past, compliance officers labored to ensure hospital bills were correctly coded. With the financial health of the institution in the balance, there was much at stake. Fast forward to today’s compliance officers and you see a plate filled with more than coding and billing concerns. Today’s compliance officer must straddle at least three worlds: government regulations, organizational efficiency, and patient protection.

It’s clear compliance touches every person who works at a hospital. It’s a subject on most orientation agendas and it shows up embedded in general job descriptions and mission statements.

We asked our experts to tell us about the misconceptions they hear regarding the role of compliance officers and auditors. Here’s what they said:

1. All compliance officers are lawyers
2. Compliance should make all regulatory decisions
3. Compliance officers sit and read regulations all day
4. Compliance is boring
5. Compliance doesn’t have any financial effect
6. Compliance is a business function; it is not about patient care
7. Compliance has nothing to do with quality
8. Compliance is a function hospitals have because it is required
9. The [name of regulatory agency] won’t care if we only get it partially right, as long as we make an attempt
10. If we don’t tell compliance about it, we won’t be held to the rules

“You’re just looking for trouble’

Being thought of as a police officer is the biggest misconception says Christine Bachrach, chief compliance officer and senior vice president at HealthSouth Corp. in Birmingham, AL. “People may think, ‘Oh, she’s here to get me in trouble. She’s only here to look over my shoulder,’ “ says Bachrach. But her role is to educate and train people to work in ways that comply with regulations. Part of her team’s job is to prove the value of compliance to the organization.

“My team functions as ambassadors in that respect,” Bachrach says.

Compliance officers should be role models, says Angel Hoffman, RN, director of compliance at the University of Pittsburgh Medical Center’s Ethics and Compliance Office. And they should be on the lookout for teachable moments.

“We incorporate both compliance and ethics principles into everything that we do,” says Hoffman. “We must take the opportunity to provide informal verbal education whenever possible in addition to formal written training.”

Bachrach says she advises her colleagues not to approach correction in a punitive manner or to place blame. Rather, she says to enlist staff members to help identify where a process went wrong with the goal of fixing it.

“Sometimes the answer isn’t finding out who to blame, but to say, ‘We have an issue. What do we do to fix it so it doesn’t happen in the future?’ “ says Bachrach.

“You don’t care about this business’

Another myth Bachrach hears is that compliance officers don’t have to be concerned about how a hospital governs its sales functions and business planning.

“In healthcare, sales is not selling widgets; it’s working with physicians to try to convince them the quality at your hospital is better,” she says. “That relationship has everything to do with the laws about the organization’s relationships with physicians.” In one case, a nurse expressed concern about how patients were admitted to
the hospital, Bachrach recalls. “I am not a clinician, but I listened. I spoke with the physician in charge. The issue involved the sales liaison. It was a communications issue and how each of those professionals involved understood their boundaries,” she says.

Bachrach consulted with all those involved in the process and then linked those professionals together to resolve the issue.

Although this may not have been a strictly compliance-related matter, maintaining open lines of communication helped everyone improve the quality of care and business at the hospital.

“The most frustrating thing about the job is dealing with those who forget that the goal of compliance is to do the right thing,” says Stella Wohlgamuth, RN, audit and compliance officer at ProMedica System in Toledo, OH.

There will be staff members who regard compliance officers as the roadblock that prevents them from doing what they want. The staff member may want to provide a needed service or leverage a new business opportunity, Wohlgamuth says.

But sometimes they miss the big picture and ignore the rules in the race toward their own goal. “Then we become the ‘bad guys’ who are impeding progress. This is especially difficult when ‘everyone else is doing it,’” she says.

For Hoffman, the misconceptions don’t necessarily affect how she performs her duties, “but it can be frustrating,” she says. “Compliance ... is growing rapidly and getting more attention overall. That is probably the reason that some confusion exists today.”

‘What’s clinical interest got to do with it?’

One of the most worrisome things Hoffman heard recently about her role is the question of why a nurse would be qualified to fill it.

Some don’t recognize how compliance is related to actual hospital operations and the clinical activity.

“Having a good clinical background provides a good foundation,” she says, adding that it can help determine what actually occurs and what possible process changes would be effective.

By considering the misconceptions and myths about the role of the compliance officer, colleagues in the field can learn some valuable lessons, says Hoffman. For example:

➤ Communicate to individuals at all levels of the organization
➤ Repeat important information
➤ Inform senior management and the organization’s board about industry trends
➤ Share news about compliance department accomplishments
➤ Summarize the issues and discuss potential risks
➤ Leave the office to talk with staff members
➤ Look at issues from a legal and operational perspective in addition to a regulatory compliance perspective

Hospital staff members tend to see compliance officers as confessors, bridgemakers, facilitators, teachers, and champions for “doing the right thing.”

Sometimes staff members bring up issues that do not fall under the compliance umbrella. That’s when compliance officers become communication consultants and mediators, linking professionals whose mind-sets may sometimes cause confusion about the boundaries of their roles.

As a former clinician, Wohlgamuth says she now sees that many hospital staff members, even though their jobs may not require direct patient care, still want to be part of the medical mission.

Those in IT or billing care about how their jobs affect the quality of care the hospital provides to its patients, she says.

Compliance officers should remember this when developing educational content.

Make compliance a real and everyday process, says Wohlgamuth. “Everyone can, and should, take an active role in compliance. Our job is to help [staff members] understand how to accomplish this,” she says.
Use internal audits to find Medicaid problems

Today you need to worry about more than Medicare billing errors—Medicaid investigations are on the rise. And it's time to take all the cautionary tales you see in newspaper headlines to heart.

“Now more than ever, it’s important to have an audit component to your compliance program,” says Maureen Weaver, an attorney at Wiggin and Dana in New Haven, CT, who participates in internal and government Medicaid audits.

Not only is the political landscape riddled with promises of future healthcare reform, but with the Deficit Reduction Act of 2005 (DRA), false claims act legislation is being backed by increased enforcement.

Further, private auditors and state budgets see big financial benefits in ferreting out ill-gotten or mistakenly billed Medicaid dollars.

“Any hospital with an effective, well-functioning compliance program should be doing regular internal compliance audits,” says Weaver.

In surveying resources about internal Medicaid audits, several hot topics arise.

Grow your own whistleblowers

You might not want to call it whistleblowing, but you can learn a lot about potential problems from your own staff members.

The DRA encourages states to create their own false claims acts. It also requires providers who receive a significant portion of their funding from Medicaid to educate their staff members about compliance issues.

Even facilities that do not fall within that threshold should actively encourage employees to report potential noncompliance issues.

Auditors want to see written plans for how staff members can report problems to internal entities and to external agencies without risking their jobs.

They also want documentation that internal stakeholders know their whistleblowing options. “We give people a number of regular opportunities to come forward, to make us aware of issues,” says Debra Muscio, a corporate audit, ethics, and compliance officer at Central Connecticut Health Alliance and chair of the education committee of the Association of Healthcare Internal Auditors in Wheaton, CO.

“We offer telephone hotlines, cover questions about ethics and compliance in our employees’ annual reviews, and address it in termination interviews,” she says. “All this sends a message that we want to know” about any potential Medicaid compliance risks.

Muscio adds that people who have so many opportunities to come forward with complaints of noncompliance are not likely to become whistleblowers in the negative sense.

Conduct statistical egg hunts

Computer and technological data mining can help you conduct complex and efficient statistical Medicaid audits. Medicaid, not to mention other payers, expect you to take deliberate steps to audit yourself using such tools, Weaver says.

Such analyses can point to out-of-target billing practices, unexplained spikes in certain billing codes, and other aberrant data that are less likely to be found through desktop audits of patients charts.

“It’s important for someone in the compliance department to have IT experience and to be comfortable and familiar with the software,” Muscio says. “If not, they should have a very good working relationship with their IT department.”

Government auditors use sophisticated software to see caches of recoverable overcharges. When contracted government auditors are paid via a percentage of recovered billings, such as recovery audit contractors (RAC) (see “Get ready for RAC audits: Six tips to help you prepare” on p. 1), the hunt takes on a heightened level of intensity.

One state, referenced in a best practices report by the Health Care Financing Administration’s National
Initiative on Medicaid Fraud and Abuse, uncovered poor billing practices that allowed a single medical professional to bill for as much as 46 hours of care in one day.

Billing was recorded in one-minute increments, not hours, so the error was not obvious without the statistical review.

Another state offered nurse anesthetists voluntary training to make them aware of common billing errors. With this training, the state recovered more than $500,000 in four months.

**Connect across departments**

Medicaid rules are complex and ever-changing. And even with IT support, compliance tasks are challenging. By all accounts, the internal auditor cannot do it all alone. “You need to know the appropriate people within your organization,” Muscio says. “You can’t work in a silo.”

Staff members from different departments should be involved, says Pandora Holloway, director of compliance and audit services at WakeMed Health and Hospitals in Raleigh, NC.

“For example, the buy-in of all departments who handle billing procedures is essential to compliant billing,” she says. “So it is very important to engage all members of the billing chain and to help them see improvement in future audit results.”

In addition, each internal audit team will change depending on the area audited, and the group might include outside consultants. “We use consulting coders to audit medical record documentation,” says Holloway.

Weaver recommends compliance officers remain vigilant of changes and trends. “Keep your ear to the ground so you’ll know what’s happening in different places,” she says. “Talk to colleagues, be active in professional organizations, be familiar with all the regulations and how they affect your organization.”

**Fishing upstream as a prevention strategy**

Compliance experts report a trend in Medicaid auditing in which compliance officers and auditors put great emphasis on finding mistakes early on in the billing process.

Payers, providers, and patients all benefit when mistakes are corrected before a charge is created or billed. This is called concurrent monitoring prior to billing.

The IT software referenced earlier can identify trouble spots, and changing broken procedures can help prevent coding or recordkeeping problems in the future.

For example, one state’s Medicaid audits revealed unclear protocols for physician-prescribed pain medications. Through an audit, the provider clarified and standardized the procedure.

Computer software generates charge error reports every day. Staff members throughout the facility review and correct them before charges appear on a bill.

Also, refunding patients’ copayments and deductibles is a sticky and almost futile chore. Catching coding mistakes early helps prevent coders from developing poor and

> continued on p. 12

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**Sample components of a state Medicaid audit**

- North Carolina’s state audit guidelines say that auditors will not accept data after auditors leave the premises.
- Provide the following data from any proactive internal audits to the auditors before or during the site visit:
  - Service plans, plans of care
  - Service orders
  - Service authorizations
  - Service notes and logs
  - Staff qualifications
  - Staff supervision plans, evidence of supervision, related policies
  - Criminal record checks, disclosure of criminal records, related policies
  - Health Care Personnel Registry checks
  - Legal documents related to patient guardianship or legally responsible parties

*Source: State of North Carolina’s 2007 notification letter.*

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Internal audits

To teach inexperienced coders how to code properly, one state flags and reviews new healthcare providers to ensure that they understand the regulations. This also helps catch new fraud schemes.

If you can catch errors before billing, you can prevent costly mistakes and potential false claims.

Document and correct

When an internal audit uncovers problems, that is the time to document the problem and act to correct it. A complete internal audit includes correcting mistakes, lest a noncompliance mistake be relabeled fraud.

The compliance/auditing team needs management’s support to accomplish this proactive step.

“If management fails to implement process improvements, future audits will indicate the same weaknesses,” says Holloway.

When you uncover potential compliance problems, call your corporate counsel and report all findings. Talk to your key executives and consult with your CFO, says Holloway.

Internal audits as a negotiation strategy

Internal audits have benefits even if a Medicaid audit finds that your organization owes money. “If you are able to demonstrate that you have an active and effective compliance program, it can help you after a government audit finds noncompliance issues,” says Weaver, who has participated in numerous internal and government audits. “It can help reduce the amount of a settlement.”

Surprisingly, Medicaid audits can also reveal opportunities for increased revenues.

“During our internal audits, we look for both inappropriate billings and missed billings that slip through the cracks,” Muscio says. “Even when [government] audits uncover underbilling issues, you can use that fact to offset any overbilling your organization might have done.”

Government auditors and healthcare administrators generally focus on inappropriate billings more than missed billing opportunities.

The problems are the headlinemakers, after all. Internal audits can help ensure you are not included in them.

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