

## *Nine steps to conduct an audit or review*

- 1. Identify the scope and purpose of the review/audit.** This step involves identifying the purpose of the study and its scope based on the problem or circumstance that prompted you to perform the study. For example, the Medicare fiscal intermediary might conduct a focused prepayment review of 100% of your facility's patient (PT) claims. To verify that billing is appropriate, you decide to perform a concurrent review of the PT coding, billing, and documentation process.
- 2. Determine how to conduct the review/audit.** Determine whether to conduct the audit internally or externally (e.g., by using an outside consultant or auditor). For certain reviews, the facility should maintain objective independence through the use of an independent review organization. In some cases, facilities should use formal audits to identify overpayments and determine necessary repayments or corrections to the coding, billing, and chargemaster process. For informal studies, internal personnel are generally more than adequate to perform the review. Internal staff can perform much of the work regarding chargemaster reviews.
- 3. Gather pertinent information about processes, policies, and procedures.** Depending on the type and scope of the study, this step may involve a great deal of work. Start by gathering any coding, billing, and chargemaster policies and procedures. These document the many decisions a hospital must make regarding coding, billing, and reimbursement flow. Because there are many third-party payer demands, these policies and procedures can serve as a guide for auditors or reviewers in making assessments and judgments about the correct chargemaster setup and use.
- 4. Develop templates, checklists, and other forms to assist the study.** Staff or external auditors conducting the study should review and assess information in a uniform way, using a standard template. If no template exists, the facility must develop an assessment process while reviewing the processes and information flow.
- 5. Select the cases and obtain documentation, itemized statement, and claims.** For prospective reviews, facilities may only need to review a relatively small number of cases through each facet of the coding, billing, and reimbursement cycle. Facilities can informally select cases for these studies. For formal retrospective audits, facilities must select an appropriate number of cases and stratify the case selection to meet the study's objectives. Facilities can use statistical software to select a sample appropriately.
- 6. Perform the study.** The study can vary in the way it is conducted. Retrospective audits are generally back-office activities. In many cases, the auditors review the case documentation with little outside contact. For concurrent and prospective audits, the process involves more personal contact and interaction with coding, billing, information system, and claims transaction personnel.
- 7. Assess and analyze the results.** For retrospective audits used to identify overpayments, the facility's analysis phase will be nearly complete at the study's conclusion. However, if a facility conducts a prospective or concurrent review, analyzing and assessing information flow and the generation of itemized statements and claims can be challenging. And because the goal of prospective or concurrent audits is to improve the

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process, facilities must make recommendations for improving the generation of error-free claims.

**8. Develop a report detailing the findings and recommendations.** The report and reporting process are extremely important. Reports from coding, billing, and reimbursement audits or reviews are living documents that identify problems and recommend corrective actions. Thus, not only is the written report important, but so is the dissemination of information and recommendations to affected hospital personnel.

**9. Follow up on accepted recommendations.** The actions you take after a study will vary considerably. For example, if the hospital conducts a retrospective DRG audit, the results may show that the hospital correctly codes and bills. Thus, the facility does not need to take corrective action. However, the audit could indicate that the hospital received overpayments and must refund the Medicare program. The necessary action may involve developing additional coding and billing policies and procedures or additional training for coding and billing staff.

*Source: Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance, published by HCPro, Inc. Visit [www.hcmarketplace.com](http://www.hcmarketplace.com) to order the book.*