

## WHITE PAPER

**Taming the Audit Beast: A Good Offense Is the Best Defense**

Today the volume and complexity of third-party claims audits and the associated appeals has grown too high, too fast to manage. And yet, your bottom line depends on your very ability to manage financial audits and the operational, financial, and reputational risks associated, all while keeping up with the constantly changing rules, regulations, and areas of enforcement focus.

Just for Recovery Audit Contractor (RAC) audits alone in FY2012, Centers for Medicare and Medicaid Services (CMS) reported that over \$2.2 billion in overpayments were collected from providers, a record amount almost tripling the previous year's collections. This trend upward appears to be continuing in FY2013 with \$1.3 billion in overpayments collected just thru March 2013, bringing the total overpayments collected to \$4.5 billion since the program was initiated in FY2010. As of the publish date of this whitepaper, 3rd quarter FY2013 results had not been released. The latest updates can be found on the [CMS website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Recent\\_Updates.html](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Recent_Updates.html).

With the recent announcement by CMS that there will be no end-to-end testing of ICD-10 payment systems, providers can expect a feeding frenzy of post-implementation audits focusing on related coding errors.

*"RACs are taking advantage of their ability to run automated reviews around the clock on much less cost than a complex review not yielding big dollars. Just because a hospital is not getting record requests, don't assume that you are not being audited and losing money," said Elizabeth Lamkin, a partner at PACE Healthcare Consulting.*

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*“Only front-end compliance and documentation can prevent these takebacks,” she continued. “Each provider needs a coordinated and comprehensive approach to ensure that the financial and clinical departments are communicating to connect these dots. For instance, clinical department directors – especially in the outpatient department – should be informed on a regular basis if there are recoupments in their particular areas.”*

<http://www.healthleadersmedia.com/page-3/FIN-269064/CMS-IDs-Improper-Payments-Top-Regional-RAC-Issues###>

To manage this growing area of risk in your enterprise and truly “tame the beast”, you need to take control of your audit process with a cross-functional strategy—or game plan—involving the development and ongoing utilization of strong policies and procedures, documentation and training, and workflow tools and automation. When combined with a clearly defined enterprise-wide audit process, communicated throughout the organization, every employee will understand where they fit into the overall plan and how they can help manage the process of mitigating financial risk.

This whitepaper will not go into the common audit findings found in the industry, as the paper would be outdated by the time of publication, but it will discuss the core components of a good organizational offense. Specifically, the following pages will discuss the importance of policies and procedures, documentation management, education and training, the audit workflow, and third-party audit risk mitigation strategies.

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## State of the Industry – Audit Activity

Health care professionals today must keep up with an overwhelming volume of rules and regulations handed down by CMS. Whether your organization represents a hospital or health care system, physician practice, DME, therapy, etc., providers of all kinds are not only facing a rapid increase in the number of audits targeted by various third-party auditors, they are also burdened with the implications of meaningful use as a result of the Patient Protection and Affordable Care Act (PPACA) - Health Care Reform, the American Recovery and Reinvestment Act (ARRA) - Health Care IT mandates, also known as HITECH, as well as the implementation of ICD-10.

The impact of third-party audits, meaningful use, HITECH and ICD-10 is not only overwhelming to individual providers, but also creates great uncertainty across the health care industry. And while suggesting that providers address these regulatory changes all at once might compel many into considering early retirement, with a strategy in place to address the mandates by priority, your organization can be well prepared. Prioritize by targeting both implementation deadlines and whether the regulation is tied to penalties which will impact your organization's bottom line.

In this whitepaper we will focus on the development of a strategy to help mitigate the risks associated with the audit activity in today's healthcare industry—strategies to assist your organization in taming the "audit beast". Whether you receive an audit request from a RAC, Comprehensive Error Rate Testing (CERT) or your very own Medicare Administrative Contractor (MAC), your best defense is to BE PREPARED!

Knowing what is happening with the overall audit program is half the battle and can greatly inform your defensive strategy. Specifically, it is important to note that the first five years of the permanent RAC program is coming to a close, but new more aggressive proposals are on the table for the 2014 permanent RAC program. You can count on the RAC program renewal along with an upswing in other third party audits.

A recent statement from CMS regarding auditor consolidation has stirred some uncertainty as to how to prepare for audits, but the outcome may be promising for providers. Specifically, in late July 2013, CMS announced that the traditional Zone Program Integrity Contractors (ZPICs) and the MACs will form into one type of Integrity Contractor focused on Medicare and Medicaid integrity issues. The new

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Unified Program Integrity Contractor (UPIC) will also include Program Safeguard Contractors (PSCs), and Medicaid Integrity Contractors (MICs). CMS states that the MACs are not going away, but “it will be their integrity responsibilities that will be included in the work of the UPIC.”

CMS also states that the “UPICs will operate, based on regional jurisdictions, as a single contractor performing audit and investigation work across a designated set of states.” Additionally, the work of the RACs will remain as is. A great offensive play: begin trending the regional jurisdictions of the UPIC, so that you can strategize accordingly.

Providers should understand that the goal of CMS will be to consolidate all of its Medicare and Medicaid data into one unified database. This knowledge allows providers to set up their offensive line by proactively ensuring that a working internal audit process is in place. Additionally, one unified database may lessen the administrative burden of multiple entities auditing providers all at once—a situation many have faced in the past.

While most of the auditing bodies have different audit targets, they are all incentivized by money. The more requests they initiate, the more opportunity they have to make money. Therefore, it is your responsibility as an organization to set up a strong offense so that you don’t find yourself constantly on the defensive.

## Managing Policies, Procedures, and other Documents

The first offensive strategy to employ in dealing with today’s regulatory environment is a robust policy and procedures methodology. Policies and procedures help an organization communicate boundaries, establish risk limits, and guide desired behaviors. While many organizations have policies and procedures, many of them have no methodology for monitoring regulations, writing new policies, reviewing existing policies, and disseminating them throughout the organization. This results in stale policies that can lead to poor outcomes, including failed audits.

Starting with a basic analogy, policies are like the rules of the game translated into meaningful terms for your team. No matter the game, there are a set of rules which constitute the foundation for playing that game and give everyone a set of expectations for associated behaviors. A football player knows that if he runs the ball ten yards, his team earns another first down. That same offensive player knows that if he starts to run before the ball is snapped into play, his team will be penalized by five yards. Everyone who watches football knows how complex the

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body of regulations can become, but rules help disseminate those regulations in easily digestible bits for the players. So rules—or policies—establish boundaries for the players of the game. Policies, just like rule books, need to be continuously updated to respond to a changing environment. In healthcare, someone must be chiefly responsible for keeping up with the regulations and audit findings that drive these policies, and managing the policy project overall.

To establish appropriate policies, you must first understand all the regulations that apply to your type of organization, and monitor for continual changes. Since this is a big job, it only makes sense to group related regulations and then establish a subject matter expert for each group of regulations who is responsible for reviewing updates, analyzing their applicability to the organization, and reporting back up to the policy project chief. Policies should be updated at least every two years, or more frequently as regulations demand.

Staff will “buy in” more readily to a policy that is linked directly to an official citation or rationale. For instance, if there is a local coverage determination that specifically states the appropriate coding and medical necessity guidelines for a given service scenario, both the clinician and the biller will benefit by being given easy access to that source document which has driven your own internal policy. This is true for compliance regulations as well, including reference to the reality that a given practice is a CMS condition of participation or OIG recommended compliance program guidance gives the document the appropriate weight.

To the extent that policies rely on identified regulations, it is prudent to map those regulations to those policies. The challenge for the document author, however, is the reality that these primary source documents may be updated much more frequently than your regularly scheduled review and revision. Consider instead providing context and a link to a place where the primary source document is kept up to date; state in your policy that the organization intends to comply with rules set forth in the target document, and then provide the link. In the appendix of the document, copy in the primary source language that was in place at the time of the document approval with the note to check for updates.

The process of continuous monitoring of regulatory updates can benefit significantly from technology. One approach is to dedicate a single person to be responsible for reviewing incoming documentation and electronically disseminating information to the subject matter experts for analysis. Using technology to filter regulations so that only those pertinent to the organization are visible would

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increase their efficiency. Another strategy is for the subject matter expert to set up automatic alerts to prompt review of policies for which they are responsible, rather than setting an arbitrary time-based review schedule. A combination of both approaches will provide you with the just-in-time data needed to ensure the appropriate adjustments are made before effective dates.

When updates to a regulation are discovered, the subject matter expert should read and understand the change(s) and assess the impact of the changes on the organization, including a review of applicability, a review of current policies and controls to determine necessary changes, an analysis of organizational risk associated with the policy, an assessment of necessary additional communication, training, and/or monitoring procedures. This impact analysis should be standardized across the organization so that all areas are assessing impact in the same manner. An example of an impact analysis that went horribly wrong involved the 2005 Deficit Reduction Act (DRA). Many hospitals assessed this law and incorrectly established that it impacted them directly. While the DRA had impact on hospitals it applied directly to states only and hospitals were only impacted once their particular state created the appropriate regulations. So while the DRA was informative about things to come, it was imprudent to act too hastily as states had the option to implement the DRA or not.

If policies need to be written as a result of a regulatory change, creating a template for policies to maintain consistency is imperative. Policy sections most likely contain the traditional purpose and scope, policy statement, definitions, procedures and legal sources, but should also include sections for sanctions, policy approvers and owners, effective date, last reviewed date, links to related policies and any training, and finally auditing or monitoring (how often and by whom). Another useful section would be a history of changes and/or a robust version tracking of the policy. During an audit, it may be necessary to go back in time and show what policies you had in place at a particular time, and even to identify the person or rule that drove the policy to understand the intent of the policy. Keeping track of frequently asked questions associated with a policy is also a good practice, as they will assist those interpreting the policy as well as assist the policy owner in clarifying future policy language.

Procedures, on the other hand, generally provide step-by-step instructions on how to achieve goals within the confines of the regulations. So, returning to the football analogy, procedures are like the playbook: a compilation of strategies to operate within the confines of the rules. Creating appropriate procedures requires

Using a research product like the [Compliance Suite](#) gives you the ability to search across multiple document types:

- Coding information
- Coverage determinations
- Regulatory issuances
- Enforcement/decision documents
  - Appeals
  - PRRBs
  - OIG reports

Search on multiple search terms simultaneously, or utilize the alerting structure to inform you of new documents containing your targeted search terms.

Best practice is to name your stored searches after the related internal policy so that your automatic alert prompts you to review the new information and specifically points to the update work that might be necessary.



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working with subject matter experts and line staff to determine the most optimal workflow; procedures should document that workflow in the simplest terms possible. When writing procedures, you should also consider how and how often they may be referenced and organize them appropriately.

After procedures are documented, the organization should consider creating a companion document that includes auditing/monitoring procedures specific to this workflow, enabling auditors to compare actual practices against desired outcomes. For example, a standard within a procedure can establish that a 90% validation is acceptable when auditing this policy.

Of course, it is not necessary to write all of your policies from scratch. In fact, relying on trusted authorities to start your process, and then modifying from the pre-written information to customize to your organization can save you time and provide additional insights. From a regulatory issuance perspective, here are a few places where you can find good verbiage to get you started:

- Rather than using the language from the CFR or Federal Register, use the language from the CMS Internet Only Manuals which may be written more concisely.
- The executive summary of most OIG Audit Reports provides an excellent summary of the CMS regulations that were under investigation and the interpretation of how those requirements should be put into practice.
- CMS publishes a myriad of fact sheets, job aids, and MLN Matters educational material handouts; as do many of the Medicare Administrative Contractors which can be excellent sources for concrete "how to" and "why" reference material.
- Corporate Integrity Agreements contain the concrete elements a health care organization has agreed to put into place to mitigate issues related to an OIG investigation; these are policies and procedures specifically approved by the OIG and are an excellent boilerplate.

Of course, after all is said and done, policies and procedures are only worthwhile if they are well communicated to the organization. There should be a single record of truth when it comes to policies so that the organization has confidence the latest version is always accessible. Emergency policies should be kept in a separate binder in case of power or computer outages, but all other policies are best disseminated electronically. Policies that are particularly important should require employee attestation to ensure that they are seen, read and understood.

It is worth noting that although we are emphasizing policies and procedures, many of these same management strategies can be applied to other documents, including "how to" manuals on the systems your staff use, etc. It is critical that these types of collaborative documents are stored in a shared location using a robust document management system, providing a secure location, the ability to check documents in or out to support version control during collaboration by multiple authors, a formal editorial review and approval process, and an archive of all past versions with clear delineation of who authored, reviewed and approved each version.

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Having discussed a general framework for policy and procedure management, one can see how pertinent this process could be to the audit framework. Establishing standards that assist staff in doing things right the first time is always a recipe for success. However, mistakes still happen, so having policies that include methodologies and standards for monitoring adherence to those policies will allow the organization to correct errors before they can be found by outside auditors. And finally, a policy and procedure establishing how to handle various types of external audits can offer a measure of control for an organization that is interested in putting its best foot forward. Outlining the audit process ahead of time helps clarify who in the organization are the key points of contact should an audit of a particular type occur.

Policies and procedures are the life-blood of an organization because they help people in the organization understand what is expected of them and how to perform their daily duties within the confines of the organization's guidelines. In other words, they are an essential tool for building regulatory awareness. From an audit perspective, a policy and procedure can give all people in the organization a view into the audit process, preparing them for steps to be taken and what they might be expected to provide. In addition, a clear view into the audit process can be a powerful deterrent: by letting people see how much extra work an audit can cause, they will be more likely to check and double check. This will not avoid some imposed auditing, but it will make the appeal process smoother and provide all those involved a measure of confidence.

**Education/ Training****Routine Education**

Education and Training is another key offensive tool in the prevention of future audit activity, as well as in protecting the organization when audits do in fact occur. Because the delivery of health care today has become incredibly complex and highly regulated, keeping up with the regulatory changes impacting a health care organization from delivery of care to reimbursement can be a daunting task for any health care professional. Therefore, it is imperative that organizations define and execute ongoing educational programs to proactively keep staff informed of regulatory and coding requirements, how to remain compliant with the various rules and regulations impacting the organization, and how to remain compliant with the organizational playbook (e.g., policies & procedures in order to prevail if subjected to audit).

**Kickoff your offense with ComplyTrack Document & Policy Manager**

Create, manage, and distribute documentation while maintaining strict control across the enterprise. Address all stages of a document or policy's life cycle from developing a new document to version tracking all the way to distribution. [ComplyTrack Document & Policy Manager](#) provides the solution to maintaining an offensive-minded Policy program.



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The best strategy is planned routine and periodic education. A comprehensive education plan should outline compliance topics and risk areas for review on at least an annual basis including a review of the organization's code of ethics, HIPAA privacy requirements, Stark rule, and patient safety, amongst others. Not to be forgotten is a review of the organization's audit workflow process, as all parties must understand their roles and responsibilities. Topics specific to current or future regulatory and coding requirements are critical. For example, as payment systems and transaction code sets evolve on an annual basis, it is imperative that organizations provide education on upcoming transaction code set changes as well as changes to the various applicable payment systems (OPPS, IPPS, PFS, Psych PPS, etc.) impacting the organization.

**Role Based/ Department Education**

While general education is necessary, each health care player is uniquely impacted by regulatory and coding changes; therefore, specialized role based education becomes absolutely critical. In some instances training can be specific to a defined role or position within the organization across multiple areas or to groups of individuals. To demonstrate this take a look at the education that will be needed in preparation for the transition to ICD-10. Varying levels of ICD-10 education will be needed across the organization. High-level education might be provided to backend billing department staff not participating in day to day coding activities, while patient access and ancillary department staff will require more comprehensive training, versus the HIM coders who will require the most intensive training. Just as the players on the football team must know the overall mechanics of each play and how the play functions, the players in specific positions must be intimately familiar with their specific role and place on the field.

**Round out your playbook with resources for writing policies and procedures**

Consider investing in a bank of pre-written policies and checklists by a trusted publisher like [Aspen Publishers](#). Here are some example titles that can be modified by your team:

- Emergency Department Manual - Clinical & Administrative Forms, Checklists & Guidelines
- Health Care Billing and Collections - Forms, Checklists and Guidelines
- Health Care Compliance Professionals Manual
- Health Care Fraud and Abuse Compliance Manual
- Health Care Registration - Forms, Checklists and Guidelines
- HIPAA Compliance Handbook
- Hospital Contracts Manual
- Hospital Legal Forms, Checklists and Guidelines
- Infection Control - A Practical Guide for Health Care Facilities
- Medical Group Practice - Legal and Administrative Guide
- Medical Lab Management - Forms, Checklists and Guidelines
- Medical Staff Management - Forms, Checklists and Guidelines
- Oncology Services Administration - Forms, Checklists and Guidelines
- Pharmacy Practice Management - Forms, Checklists and Guidelines
- Radiology Administration - Forms, Checklists and Guidelines



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In addition to role based training, department-specific education and training is also necessary, especially as it relates to coding changes. For example, this past year therapy coding and reporting requirements changed significantly and additional audit activity has directly impacted this area. This was the perfect offensive opportunity to educate the therapy department staff on the coding and regulatory changes to ensure that they were prepared.

Further, as many audit issues stem from inaccurate charge capture, it is also imperative that department-specific training is provided on a regular basis to ensure that staff is aware of and fully understands requirements impacting their area. Department charging staff must have an understanding of what each chargeable item represents, how it is to be charged, and any other associated billing rules impacting their services. They should also be provided with prompt feedback related to any issues identified more proactively through the billing cycle or internal review activities as part of just-in-time training.

Regardless of the method employed, all education and training efforts should be clearly documented, including the date of training, program content, attendees, method, and presentation materials utilized, as well as program effectiveness, most often evidenced through post-training testing.

Education and training is a key component to an effective compliance program. Robust training and education initiatives demonstrate to the auditing body the organization's intent to successfully comply with the myriad of rules & regulations. Up-to-date knowledge coupled with efficient workflow and well-defined policies and procedures enable organizations to have a winning season.

## Audit Workflow

### Managing the Request

Defining the audit workflow process, including specific roles and responsibilities, is another offensive maneuver in taming the impact that various audits can have on an organization's day to day operations. In managing the audit life cycle, whether it is a RAC, MAC, commercial payer or internal audit, it is imperative that organizations have clear processes in place to manage each type of audit request from the initial audit response through the ultimate audit outcome, including any appeal activity.

A variety of techniques can be leveraged across an organization to successfully deploy ongoing educational plans. Most organizations find success with a hybrid approach, with the mode of training determined by the audience and the complexity of the material to be covered.

- In-person Training Sessions
- Online Training
- Self-guided Training
- Vendor Training
- Lunch & Learn

Beyond formal training sessions, other techniques can be utilized to keep staff informed of changes. For example, Newsletters are a good informal vehicle for providing informational updates to staff, reiterating training efforts, reinforcing organizational policy, and providing routine updates on audit activity.



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Audit requests tend to find various entry points into the organization, especially within larger organizations or health systems. While it is optimal to have one central management point for all audit requests, even when specified there is no guarantee that requests won't find alternative points of entry. Alternatively, some organizations choose to assign RAC audit request management to a different business unit or workgroup than non-RAC audit requests. Therefore, all staff members must be able to identify various types of audit requests and who to contact within the organization when a request is received through an alternative entry point. The time taken to get the request to the responsible party within the organization can quickly eat away at the initial response game clock, so communication is of the utmost importance!

While the RAC program has consistent stages established with clearly defined due dates, this is not the case with other regulatory and payer audits, where due dates can vary drastically. Therefore, organizations must be attuned to each request due date, communicate those dates to the audit response team on a per-request basis, and respond promptly to all requests. Audit management systems can assist organizations in managing the process and add efficiencies by leveraging the ability to assign tasks, send reminders, and track ongoing progress throughout the audit lifecycle.

While the process itself can be centrally managed, responding to audit requests is most appropriately tackled using a multidisciplinary approach. Beyond producing copies of the requested record, internal review processes are required to ensure a comprehensive response to the audit request. Throughout the process, having the ability to assign tasks related to a request or specific claims associated with the request can facilitate the overall process, whether to copy records, review documentation, etc. An organization cannot lose track of assigned tasks associated with the required steps required to respond appropriately, so the system utilized must have the ability to track both the status of each task and of the request response overall.

## Tracking Audits

With audits coming at an organization from all sides, having a tracking process in place is mission critical. Some organizations view audit requests as a "task" item that can be checked off as complete once the requested records are sent back. Just copying the records and sending them back for review, however, is not sufficient. The response to the audit is just the beginning.

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The need for a tracking tool depends on the organization it will serve. Smaller facilities may be fine with a very basic tracking tool, while larger systems will require extensive detailed functionality and reporting capabilities. Regardless of its size, an organization that receives relatively few audits should not relax and believe all is well. The volume of audits will continue to increase substantially.

Audit tracking functionality should encompass all the steps required in the audit. As it is essential to ensure due dates are met, a tracking tool should alert audit management staff of upcoming and missed due dates. The tool should also ensure that the auditor is meeting its due dates. For Recovery Audits, the auditor must render its review results letter 60 days after it receives the requested records and they often fail to meet that requirement. Organizations should contact auditors when statutorily prescribed response times are missed and hold them accountable to their timeframes—they will certainly hold your organization accountable to its timeframes. With a solid tracking tool that alerts the audit staff to missed response times, the organization can more proactively communicate with the auditor to ensure more timely responses.

Audit management is a team sport, played across the entire enterprise by a diverse group of specialists. Not only are there many players to manage, but also there are a myriad of required steps, including: entering the audit into the tracking tool, compiling and sending the requested records, simultaneous review of the records for any aberrations or underlying issues, ensuring recoupments are monitored and documented, ensuring refunds are received and posted correctly in the event of an underpayment, and reviewing any denials for possible appeals. As these types of tasks are managed throughout an organization, audit tracking functionality should include an ability to assign these tasks with due dates to appropriate individuals across the enterprise to ensure everyone understands their required contributions and are accountable for them.

Reporting is also an essential part of audit tracking and management, with reports required by a variety of staff across the organization. Each functional area holds a unique perspective on the impact of the audit process. For instance, executives will use a condensed view of the financial impact to plan financial reserves accordingly, while the quality and coding staff want to know precise reasons for denials, using the information to identify trends to adapt their training and work product accordingly. As some functional areas may not know the value of audit tracking reports until they see them, the right report can increase buy-in across the organization—include as many areas in the outcome review process as possible.

The efficiencies inherent in technological solutions to provide significant support are just one piece of an overall ICD-10 readiness strategy. A solid combination of both CDI strategies, including education and training of the physician and technology, is required for a smooth, successful transition to ICD-10.



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The reporting functions in a tracking tool should include in-depth financial data, such as the comparison of original denied amounts and final denied amounts. The reports should also be able to demonstrate specifically where issues are, such as codes/physicians/procedures that are costing the organization money, as well as show the status of tasks across the organization to identify and document functional areas or individuals who are consistently not meeting required due dates. In summary, while the reporting needs of an organization vary greatly, the audit tracking process in place should provide a deep understanding of all audit-affected functional areas.

## Managing the Appeal Cycle

Managing the audit appeal process is vital to limiting exposure under any audit program. Although a variety of audits bring with them differing appeal processes and levels, the audit tracking tool must be able to manage audits through all levels of appeal and should allow for the wide variety of appeal stages and time frames from the ever-growing list of audit types.

An organization should evaluate the success rate of their appeals processes (whether internal or external) regularly. The audit tracking tool reporting functionality should include an ability to review appeal outcomes, and, using the appeal outcome data, a policy should be developed to dictate when appeals are warranted (a dollar threshold and/or specific denial types) and what levels of appeals should be pursued, giving the organization a standard process for reviewing when to appeal and when to cut its losses and move on.

The appeals management process can be handled internally or can be outsourced to a professional organization, of which there is a growing list. As the cost and quality of these professionals vary greatly, each organization should determine if an external appeal professional should be used only on certain case types or at a certain appeal level or dollar threshold as well as constantly revisit the value external audit management professionals bring to the process.

## Converting Audit Findings into Risk Mitigation Strategies

### Root Cause Analysis

In taming the audit beast, it is also important for organizations to understand why at times they are unsuccessful when faced with an audit and to be inquisitive about:

- What went wrong?
- Which process failed?
- How can a recurrence of the issue be prevented moving forward?

Remember, to be wise and seasoned in the health care industry is to know that every compliance issue is an operational failure. Organizational leadership must invest time in root cause analysis to ultimately improve processes, enhance staff knowledge and reduce any future risk to their revenue.

Reporting related to the audit outcomes is a critical first step in root cause analysis. Utilizing an audit management system, organizations can quickly get their arms around the most frequent outcomes across the various audit types and further drill into the qualities associated with each issue population, such as patient type, place of service, specific DRGs, diagnoses, procedures or medical staff members. This will enable the organization to further prioritize its investigations. Let's face it: no organization has an abundance of time on their hands, so strong data analytics is critical, allowing the organization to focus efforts on specific problem areas.

Data analytics alone may not be enough in determining the root cause of audit findings, more than likely further hands-on analysis will be required once target populations have been identified. This may involve engaging HIM professionals to review coding, a CDI specialist to review supporting documentation, clinical department and charge master staff to evaluate charge capture processes, or utilization staff to evaluate the patient placement processes, as well as engaging other professionals throughout the organization. These analyses will assist in defining improvement opportunities throughout your organization, in some instances uncovering employee issues, workflow issues, resource availability issues, or the need for additional education and training. Further quantification of the root causes identified through these subsequent analyses will enable organizations to prioritize and implement improvement opportunities to mitigate future risk.

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## Workflow Redesign

Once the root cause of the operational breakdown is understood both quantitatively and qualitatively, operational processes often need to be redesigned to prevent the same issues in the future. Although the clinical and financial impact may be significant, sometimes the workflow change can be simple and far less costly than the risk associated with failing to mitigate the issue, often as simple as providing staff with the right tools and information. As an example, consider the World Health Organization's surgical safety checklist, a simple set of common questions and statements made before, during and after surgery to prevent errors. Implementation of this takes very little time, training is fairly straightforward, the checklist fits on a laminated notecard in the surgical suite, yet the impact is huge. A study conducted in the Netherlands from October 2007 to March 2009 and published in the New England Journal of Medicine found that the consistent use of a checklist reduced surgery complications by more than one-third and deaths by almost half (from 1.5% to 0.8%) in test hospitals compared to control hospitals.

This kind of simple offensive strategy has immeasurable impact on the financial risk of the organization. Similar workflow redesigns exist for the most common audit risk areas as well. For instance, ensuring that your registration and scheduling, coding, billing, and claims denials management staff have the right resources up front will save significant time later investigating improper information. As an example, here is a short list of resources from AMA and CMS that staff should have access to and understand how to use:

- Up-to-date coding information and descriptions for CPT, HCPCS, ICD-9-CM and now ICD-10-CM and ICD-10-PCS, in an easy to use format that does not slow them down or become an obstacle.
- Easy access to payment indicators, local coverage determinations and benefit policy rules to ensure that Medicare patients receiving non-covered services are provided with advanced beneficiary notices. It is also a good idea to use these published materials to inform the clinical documentation improvement program so that clinicians are prompted to provide appropriate specificity at the time of ordering a test or procedure.
- Resources which explain the most common claims errors to allow the coder and biller to complete the claim right the first time. This should at a minimum include gender and age edits, national correct coding initiative (NCCI) edits, Medically Unlikely Edits (MUEs), and coding instructions from the AMA, but should expand to include common inpatient edits (CC/MCC, present on admission codes, and codes not allowed to be presented as a reason for admission) and other edits like quality reporting rules.

## Manage Root Cause Analysis with ComplyTrack Activity & Event Manager

Activity & Event Manager (AEM) is a powerful solution that administers your organization's compliance, audit, and risk activities from one central location. Robust documentation tools and precise workflows make Root Cause Analysis projects easy to administer. Coupled with robust reporting capabilities, AEM empowers your organization to gain clear insights into issues and track them through to complete mitigation.



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Not only is access to resources important, but also equally important is the ease of use of those resources. While coding resources may be available within your chargemaster or electronic health record solution, check with the professionals utilizing these resources in their daily workflow when considering the option for more comprehensive and easy-to-use tools, like the Coding Suite.

And finally, if a workflow review results in process redesign, you cannot forget to update existing procedures to reflect these changes.

## Education/Training

As discussed previously, proactive routine education and training is a critical strategy in mitigating overall risk. Equally important, however, is education specific to issues identified through the audit process and root cause analyses conducted. Often negative audit outcomes result from a failure to follow a defined procedure, from a lack of understanding of the existing procedures, or from an incomplete understanding of the current rules and regulations.

To further mitigate negative audit findings in the future, educational initiatives should specifically be targeted to these risk areas. Focused, in-person training sessions should be conducted with populations where specific policies and procedures have not been followed to ensure that all parties have a complete understanding of the defined process as well as the associated regulatory and coding requirements. While it may be appropriate to conduct an overall review of the process with all involved staff, it is imperative that education is focused toward staff that has specifically demonstrated a deficit. The importance of proactive and just-in-time training cannot be underscored enough, as staff must be armed with the right regulatory knowledge, resources and tools, and defined processes and controls to establish the most effective game plan to mitigate future risk to the organization.

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## Our Solutions

**Confidently manage audit and risk, track with regulatory change and drive compliance with ComplyTrack and Regulatory Solutions from Wolters Kluwer.**

Your bottom line depends on the ability to manage audits and risks, and maintain an enterprise-wide culture of compliance while keeping up with constant change. Proactively assess, communicate, and—most importantly—mitigate risk across your entire enterprise in the face of constant regulatory change. These powerful solutions give you the visibility, controls, and workflow tools you need to manage your GRC program from the top-down and the bottom-up. Our up-to-date regulatory content and unparalleled expertise are woven into the question sets and controls for complete decision support. Confidently manage audit and risk and drive compliance with our customized, scalable SaaS solutions created and supported by experts in healthcare audit, risk and compliance.

**Today the volume and complexity of audits and appeals has grown too high, too fast to manage.**

Reactively, you know you need an automated workflow solution to increase the efficiency and accuracy of all your claims-based audits. But to get out ahead—to proactively reduce your audit risk—you need to add predictive analytics and you must keep up to date with the daily changes to the regulations. Use business intelligence to not only proactively mitigate your audit-related risk, but also to uncover coding, compliance and reimbursement risks and opportunities hidden in provider claims and other detail data.

Track both RAC and Non-RAC Claims-Based Audits from letter to last appeal with the ComplyTrack [Audit Detail Manager \(ADM\)](#) solution. Increase efficiency and accuracy by focusing the efforts of audit response teams on the overall process, eliminate redundant manual processes,

and document the audit impact for facility management and board members. Add ADM Connect to track and manage the decision workflow through every appeal with Executive Health Resources (EHR), with real-time electronic communication. Use ADM Gateway, with MEA's esMD capability built right in, to help handle the high volume of record requests. With this complete, integrated workflow and communication management solution, you can quickly attain real financial return on your investment without an investment in additional staff.

When combined with the powerful capabilities of ComplyTrack's [Document Policy Manager](#), [Survey Manager](#), and [Risk Assessment Manager](#), you can proactively manage all aspects of audit management across your entire enterprise.

**Quickly access the up-to-date information you need to make informed coding, compliance and reimbursement decisions while streamlining workflow processes**

The [Coding](#) and [Compliance](#) Suites provide advanced primary source content and expert tools—updated in real time—to ensure the integrity of your program, revenue, compliance and audit documentation. Both suites are available in three levels, to ensure we can fit the right solution to the right resource. Each suite includes all the resources that your coding, compliance, billing, reimbursement, and HIM teams need to work effectively, whether it's a simple coding tool with integrated medical necessity information, support for claims processing rules and edits, a provider-specific Medicare-compliant reimbursement resource, high-level CFR and FR searches, or a deeper dive to support compliance program reviews and accreditations.

**Know what's right, right now.**