



## Medicare Prepayment Reviews: Revolutionizing Healthcare Compliance

- » How clear, historical data can help hospitals improve the quality of claims

### Executive Summary

In a move that promises to revolutionize the healthcare compliance landscape, the Centers for Medicare and Medicaid Services (CMS) has launched a plan to dramatically expand prepayment reviews on Medicare claims. The prepayment audits are expected to lower appeal rates, lessen the burden on hospitals, and save CMS money. Ultimately, CMS anticipates that the audits will prevent improper payments by encouraging healthcare organizations to reduce or eliminate the processes that create errors in the first place.

With the recovery audit contractor (RAC) prepayment reviews expected to take effect nationwide, the onus for reducing improper payments now rests squarely on the hospital's shoulders. No longer can healthcare organizations take a wait-and-see approach to Medicare audits. The prepayment audits will affect cash flow and documentation requirements and drive system-wide process improvements.

To respond to prepayment audits with confidence, hospital administration must work with financial, clinical, and medical personnel as equal partners to coordinate care and ensure long-term compliance. This paper examines how data analytics solutions can help hospitals with this endeavor. The right tools will enable hospitals to review their processes and data to proactively prepare for prepayment audits and ensure the integrity of their revenue.

### Market Drivers: The Evolution of Medicare Reviews

The move toward prepayment audits is considered by some to be more evolutionary than revolutionary. Seen as the next logical step in reducing improper payments, prepayment reviews capitalize on the results garnered by RACs and prepayment reviews historically conducted by Medicare audit contractors (MACs).

The progress of the RACs has proven fruitful. To date, Medicare compliance reviews have netted the HHS Office of the Inspector General more than \$4 million, and the process is only in its infancy. The current estimated error rate with Medicare claims is 8.6 percent, which translates to \$29 billion spent on erroneous claims.

Given these results, the move to prepayment audits makes good financial sense. In stark contrast to the previous pay-and-chase methodology, prepayment reviews allow the government to hold onto its money while the hospital proves that its claim is valid.

Yet while the shift makes sense in the government's eyes, the change puts hospitals on the defensive.

"It's a whole new ball game for us," said Monica Lenahan, CCS, coding education and compliance manager at Centura Health in Englewood, Colo. "It really is a huge payment burden."<sup>1</sup>

With prepayment reviews, CMS will increase the number of claims subject to review from 1.2 million to 2.7 million claims per year. The following types of claims, representing high improper payment rates, will take center stage in the new audits:

- » Short hospital stays (two days or less)
- » Claims incorrectly coded with the wrong diagnosis-related groups (DRGs)
- » Patients who should be treated in ER observation rather than be admitted
- » Elective surgery patients with short-term stays who should have been treated on an outpatient basis

As an incentive to hospitals that take corrective action to reduce their erroneous claims, CMS will remove an organization from its list (for a particular DRG) if prepayment reviews show no findings. And if a claim passes prepayment scrutiny, it is exempt from any future audits.

So while prepayment audits place a significant burden on the hospital, those that make relevant and noteworthy process improvements will weather the change with relative ease and actually avoid some of the post-payment auditing scrutiny.

## Challenges: Process Improvements Required throughout the Healthcare System

There is little doubt that the most significant effect of prepayment audits is on cash flow. No longer can a hospital submit a claim, receive payment, and then worry about any audits. Very simply, cash flow stops until all erroneous claims are corrected.

"For the first time ever, this is impacting our cash flow," said Paul Belton, vice president of corporate compliance at Sharp HealthCare in Southern California.<sup>2</sup>

With such a significant impact on a hospital's bottom line, process improvements are more important than ever. Specifically, all claims must be appropriately documented.

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Manager, Centura Health

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Compliance, Sharp HealthCare

Documentation guidelines state that all claims must be complete, identify the patient, support the diagnosis, justify the care and services provided, and document the course and results of care. In addition, physicians must clearly state what is apparent in the patient condition that requires an inpatient setting rather than ER observation or outpatient care. What's more, claims must be dated, timed, authenticated, and legible.

With cash flow on the line, these requirements cannot be ignored. For a claim to be denied for something as simple as a missing signature is simply unacceptable. For the hospital that chooses to make them, system-wide process improvements will help ensure complete and accurate documentation.

At the same time, physician documentation will receive more scrutiny than ever before. Auditors have denied some surgical procedures because the hospital's documentation did not support medical necessity. The medical necessity documentation resided in the surgeon's records.

For example, for a major joint replacement to meet medical guidelines, the documentation must include failed prior treatments. Often, the hospital's legal record doesn't have this information since it often resides in the physician office record or even outpatient physical therapy records.

Thankfully, the prepayment reviews give the hospital leverage with physicians, since prepayment auditors will review physicians' claims if the entire hospital admission is denied.

"Now it affects physicians' bottom line, and they're very interested in this," said Lenahan. "If we're getting a payment denial, they're getting one right behind it."<sup>3</sup>

Hospitals and physicians will benefit from an objective, critical review of all documentation. They should ask themselves:

- » Does the documentation clearly show why care could not have been provided on an outpatient basis?
- » Are electronic medical records systems implemented thoroughly and consistently to avoid documentation gaps?
- » Does a review of post-payment audit documentation show any vulnerabilities?

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The days of documentation gaps caused by time are over. No longer can a hospital claim that a physician has left the organization, that computer systems have changed, or that processes are different. Prepayment auditors are reviewing current, “here and now” documentation.

The physician’s judgment of the care and course of treatment will not be called into question. It’s the documentation supporting the physician’s decision that will be examined.

In the end, the documentation must thoroughly tell the appropriate story for each and every patient. It must substantiate revenue integrity and stand up to critical scrutiny now and against any future audits.

## **Solution: Data Analytics Drive Intelligent Claims Improvements**

Given the heightened scrutiny that a hospital’s claims will face, what can be done to reduce or eliminate the processes that create incomplete or erroneous claims in the first place?

Recognizing documentation requirements is the first step. However, to thoroughly prepare for the changes that prepayment audits will bring, hospitals must review their data and historic audit results to identify where vulnerabilities may exist.

The answers lie in data analytics. A complete evaluation of previous audits and any data behind them will help hospitals determine where future audits might happen. Predictive modeling methodologies will identify where the highest potential for error might exist.

Given the high stakes, the time to fix processes is now, not after a prepayment review is made. A review of healthcare legislation shows that regulatory agencies are armed with strong data analytics solutions. With extensive data at their fingertips, auditors can now pinpoint high error rates and target them for prepayment reviews.

It stands to reason that healthcare organizations would be well served by the same data and analytical expertise when reviewing their own claims.

### Evaluate previous audits and data

When evaluating data, it's important to understand that the government will not review every claim. Prepayment auditors will focus their efforts where they will find the best return.

To understand where weaknesses lie, data analytics solutions can help an organization evaluate its data with several features:

- » Reports on previous audits by DRG and by physician
- » Reviews of audit risk across entire claims volume (via 837 billing data)
- » A rules engine based on audit rules
- » Ongoing self-audits performed against 100 percent of claims based on actual audit rules
- » Complete historical data going back three years

Data analytics solutions offer a complete array of reports, including claims audited, denied, overturned, and paid. All claims are categorized by DRG and identify the associated physician.

While such data will empower hospitals to improve their own processes, it also helps motivate physicians to improve. Data will show physicians the need for improvement initiatives, including clearer documentation, better protocols, and clearly defined discharge processes. What's more, the hospital can convince the physician that doing it right the first time will eliminate the need for time-consuming appeals.

### Manage the audit process

With typical audits, a data analytics solution proves useful in managing the audit process, including making sure deadlines are met. With prepayment audits, there are no deadlines. The government will simply withhold payment. So it's all the more important to deploy a solution that tracks audits, automates the audit process, and ensures quality documentation.

In addition, a data analytics solution will track the success rate of prepayment audits to ensure a claim doesn't get audited twice. A claim that survives scrutiny in prepayment review is exempt from future audits. However, with so many auditors involved, a claim getting audited twice is certainly possible.

In fact, one large hospital system experienced this fate but did not recognize the duplicated audit until it was too late. The organization voluntarily repaid millions of dollars based on an extrapolation methodology. A recovery auditor then audited the same claims and recouped over \$2 million.

Had the organization deployed a system that managed and tracked audits, it would have avoided the extensive struggle of getting the money refunded. What's more, while the organization waded through the red tape, millions of dollars were held up.

### Make clinical and documentation process improvements

If an organization's data evaluation shows vulnerabilities in clinical and documentation processes, the organization can use this information to make meaningful improvements. Having a concrete project plan to assess, evaluate, act on, and monitor past results can increase future audit success rates.

Effectively working with case management, utilization review, and clinical document improvement specialists will serve as the foundation for process improvements.

Even simple checklists will help improve documentation:

"There may be lots of documentation in the physician record that would help us substantiate these procedures," said Lenahan. "We're establishing a checklist at the beginning of the process to ensure that we have everything we need because we're pretty sure this will be challenged on the back end. That's something we've never done before."<sup>4</sup>

At the same time, more complex processes may need to be improved. For example, the organization should assess whether its medical necessity admission review process is in effect seven days per week, 365 days a year. Off-hours admissions create significant challenges. Since short stays are a focus of prepayment audits, a physician can no longer "just admit and check on the patient in the morning."

What's more, electronic medical records systems will play a big role in ensuring complete and accurate documentation. These systems can be designed to capture the necessary requirements in a way that paper is simply unable to provide. Hospitals would be wise to evaluate their electronic medical records systems and adjust them as needed to ensure all documentation needs are met.

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### Capitalize on the silver lining

Despite the “sky is falling” mentality that prepayment audits often instigate, there are several benefits of the change that offer a silver lining. Given that a data analytics solution can be so crucial in helping a hospital respond to prepayment audits and that the audits have such a profound effect on cash flow, compliance departments may secure the buy-in they need. Whether that buy-in comes in the form of resources or corrective actions from finance, the direct cash flow impact will be powerful and difficult to deny.

Upper management will see that data and predictable results are the best offense for prepayment audits. Not only will this help compliance get the help it needs, but it will help improve the negative reputation that often plagues compliance professionals. Prepayment reviews may actually help compliance gain credibility and earn value within the organization.

Another silver lining offered by prepayment audits is the reduction in the money and resources spent on appealing audits. If claims are improved and documentation is accurate from the beginning, few appeals will be necessary. In fact, given that a lack of resources often limits the number of claims a hospital can appeal, improving claims upfront will help ensure the hospital gets every dollar earned.

Finally, prepayment reviews and any improvements to claims will help ensure the integrity of the organization's revenue. Ensuring revenue integrity can demonstrate to auditors a sincere, substantive attempt at process improvement and provides considerable peace of mind to finance and compliance professionals.

### Conclusion

With prepayment reviews representing the next step in the evolution of reducing improper payments, healthcare organizations must take a proactive approach to ensuring the integrity of their revenue and the quality of their claims and documentation.

Threatening to dramatically alter cash flow, prepayment audits will force hospitals to take responsibility for the quality of their claims. No longer can hospitals take a wait-and-see approach to Medicare audits.



Compliance professionals must also recognize that if the government finds success with prepayment reviews, commercial payers and Medicaid programs will follow suit. If Medicare prepayment reviews consistently drive claims improvements, why wouldn't other payers do the same?

Healthcare organizations that don't take corrective action will be hit hardest by prepayment audits. Conversely, organizations that improve their processes, evaluate data for vulnerabilities, and ensure complete documentation will respond to prepayment audits with confidence.

### About MedeAnalytics

Founded in 1994, MedeAnalytics delivers performance management solutions across the healthcare system—including hospitals, physician practices and payers—to ensure accountability and improve financial, operational and clinical outcomes. For more information, visit [www.medeanalytics.com](http://www.medeanalytics.com).

## References

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