

Instructions for Using the Audit Tool for Admission and DRG Review

Purpose

The audit tool for admission and DRG review can be used to evaluate the appropriateness of admissions, procedures, readmissions, transfers, and DRG assignment. It can be used to identify problems in these areas or to monitor improvement in any areas previously identified as problematic. This form may be utilized to perform post-payment (retrospective) or, with some adaptation, prepayment (prospective) review.

Record/Claim Comparison

Before conducting an audit, compare the medical record to the claim to ensure that the documentation matches the information on the claim. If the medical record does not match the claim in terms of the patient name, admission date, physician orders, discharge status, and/or provider number, a payment error may result. You may need to consult with the physician and provide an addendum to the medical record, correct the claim and rebill the services, or take other action. Ultimately, you must ensure that the medical record reflects the services rendered and that the claim is consistent with the medical record documentation.

Admission/Procedure Review

Review the medical record to determine if it supports that the patient had a condition and received treatment that could only be performed in the inpatient setting. In addition, evaluate the medical necessity of any surgical procedures performed. You should use physician-developed screening criteria to evaluate medical necessity. Refer cases that fail criteria to a utilization review physician. He or she should contact the attending physician to determine if additional documentation can be provided to support the admission/procedure. If you determine that an admission was not medically necessary, or that it was required only for a surgical procedure that was not medically necessary, evaluate potential causes of the problem. Establish the causes of the problems, such as deficiencies in your utilization review program, physician knowledge deficits, changing standards of care, documentation inadequacies, or other issues. Ultimately, you should implement corrective action that will prevent a recurrence.

Short Stay Admission Review

Review the medical record to determine if there was medical necessity for a short stay. Because admission is questionable when stays are shorter than the expected average length of stay for a specific diagnosis related group (DRG), you should closely evaluate whether the patient could have been cared for in outpatient observation or other alternative to inpatient admission; or, if the patient was cared for initially in outpatient observation, whether the patient could have remained in observation. You should refer these questions to a utilization review physician. If your physician determines that admission was unnecessary, evaluate potential causes of the inappropriate admission and implement interventions to address the problem. If the patient was admitted after a stay in observation, the physician should also evaluate whether the patient needed inpatient admission earlier. If you determine that the patient needed inpatient admission earlier, you should evaluate why this did not occur and establish the cause of the problem. Ultimately, as stated above, you should implement corrective action to prevent recurrence.

Readmission Review

Review the medical record to determine if readmissions were related. If it is determined that they were, ask a utilization review physician to evaluate whether a problem on the first admission necessitated the readmission. Your physician should determine if the patient was stable on discharge on the first admission, or if the readmission occurred because of internal technical problems such as scheduling delays. Refer to the fiscal intermediary for appropriate billing when the patient was readmitted for care that should have been provided on the previous admission but was cancelled or rescheduled due to unavailability of surgical suite, the surgeon becomes ill, etc. If the readmission was due to premature discharge or incomplete care, then the readmission was unnecessary and therefore, a payment error exists. Premature discharges should be referred to your quality review committee or other peer review process for follow-up. Evaluate and establish causes of problems such as discharge planning deficiencies, internal resource or scheduling problems, or physicians simply sending patients home too soon. Ultimately, corrective action should be implemented to prevent recurrence.

Transfer Review

Review the medical record to determine the appropriateness of transfers (PPS to PPS-exempt areas or vice versa). Refer any questions to a utilization review physician. If the patient could have received the care needed in one area of the hospital rather than two, the transfer was not needed. Ultimately the causes of problems should be established and corrective action implemented to prevent recurrence.

DRG Review

List the principal and secondary diagnosis codes and the procedure codes. Review the medical record to ensure that the documentation supports the principal and secondary diagnoses as well as the procedures and indicate this in the second column (Y/N). The principal diagnosis must 1) have been the principal reason for admission, 2) have been present on admission, and 3) received treatment or evaluation during the admission. If questions arise as to the presence of a condition, query the physician. The physician must document any addenda in the medical record.

Determine if the diagnosis and procedure codes are correct as originally billed (third column, Y/N). If they are not, determine the cause of the coding error (fourth column). List the revised diagnosis and/or procedure codes (fifth column) and indicate in the sixth column the cause of any DRG change.

Result of Review

Indicate whether the DRG was originally billed correctly, whether the inpatient admission was found to be appropriate, and whether any billing errors exist. State the rationale for revising a DRG or finding an admission inappropriate. If any payment error is identified as a result of this review, the hospital must submit an appropriate adjustment to the Medicare Part A fiscal intermediary.

Note regarding documenting auditor name and date: *You should sign and date the audit form. This allows you to be able to demonstrate that audits are being performed to ensure an effective compliance program. Also, should a government investigation occur in the future, this documentation will demonstrate that auditing pre-dated the investigation. Be certain to consult with your legal counsel regarding how to document this type of information.*

Compilation of Summary Report

Note any problems that were identified. Your legal counsel should guide you regarding how to document this and the following information.

Develop recommendations for corrective action specific to the problem. Initial recommendations may be for physician review to be performed on the problem cases. Based on the final review, corrective action may ultimately include education such as coding education for coding staff or documentation training for medical staff. It may include obtaining better coding resources for staff or new coding software, enhancing the utilization management or discharge planning program, or performing pre-admission review, pre-surgical, pre-transfer, or pre-discharge review on certain physician's cases.

Note regarding follow-up: *Compile individual audit results to identify any undesirable patterns and trends. Once a problem area or opportunity for improvement has been identified, you should implement corrective action. Establish indicators that allow you to target cases for auditing to monitor improvement. Indicators may involve such areas: one- and two-day stays, readmissions within three days, admission for particular procedures, etc. After improvement has been noted, you may want to focus on new areas, being sure to periodically recheck this area to ensure that improvement is sustained.*

Audit Tool for Admission and DRG Review

Patient Name: _____ HIC: _____

Age: _____ Sex: _____ Admission date: _____ Discharge date: _____

Billed principal diagnosis: _____ ICD-9-CM code: _____
(narrative)

Admission Review

Record/Claim Comparison	Yes	No
Does documentation in the medical record:		
a. match the claim being reviewed (patient name/admission date);	_____	_____
b. contain an inpatient admission order for the date of admission and the level of care billed, e.g., inpatient versus outpatient;	_____	_____
c. match the discharge status billed; and	_____	_____
d. match the provider number billed, e.g., PPS versus non-PPS?	_____	_____

If any of the above are "No," a potential payment error exists.

Admission/Procedure Review

Use screening criteria to determine the following:

1. Did the patient have a condition that could only be treated in the inpatient setting?	_____	_____
2. Did the patient require treatment that could only be performed in the inpatient setting?	_____	_____
3. If a procedure is the sole reason for the admission, does the procedure meet criteria for medical necessity?	_____	_____

If any of the above are "No," refer the case to a physician reviewer to determine medical necessity of the admission/procedure.

Short Stay Admission Review

Is it possible that care could have been provided using alternatives to admission such as outpatient observation, home health agency, or skilled nursing facility care? _____

If this is "Yes," a potential payment error may exist. Refer to a physician reviewer to determine medical necessity of the admission.

Readmission Review

Was this readmission within three days?	_____	_____
1. If yes, was the condition necessitating this admission related to the previous admission?	_____	_____
2. If yes, refer to a physician reviewer to determine:		
a. Was the patient prematurely discharged on previous admission?	_____	_____
b. Was the patient readmitted for care that should have been provided on the previous admission, e.g., surgeon ill or surgical suite not available and surgery canceled and rescheduled?	_____	_____

Transfer Review

If this case involved a transfer from a PPS to PPS-exempt or vice versa, was the transfer medically necessary? _____

If this is a "No," a potential payment error may exist. Refer to a physician reviewer to determine medical necessity of the transfer.

DRG Review

Billed Diagnostic ICD-9-CM Codes	Supported by Medical Record (Y/N)	Coded Correctly (Y/N)	Other Coding Errors (A-E)**	Revised ICD-9-CM Codes	Cause of DRG Change (D1-D99)***	If Not Supported, Note Problems
Principal (1-3)*						
Secondary						
Billed Procedure Codes						
Billed Discharge Status						

DRG: _____

Revised DRG: _____

- * The principal diagnosis must be:
1. The reason for admission
 2. Present on admission
 3. Treated or evaluated during the admission

- **
- A. Code does not match diagnosis/procedure
 - B. Code lacks specificity
 - C. Sequencing is incorrect
 - D. Coding does not follow ICD-9-CM coding conventions
 - E. Coding does not follow Coding Clinic guidelines

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- D1. Principal diagnosis not present at admission
 - D2. Principal diagnosis not treated/evaluated during stay
 - D3. Principal diagnosis not principal reason for hospitalization
 - D7. Secondary diagnosis or complication/comorbidity billed but not substantiated
 - D8. Secondary diagnosis or complication/comorbidity substantiated in record but not billed and it changes the DRG
 - D9. Procedure omitted from claim
 - D10. Procedure billed but not substantiated in record
 - D12. Procedure determined to be medically unnecessary and must be removed from the DRG
 - D13. Disposition status is incorrect and it changes the DRG
 - D14. Patient's age is incorrect and it changes the DRG
 - D15. Correct diagnosis or procedure is incorrectly coded
 - D99. Other: _____

Result of Review

DRG originally billed: _____
 Correct
 Incorrect

Inpatient admission:
 Appropriate
 Inappropriate

Billed:
 Correctly
 Incorrectly

If incorrect, revised DRG: _____

Reviewer name: _____ Title: _____ Date: _____

State rationale for revised DRG or inappropriate admission: _____

Follow-up Action Required by Hospital for Payment Errors:

If payment errors are identified, the hospital must submit an appropriate adjustment to Medicare Part A fiscal intermediary.