



Billing and coding audits made easy

Dear reader:

HCPro, Inc., is pleased to present this 12-page report to help you perform billing and coding audits. This special report will offer you advice from the experts on auditing for accuracy of ambulatory payment classification coding, diagnosis-related group coding, one-day stay billing, evaluation and management coding, and same-day readmissions billing.

This report will serve as a tool to help you put top-notch auditing programs in place. We look forward to continuing to provide you with timely, pertinent information and tools to aid in your compliance efforts.

Sincerely,

Melissa Osborn

Melissa Osborn, managing editor

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Why perform billing and coding audits?

When considering compliance auditing, most providers focus on the fact that it must be performed pursuant to federal government regulations. Instead, try to put auditing in a more positive light.

When presenting the concept of medical-record and coding audits to the administration, governing board, and others, present it as a process that will improve the organization, rather than as a chore it has to complete. To make this shift, offer the following 10 benefits of medical record and coding audits:

1. Improved operational efficiency. If performed correctly, audits should identify all types of errors and direct you to the root of any coding problems. Audits can also increase productivity. If employees see auditing as a normal part of their work process rather than as a function that threatens their jobs, they are more likely to perform with a higher degree of effectiveness and efficiency.

2. Mitigated damages in the event of an investigation. The government considers the existence of an effective compliance program to be a potential mitigating factor in the event of an investigation. The key word here is “effective.” The auditing program must identify compliance concerns, create a feedback mechanism that prevents the same errors from recurring, and initiate repayment of any funds received in error.

3. Additional protection against certain legal exposure. An effective auditing program will likely uncover potential non-reimbursement related problems that could develop into legal issues, such as risk-management and quality-of-care issues. The organization will then be able to rectify these issues before they develop into full-blown legal exposure.

4. Improved data quality overall. If compliance auditing is performed appropriately, with the necessary feedback, education, and follow-up, it results in improved data quality. All data users have an interest in ensuring that data is reliable.

5. More reliable data for reporting and research

purposes. Quality data are essential for reliable reporting and research. Government funds may be awarded to facilities based on certain reporting requirements. In addition, statistical reporting of healthcare data plays a role in the awarding of grants for research purposes.

6. Improved relations between HIM/billing staff and physicians. An effective audit will identify errors caused by physician documentation problems. Physicians responsible for poor documentation should be informed and educated on these issues, and receive regular feedback from health information management (HIM) staff.

7. Correct reimbursement to the organization. Audits should identify underpayments as well as overpayments. Because of the improved operational efficiencies that can result from auditing, many facilities have seen an increase in their overall revenue base.

8. Better relations among all departments and functions involved in the reimbursement process. Employees work better when they understand why they are doing what they are doing. It is also helpful if employees understand how individuals in other functions or departments affect their work processes—and how their own work processes affect others.

9. Enhancement of auditing by current quality assurance/utilization review efforts. Organizations should take stock of any functions that could enhance compliance auditing or be used in the compliance monitoring process before reinventing the wheel.

10. A new public relations tool. Developing a successful auditing system is something to be proud of. It's one more achievement your organization can use to attract new patients and ensure that patients receive the best quality of care. ■

Editor's note: This article was adapted from the book Coding Compliance: A Practical Guide to the Audit Process. Go to www.hcmarketplace.com/Prod.cfm?id=106 for more information on this book.

APCs: Ensure accurate billing and coding

When much of your facility's billing depends on accurate and timely use of thousands of HCPCS/CPT codes that generate Ambulatory Payment Classification (APC) groups, you need to have a system in place to check your billing and coding department's work. Accurate and complete coding is the single most important element driving your success in the environment of APC reimbursement.

Conducting an APC audit is a great way to ensure that your organization identifies, monitors, and rectifies inappropriate billing practices, which will benefit your bottom line while simultaneously highlighting potential compliance issues, says **Jugna Shah, MPH**, president of Nimitt Consulting in St. Paul, MN.

Auditors should also conduct periodic follow-up audits to ensure that the organization has procedures in place to address issues regarding the quality and accuracy of the coding and billing process, said Janet Kucinski, RHIA, CCS, CCS-P, a senior consultant with Hospital Resource Management of Dallas.

Cover at least these main areas in your audit:

- Compliance with coding and claim development laws
- Policies that affect appropriate and efficient outpatient coding, including physician documentation and department processes
- APC reimbursement losses from improper or missing documentation and charge-capture problems

The audit

Review the HCPCS/CPT codes currently used by all departments performing APC-reimbursed services. Cases from any departments that don't pass Medicare outpatient code editor (OCE) edits can serve as your starting point for further analysis.

1 Select cases. Auditors can organize cases by department or other criteria and then, for further review, select a random sample of cases within each APC group. The sample does not need to be large: 100–150 cases is usually sufficient. "I suggest that you start by auditing with a random sample before starting

a focused audit," says Kucinski. "There may be a lot of opportunities to fix problems you're not aware of."

Consider relying on data and edits generated from the OCE to pinpoint areas where claims are showing up with problems on them. This is a more strategic, unbiased approach than attacking known problem areas, says Shah. Moreover, by starting with your highest volume of OCE edits, you have the opportunity to fix high-volume problem areas first. Shah stresses that the OCE can help you find your problems, and that the priority should be fixing them on the front end, rather than making quick fixes in the billing office.

2 Gather your toolkit. Gather the medical record and audit trail of codes assigned by the health information management (HIM) coding staff for each claim selected as part of your review. The printed coding summary from the HIM abstracting system or the encoding software makes the best audit trail, said Julia Palmer, MBA, RHIA, CCS, president of the division of Hospital Resource Management. Palmer and Kucinski spoke during an audioconference sponsored by HCPro, Inc.

For each record, Palmer suggested that you also pull the UB-92, the hospital itemized bill, and the detailed Medicare remittance advice that shows the CPT codes Medicare received for payment, how those codes were paid, the APC assignment for each, and any modifiers and units of services, said Palmer.

3 Code review. Once you have selected your sample and assembled your tools, review the codes your organization submitted to the fiscal intermediary on the UB-92 against the information on the medical record. Also compare medical record documentation with the following:

- Codes reported by HIM coding staff
- Codes reported via the chargemaster (itemized bill)
- Codes paid on Medicare remittance advice

When reviewing claims, focus on whether your organization included all relevant codes and documentation to support the codes billed, and correctly listed all modifiers. Include modifiers 25, 59, 52, 73, and 74 on your organization's compliance hit-list, says Shah.

Watch for potential human errors. Many organizations have not updated their HIM abstracting system to accept and transfer modifiers to the billing file. Doing so requires manual intervention by billing staff, inviting human error and omission.

Many organizations also do not appropriately assign modifiers for service areas with CPT and HCPCS codes that they submit via the chargemaster. Even worse, some HIM department's coding competes with chargemaster codes for the same procedures. When this happens, one or both codes can appear on the UB-92, says Palmer.

4 Analysis. Compare the revenue the facility would have received under "best practice" coding against the money it actually did receive. The difference is generally a reasonable measure of potential improvements available to the hospital. Keep track of increases and reductions in outpatient revenue associated with

best-practice coding and billing.

It is important to recognize that the size of reductions made to Medicare reimbursement due to discovered over-coding is one measure of the compliance risk. Under-coding is also a risk and an opportunity—a risk from the compliance end, and an opportunity in terms of increasing revenue. One area to look for missed charges is in the Emergency Department, says Shah, where providers are still not capturing all the services they provide.

If you find a lot of errors through your audit, consider their magnitude and whether your organization can fix them internally. Determine whether errors are due to carelessness or lack of education. If they are, your organization may need to revamp its APC task force by broadening its role, adding new members or discarding old ones, and finding ways to make the tasks interesting, valuable to senior management, and rewarding for those participating, says Shah. ■

Essential audit toolkit

Gear up for your audit. No audit of Ambulatory Payment Classification (APC) coding is complete without the following:

- CPT code book
- HCPCS Level II code book
- Medical record
- Audit trail of codes assigned by HIM coding staff (e.g., pencil codes on face sheet, a coding summary printed from encoder software, etc.)
- UB-92
- Itemized bill
- Medicare remittance advice—detail remittance showing payment by APC, CPT code plus any modifiers, and units of service reported
- Hospital chargemaster
- List of high volume CPT procedures, like gastrointestinal endoscopies
- List of high-dollar (charges or APC reimbursement) CPT procedures, like pacemakers, brachytherapy, or chemotherapy
- List of problem-prone CPT procedures by

body system, such as the following, for the integumentary system:

- Fine needle aspiration v. core needle biopsy
- Wound repairs—simple v. intermediate v. complex
- Excision of lesions—new rules for 2003
- Adjacent tissue transfer—check whether wound repair was coded instead
- Nail procedures—check whether excision of nail and nail matrix include amputation of distal tuft
- List of CPT code pairs:
 - "simple" v. "complicated" v. "complex"
 - "with" and "without"
 - "without anesthesia" and "requiring anesthesia"
- List of procedures paid at 150% when modifier -50 is appended to the CPT code ■

Source: Julia Palmer, MBA, RHIA, CCS, president of the health information management division of Health Resource Management in Dallas.

Audit for inaccurate DRG assignments

Diagnosis-related group (DRG) upcoding has been on the government's plate for the last eight years—and it probably won't go away. The government has collected hundreds of millions of dollars from U.S. hospitals for pneumonia DRG upcoding and other upcoding issues.

If that's not enough incentive to audit DRG assignment, consider this: On the inpatient side, incorrect coding can change your hospital's reimbursement by thousands of dollars, says **Jugna Shah, MPH**, president of Nimit Consulting in St. Paul, MN. "It's worth your organization's time and money to perform this audit."

"Upcoding leaves the door open for investigations, while undercoding denies providers compensation they deserve," says **James Kopf**, senior vice president of Healthcare Oversight in New York City. "The fallout to undercoding is lower Medicare reimbursement rates in future years."

Organizations should audit DRG assignment to ensure that the patient's condition supports the diagnosis, says Shah. Hospitals should audit DRGs for two main reasons:

- To ensure that the organization is complying with all rules and regulations.
- To identify revenue opportunities. "Don't leave money on the table," says Shah. "You may find places where your organization has missed revenue or where you could improve processes."

TIP: "You need to walk the line very carefully to minimize compliance risk, while generating all the revenue that is due to your organization," says Shah.

Audit plan

Use the following tips to put together a DRG audit tool:

- 1 **Assess your risks.** No organizational risk assessment is complete without addressing DRG assignment. This is critical for monitoring

compliance, says **Susan Parker, BSN, RN, LNCC, CCS**, a consultant with Parente Randolph, a national consulting firm with 15 offices in Pennsylvania.

"Pay close attention to the DRGs that the government targets as 'high risk' for fraud and abuse enforcement," she says.

- 2 **Review target DRGs.** Begin by reviewing the DRGs of highest vulnerability: those targeted by the OIG or those considered "high risk" due to their variation from national norms, says Parker.

Focus your assessment on coding accuracy. Examine the following:

- Assignment of proper codes
- Appropriateness of the code sequencing
- Identification of all reportable diagnoses and procedures

- 3 **Compare DRG distribution.** Organizations should also compare their distribution of DRGs with and without complications and comorbidities (CCs), says Shah. "Most hospitals will see a normal distribution of complicated cases and normal cases. If all of your cases are complicated, there should be a good reason."

- 4 **Choose a sample.** Before selecting a sample, organizations must decide which patients they want to review.

If your organization hasn't audited DRG assignment recently, randomly select 20 inpatient medical records from each department, says Shah. Review each medical record and test it by assigning the case a diagnosis; then see whether the coder assigned the same diagnosis.

Organizations can also generate a report of their top 25 DRGs, either by volume or by Medicare payments. If your top DRGs include a lot of CCs, determine whether medical records support that data,

says Shah. "Start with data, then let that help to focus where you look next."

5 Review code use. Analyze whether one code is being used more than the others in the sample. Also check for "standing orders" for coding (e.g., always bill an emergency department service at level four). Look for the sudden increase in use of one code, add-ons, and outlier payments, says Kopf. "This is what the contractors do."

6 Review the medical record for clarity and completeness. "Determine whether code assignments accurately reflect the services provided," says Parker.

Begin the claim review by examining the UB-92. "This will ensure that there are no glitches in the submission of ICD-9-CM codes and subsequent DRG assignment to the billing department," she says.

During your review, verify the principal diagnosis and secondary diagnosis, as well as the sequencing of diagnosis and procedure codes. Also verify the patient's age and discharge status, since these can affect DRG assignment, says Parker.

"When you review the medical record, you are basically looking for a story, with certain phrases," says Shah. "If complications arose, there would be a narrative description. There should always be a trail."

7 Review coding safeguards. Your organization's coding and documentation policies and procedures should address all of the pertinent federal and state statutes, regulations, and guidelines, says Parker.

Other safeguards against upcoding include the following:

- Reviews of high-risk DRGs.
- Reviews of the distribution of all DRGs that include CCs. "The medical record must verify that the treatment or length of stay were affected by the assigned CCs," says Parker.

Try to determine the cause of any variations through focused reviews, says Shah. "These will help to identify

deviations, such as patterns in claims denials or areas where services are under-reimbursed. Organizations can address coding weaknesses through targeted education."

8 Perform ongoing monitoring. After completing your audit, review in a few months whether your organization effectively implemented the changes you recommended. Find out whether training and education was effective by comparing documentation in both a pre-audit record and a recent case that's similar, says Shah.

Use the Office of Inspector General's *Work Plans* to learn where the government is finding aberrant coding patterns, says Parker.

"Providers should monitor their code distribution in comparison to their peers' to identify aberrant coding patterns and to examine the reasons for those variations."

This type of monitoring can lead organizations to discover inappropriate coding patterns, Kopf says. "However, changes in coding distribution may also be due to changes in the services that your facility provides. It is important for providers to correct inappropriate coding and to be able to explain the reasons for differences." ■

Illustration by Dave Harbaugh



"OIG says their next audit will concentrate on auditing DRG coding, and they expect to hit pay dirt."

Assess the appropriateness of one-day stays

Your organization may pride itself on caring for patients efficiently. However, if it is so efficient that it consistently discharges patients after only one day of inpatient admission, your organization may be inadvertently overbilling Medicare.

Perform an audit of one-day stays to verify that your organization admits patient under the appropriate status (inpatient v. observation).

Medicare pays more for an inpatient admission than it does for observations, says **Tammy Forgatch, BSN, RN**,

nurse auditor supervisor for Southern Illinois Healthcare in Carbondale.

"It is fraudulent to bill Medicare for an inpatient stay when the patient may have met observation criteria."

OIG focus area

The Office of Inspector General (OIG) has looked at this issue closely, according to its last three *Work Plans*. **Anthony Almeda, CPA**, senior internal auditor for Community Health Systems, Inc., in Brentwood, TN, says the OIG wants organizations to have adequate controls in place to detect inappropriate Medicare payments for one-day stays.

Although one-day stays aren't included in this year's OIG *Work Plan*, Almeda says hospitals should still find ways to ensure that they are appropriately billing these claims.

Also review one-day inpatient admissions for non-Medicare patients, says Almeda. "Admitting a patient for only one day brings up medical necessity and quality-of-care issues."

Review focuses

According to Forgatch, try verifying the following to determine whether a patient's status is appropriate:

- **Status on medical record** (i.e., physician

order)—does it match the status on the billed claim?

- **Charges on the claim**—Are they consistent with patient status (no outpatient charges for an inpatient stay)?
- **Medical necessity of the stay**—Is it based on clinical criteria (e.g., Interqual)?
- **Stay**—Ensure that it wasn't just for patient or physician convenience.

Evaluate discharge criteria to make sure the organization did not discharge the patient too soon.

Also, consult with the utilization review nurse to determine whether the organization assigned an appropriate diagnosis code for this admission, or enlist a coder to evaluate the coding, says Almeda.

TIP: Use the steps on p. 9 to guide your one-day stay audit.

Monitoring one-day stays

If your organization doesn't have a policy for managing one-day stays, recommend one. A few months later, check whether the disciplines involved are following the policy, says Forgatch.

Audit a sample of inpatient claims in three months to verify whether applicable departments implemented all of your recommended changes.

Follow up

If the utilization-review department is evaluating Medicare inpatients according to appropriate criteria, the auditor could follow up by looking at the department's review methodology to determine whether it has a sound process for evaluating the medical necessity of Medicare admissions, says Almeda. ■

Step-by-step review of one-day stays

Auditing one-day stays is easy, with a little help from the experts.

Use the following steps when you audit one-day inpatient stays:

1. Enlist the help of your organization's utilization review department, says **Anthony Almeda, CPA**, senior internal auditor for Community Health Systems, Inc., in Brentwood, TN.
2. Pull any of your organization's policies on monitoring one-day stays, says **Tammy Forgatch, BSN, RN**, nurse auditor supervisor for Southern Illinois Healthcare, in Carbondale.
3. Find out how your organization's utilization review department is managing these patients, says Forgatch.
4. Obtain data from the hospital's accounts receivable system, says **Terri Allen, CIA**, a hospital internal audit director.

Collect the following information:

- Account balance
- Admit day
- Diagnosis related group (DRG) assigned
- Discharge date
- Discharge disposition code
- Financial class
- Hospital service
- Inpatient/outpatient indicator

- Last activity date
- Medical record
- Patient account
- Social Security number
- Total adjustments
- Total charges
- Total payments

5. Using ACL software, analyze a period of time (usually a year) by extracting all inpatients with a length of stay that is equal to zero or one.
6. Eliminate from your review any patients whose discharge disposition code indicates that he or she passed away or was transferred.
7. Select a random sample from each remaining group (zero-day stays and one-day stays).
8. Review the medical records. Determine whether the physician's order indicates that the hospital should have admitted the patient under inpatient status.
9. Review the nursing notes and the physician's order and notes to determine whether the DRG assigned is supported.
10. For accuracy, compare the discharge disposition code to the discharge-planning document.
11. Enlist a clinical coding specialist to review any charts that do not appear to support an inpatient admission. ■

Evaluate your coding and documentation of E/M services

Tips for safer billing under the government's watchful eye

The government is on the hunt for services that do not meet medical necessity requirements—and the stakes are too high for your organization to ignore. Between October 2001 and March 2002, the federal government collected more than \$780 million from healthcare providers accused of Medicare and Medicaid billing irregularities.

Make sure your organization is up to par before the Office of Inspector General (OIG) comes knocking. Audit your organization's evaluation and management (E/M) services documentation and coding to see whether they meet the OIG's standards. Start by performing these five steps:

1. Perform a baseline audit to identify problem areas.

Review the billing report for the following patterns and practices:

- Physicians who always assign the same level of E/M service
- Unexpected codes (code categories, E/M levels, procedures, or modifiers).
- Codes not being used that you would expect to see
- Patterns that differ from national norms or from others in the group practice
- Graph physician usage of the various codes, as compared to the national use of the codes for physicians in their specialties

2. Determine the type of audit. Choose whether to perform a focused review or a general review. Use these guidelines:

- Focused review—assess a particular physician or specialty to identify any problematic codes to single out and review
- General review—evaluate the current procedural terminology and code utilization report or analyze high-usage or high-payment codes

3. Choose the sample. Determine the size and scope based on the audit's purpose.

- Statistically valid random sample—select 30 records per physician, or 5% of the total number of surgical cases for a three-month period

- Smaller probe audit—choose five to 10 services per physician
- Choose whether to review claims prospectively or retrospectively

4. Review the medical records.

- Determine whether each medical record is complete and legible
- Identify whether the following documentation is present:
 - Reason for the encounter
 - Relevant history
 - Physical exam
 - Prior diagnostic test results
 - Physician's assessment of the patient's condition, clinical impressions, or diagnosis
 - Treatment plan
 - Date and legible identity of the observer (physician, nurse, etc.)
 - Time (only a factor when counseling is 50% or more of the visit)
 - Documentation of the patient's progress, response to treatment, and changes in treatment or diagnosis

5. Watch for common problem areas, such as

- disproportionate use of high-level E/M codes
- lack of medical necessity documentation
- physicians and coders using the wrong local medical review policies (e.g., using Part A guidelines instead of Part B)
- physicians using hospital coding guidelines to perform office coding (the E/M guidelines are different for physician coding and hospital coding)
- consultations—if the physician uses the words “referring” or “referred” in written correspondence with the requesting physician, the carrier can downcode the visit from a consultation to an inpatient or office visit ■

Sources: Ellen Arrington, RN, a clinical auditor for the North Shore Medical Center in Salem, MA, and Stacie Buck, RHIA, LHRM, president of HIM Associates, a consulting firm in North Palm Beach, FL.

Tips for auditing same-day readmissions

Your hospital may try to do its best to treat and discharge patients efficiently. But if you routinely discharge patients too soon and then readmit them later the same day, your policy may not pass muster with the Office of Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS).

Patients who are discharged earlier than necessary and then readmitted face potential medical risks. In addition, hospitals could be overbilling Medicare if they don't include the charges for the second inpatient stay on the original claim or they treat the situation as a transfer, says **Terri Allen, CIA**, a hospital audit director.

OIG's target areas

The OIG has been looking into same-day readmissions for years, says **Hank Vanderbeek, MPA, CIA, CFE**, a consultant and former auditor for the OIG's Office of Audit Services. The OIG looks for the following in its audits of same-day readmissions:

- Claims for a second patient admission when the patient was actually transferred to a non-acute care

unit within the same hospital

- Whether the readmission claim should have been a continuation of the initial admission
- Premature discharges or incorrect discharges (e.g., the patient never left the hospital)
- Medical conditions that do not require a readmission after a discharge

Hospitals should conduct a prospective review of all same-day readmissions based on the OIG's review protocol, says Vanderbeek. They should also repay any overpayments they uncover. Auditors can select a probe sample of same-day readmissions from the prior 12–24 months to determine whether the hospital is correctly billing for these admissions.

Nine steps

Vanderbeek and Allen outline nine steps that auditors can follow for reviews of same-day readmissions:

continued on p. 12

Evaluate controls for same-day readmissions

Providers should use a system to monitor readmission rates by diagnosis and provider, as well as by clinical certification. Include this information in the overall utilization statistics. Hospitals can also use this information to identify opportunities for increased cost savings and inclusion of heavily used practitioners in the network, says Vanderbeek.

Examine the following areas to evaluate the controls on tracking/follow-up actions for hospital readmits:

- Whether anyone reviews claims for coding errors or readmission errors.
- What the internal audit department has done to ensure that the hospital prevents the errors the Office of Inspector General and Centers

for Medicare & Medicaid Services identified.

- Whether there is a quality assurance indicator that includes reviewing all readmissions within 72 hours of discharge. "This is a key quality assurance indicator used in the Veterans Health Administration medical centers and hospital systems," says Vanderbeek.
- Whether the local intermediary or quality improvement organization is tracking readmissions for potential medical necessity and billing errors.

Lastly, don't get lulled into a false sense of security if your review shows that the controls are adequate. The adequacy of controls indicates only the extent of transaction testing needed to augment control review, says Vanderbeek. ■

1. Determine whether there are any internal reviews, current or past, of readmissions. If the hospital reviewed readmissions, obtain and analyze the prior audit results, says Vanderbeek.
2. If your hospital has never audited readmissions, contact the fiscal intermediary (FI) and local quality improvement organization (QIO) to determine whether they are reviewing readmissions, says Vanderbeek.
3. Proceed with a review if the FI and QIO are not reviewing readmissions. Start by notifying management and applicable staff of the objective of your review. If the FI and QIO are reviewing your readmissions, decide whether their review of your hospital readmissions is sufficient, he says.
4. Obtain inpatient claims from the inhouse claims database or CMS' Standard Analytical File, which includes data on claims that have the same discharge date of service, subsequent date of service, and provider numbers.
5. Research applicable federal and state regulations, quality assurance policies, local medical review policies, and codes associated with readmissions, says Vanderbeek.
6. Analyze discharge codes to determine to which location the patients were discharged between the initial admission and readmission, he says.
7. Review medical records to determine whether same-day, same-provider readmissions were billed correctly and were medically necessary, he says. Analyze the following as part of your medical record review:
 - Physician orders for admitting and discharging
 - Physician notes
 - Nurses notes
 - Discharge planning summary
 - Discharge coding record
8. Report findings to the audit committee and other appropriate internal managers.
9. Repay any overpayment identified through the review and issue a written report on the audit findings, says Vanderbeek. ■

Allen obtains and analyzes patient accounts receivable information using Audit Command Language (ACL) software. This software produces reports of all patients with hospital stays of zero or one day and then attaches the discharge disposition code to each account, says Allen.

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