Instructions 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, such as the TMF Screening Criteria Manual, 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 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 to a utilization review physician any questions. 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 cause 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 Medical 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, admissions 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.