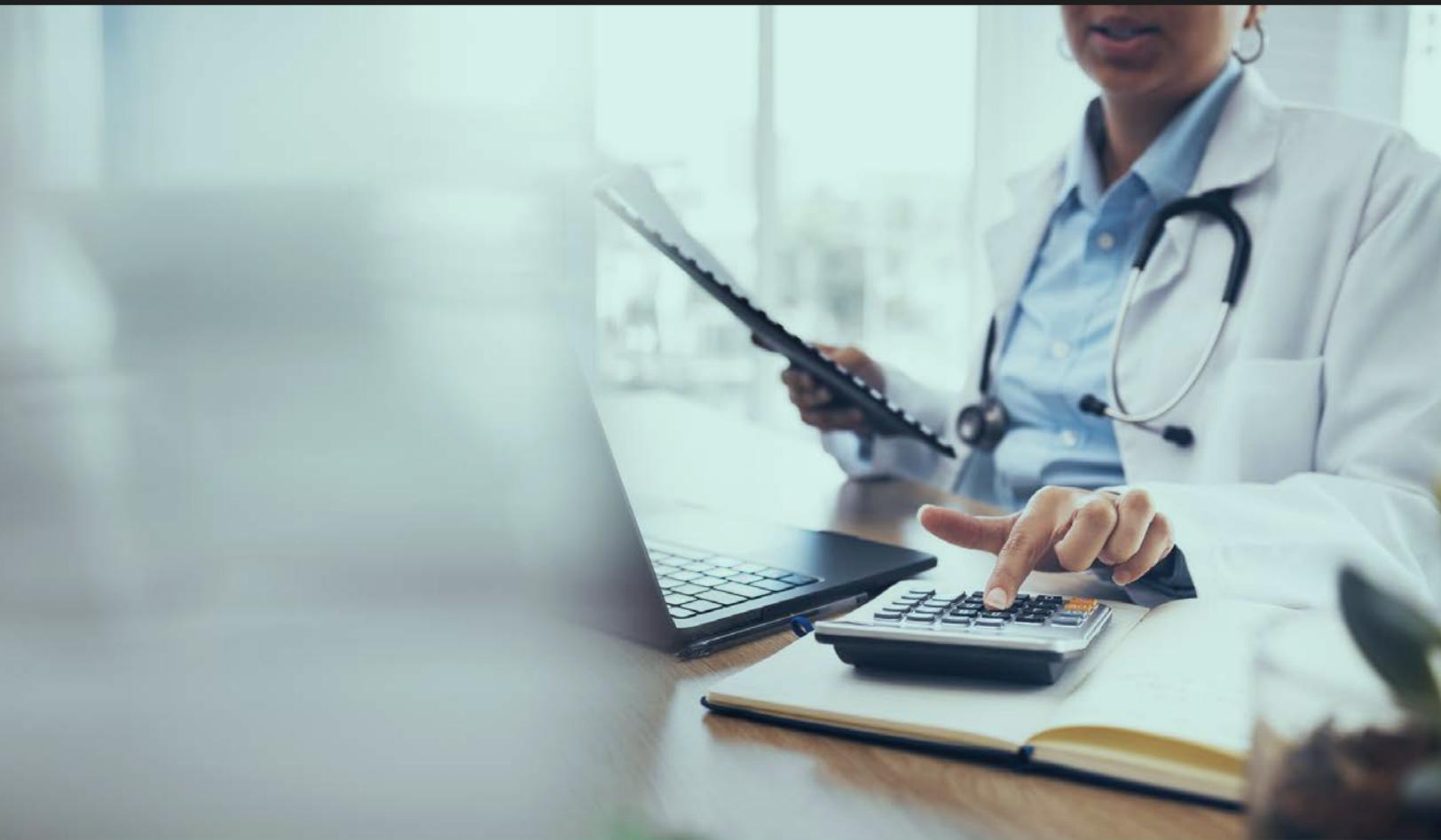


# The Evolving Role of DRG Audits in Payment Integrity

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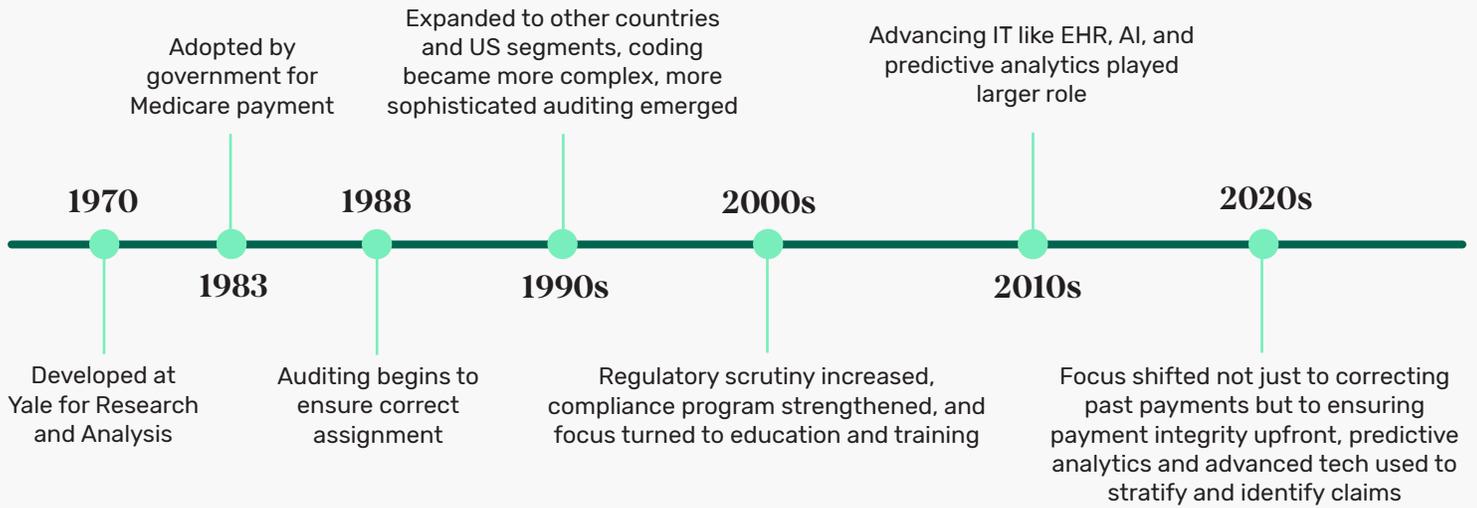


# Foreword

In the landscape of healthcare, the past 12-months have been marked with increasing AI advancements, medical inflation, cost pressures, an ongoing demand for affordability, and workforce challenges for payers.

As we look at healthcare finance and management, one thing that stands clear is the need for rigorous, yet adaptive payment integrity planning. Payers who continually refined their DRG review process, find themselves ahead of the curve in accuracy and fairness of healthcare costs.

Throughout its history, DRG auditing has evolved from a basic manual review process to a complex and technologically sophisticated system integral to the healthcare payment landscape. The goal has always been to ensure hospitals are paid accurately for the care they provide, preventing both underpayment and overpayment, and avoiding the potential for fraud and abuse in the system.



This article explores the evolving role of DRG audits within the ecosystem of payment integrity. We dissect the industry drivers, the restraints and challenges faced, and the opportunities we see as we progress through 2024.



**Greg Dorn**  
President



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# The Evolving Role of DRG Reviews

## Overview of DRG Reviews

DRG reviews are an essential foundation to protect against inaccuracies in healthcare reimbursements. The pillars of a DRG-based payment system are an exhaustive patient case classification system—the diagnosis-related groupings—and a precise payment formula predicated on a base rate adjusted by a relative cost weight for each DRG.

DRG clinical audits and DRG coding reviews represent distinct yet complementary approaches to securing accurate reimbursement.

- Coding reviews look at the accuracy of the documentation and the codes applied to ensure clinical evidence supports the DRG assigned and ensures compliance with coding guidelines and regulations.
- Clinical audits encompass a broader lens, examining industry guidelines and medical records to pinpoint the precise DRG-associated reimbursement.

DRGs can have conflicting guidelines for like conditions which can confuse the reimbursement decisions. Clinical DRG audits, informed by the latest industry guidelines and authoritative white papers, stand to provide evidence-based clarity, ensuring reimbursement processes are both fair and precise.

## DRG Evolution

Crafting an advanced DRG audit model requires expert coders and clinicians along with a multifaceted team. By outsourcing these tasks to an organization like CERIS, you can ensure your DRG model is utilizing the latest industry guidelines, medical records, and claims data to identify relevant features associated with each DRG concept.

**Work With Experts to Craft an Advanced Audit Model**

- Features considered for fine-tuning audit variables into cohesive decision mapping include patient demographics, diagnoses, lab results, medications administered, procedures, and diagnostic tests.
- A team consisting of clinically trained and certified coders, with the support of a Medical Director and proprietary machine learning technology, has allowed CERIS to achieve \$10K in average savings per DRG claim by identifying claims with a high probability of upcoding.
- By leveraging the outcomes of previous DRG audits CERIS can further modify variables and analyze them to determine their weight of importance and how they should be incorporated into a decision tree.
- Incorporating additional clinical and coding rules into the algorithm ensures adherence to coding guidelines and address' time constraints and documentation requirements.

## Factors Influencing DRG Evolution

Evolution requires continuous maintenance steered by clinical and coding experts to ensure a model's alignment with the latest industry standards. The appropriate maintenance of your DRG audit models will create ongoing audit efficiency driven by proven data results and transparent decision-making insights. Below are four factors influencing the success of an ongoing audit evolution:

**1: Appropriate AI, Prepay, and Post Pay**

**2: Ongoing Audit Rule Determinations**

**3: Insight and Analysis Oversight**

**4: Implementation and Ongoing Improvement**

### 1: Appropriate AI, Prepay, and Post Pay

AI predictive models are revolutionizing DRG reviews, offering an arsenal of benefits with the top 3 being:

1. Enhanced efficiency
2. Streamlined processes
3. Improved consistency

**AI + Humans in the Loop =  
Desired Accuracy Threshold**

At its core AI can continue to pave the way for a shift from reactive post pay to proactive prepay models, bolstering financial performance and accelerating the journey toward a successful payment integrity program.

We all desire claims to be paid correctly the first time, but this requires determining which DRG methods can be moved into prepay while still ensuring a quick turnaround to payment. Predictive AI models are designed to scale and handle large amounts of data, allowing organizations to analyze claims more quickly. By leveraging these predictive capabilities, payers can confidently transition specific audits into a prepay workflow.



Additionally, clinical natural language processing allows clinical notes and data on diagnoses and impressions to be extracted from radiology reports allowing for normalization and labeling. The output can be evaluated by both coders and clinicians for accuracy, and based on their feedback, content can be refined and adjusted to incorporate additional filters.

Humans in the loop make it possible to add features until the desired accuracy threshold is met in clinical normalization. This continually iterative process between humans and machines ensures a model that can expand and grow across different medical record formats and claims.

Consistency is key as audits are being deployed. Auditors may interpret guidelines differently, leading to inconsistencies in reimbursement decisions. Additionally, some organizations may not have clear guidelines for specific DRG concepts, resulting in more variations. Utilizing AI appropriately will create standardization in the audit approach resulting in reduced provider abrasion and fair and accurate reimbursement across all healthcare services whether decisions are made prepay or post pay.

## 2: Ongoing Audit Rule Determinations

The average medical record can span hundreds of pages, making any audit process time-consuming and labor-intensive. Determining which edits to deploy can narrow the focus to key clinical indicators, significantly reducing the time and effort required for auditing.

**The Idea State of PI includes Prepay and Post Pay Configurations.**

Automating the identification of relevant features, payers can streamline their audit process and allocate resources more efficiently, allowing employees to do more high-value work.

Naturally, it would seem logical to turn on all edits available to ensure optimal payment integrity results. However, within the complexity of claims processing, several considerations, including organizational goals, resource allocation, and operational integration, should dictate the type of edits to be included in any audit process. As we look at an ideal state of payment integrity, it's evident a blend of prepay and post pay assessments will create the most accurate healthcare reimbursement.

Before deploying an edit rule in any environment, each available rule has to be installed, configured, validated, and tested. Demands on resources and the complexity of integrating code edits into operational workflows, payers may need to phase in available rules and edits.



Additionally, as patterns and issues regarding improper billing are identified, focused investigative resources are required. Moving strong controls several steps upstream to a prepay position is highly desirable; however, many payer organizations do not have the infrastructure required to make this advance a reality. Post pay review continues to be a necessity even if prepay audits are in place to determine additional payment discrepancies, the reasons for those discrepancies, and the financial impact on the payer.

It is also important to remember individual claims with true irregularities may not score at a pre-determined threshold sufficient enough to warrant the use of resources to review claims in the prepay space, which is another area of opportunity for post pay review. Once an analysis is done and the volume of an edit warrants moving it upstream, prepay logic can be developed to shore up the gaps and create an end-to-end solution for payment integrity.

### 3: Insight and Analysis Oversight

Within the array of insight tools, it's crucial to distinguish aberrancies from the norm in order to reduce abrasion and efficiency by only auditing bills with a high potential for findings.

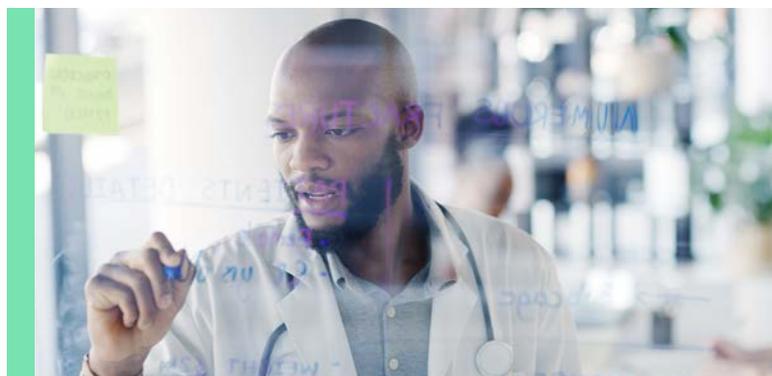
**CERIS delivers panoramic view across all potential cases.**

While challenges still exist with prepay scoring programs and systems, advanced models for the detection of improper billing are emerging in the market as an integral component of a successful auditing program.

There are a multitude of analytic models involved which continue to advance including:

- Predictive modeling
- Regression analysis (linear and non-linear)
- Data manipulation
- Processing inefficiencies and errors
- Uniformity assessment of data sets
- Various cost distribution models (provider, recipient, encounter)
- Outlier models (canned and customized distribution models)
- Targeted queries
- Scoring of claims

Refinement is necessary to move analytics into active DRG audit models. It is important to remember “aberrancy” does not always mean improper reporting or delivery of healthcare services. A service rarely reported may in fact be entirely suitable for reimbursement depending upon the clinical picture. Each model will have certain strengths and weaknesses, and it is important for any payer to understand the limitations of the analytics deployed.



Various analyses can assist payers in identifying abnormalities and in the creation of new rules and edits. The identification of true positives, false positives, and just as important - false negatives not captured by technology, can be used to refine the outputs of the tools.

CERIS surfaces as a beacon in this space, with analytical depth and a balanced mix of technology and a human touch to provide payers with a panoramic view across all DRG auditing potential cases.

## 4: Implementation and Ongoing Improvement

Evolving your DRG audit processes requires a strategic focus on the implementation of edits to ensure accuracy and efficiency. As stated above, you should focus your implementation on your data analytics, AI, and most valuable edits. Prior to full-scale implementation, it is important to conduct pilot tests of proposed edits to measure their impact on workflow, accuracy, and efficiency.



When introducing new edits in phases, you can assess the impact at each stage before full implementation to avoid overwhelming the system and to identify any unintended consequences early.

There should also be governance to regularly review the impact of implemented edits to determine their efficacy and make decisions on whether to continue, modify, or discontinue their use. It's important to continuously prioritize edits on high-risk areas where the potential for incorrect coding can have the most significant financial impact.

It is also important to allocate resources efficiently and set them up for success by using audit results to identify areas that require more extensive training or process improvement.

Resources should also have feedback mechanisms where they can provide input on the editing process, identifying challenges and suggesting additional, practical edits to incorporate. Clinical staff, coders, and financial teams should all be part of the implementation and ongoing process to ensure edits make sense from both a clinical and coding perspective and do not unnecessarily delay the billing process.

By following these methods, DRG audit processes can evolve to become more precise, efficient, and effective, ensuring they support the organization's overall financial health and compliance objectives.

**Ongoing governance ensures  
continuous improvement**

# Conclusion

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The DRG audit process has come to represent a vital facet of payment integrity, balancing the scales of fiscal responsibility and quality care. The evolving nature of these audits reflects a healthcare industry that is increasingly data-driven and technologically equipped yet remains guided by the principles of fairness and accuracy. The path forward demands embracing advanced analytics, AI efficiencies, human expertise, and a proactive stance toward payment integrity. By judiciously applying these technological advancements and refining audit processes, payers and providers can ensure that reimbursement aligns seamlessly with the complexity and nuance of patient care. The continual refinement of these processes, powered by collaboration and innovation, can safeguard the integrity of healthcare payments as we navigate the landscape of modern healthcare economics.

CERIS offers solutions that augment and enhance a payer's payment integrity performance and DRG audit processes. Our understanding of prepay and post pay rules, combined with our expertise in the application of proper coding methodologies, identification of abnormal and inappropriate payment, and the future state of payment integrity, make CERIS a favorable choice for any partner wishing to achieve optimal payment accuracy.

**CERIS has partnered with payers across the nation to support their payment integrity program and help them advance where they are in their journey.**

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