

Compliance and Auditing Benchmark Report 2017

From Us

Healthicity

We set out on a journey to learn as much as possible about the industry we all call home. To do so, we conducted a survey of over 1,200 coding, auditing, compliance, and healthcare executives. Many of you might have even participated in the survey. The 50-question survey aimed to understand how healthcare professionals and organizations manage their compliance and auditing programs.

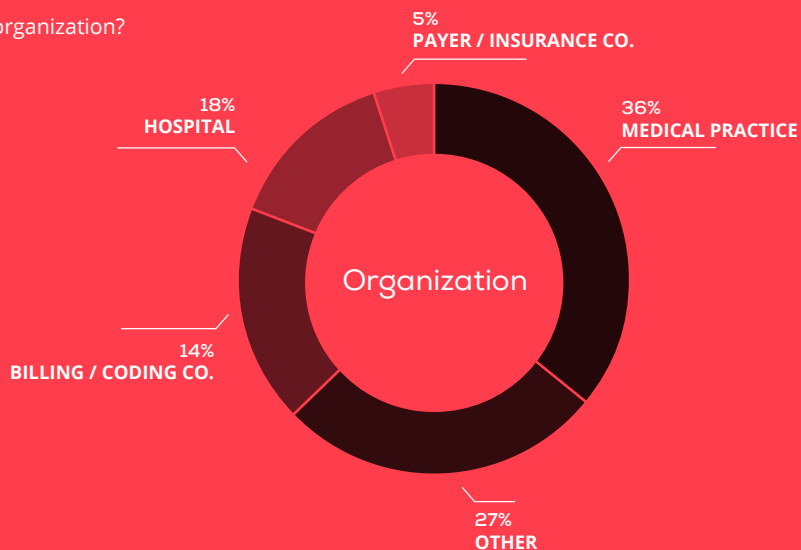
The survey results are even more interesting than we anticipated and reveal how compliance programs are funded, the state of technology in healthcare billing and compliance, the level of satisfaction many of you feel in your chosen careers, and much, much more.

The survey data has been compiled into a thorough industry report - the very one that you're about to read. This report shows where organizations stand in their compliance and auditing programs and serves as an industry benchmark to help many of you better manage your own compliance and audit programs - and your careers.

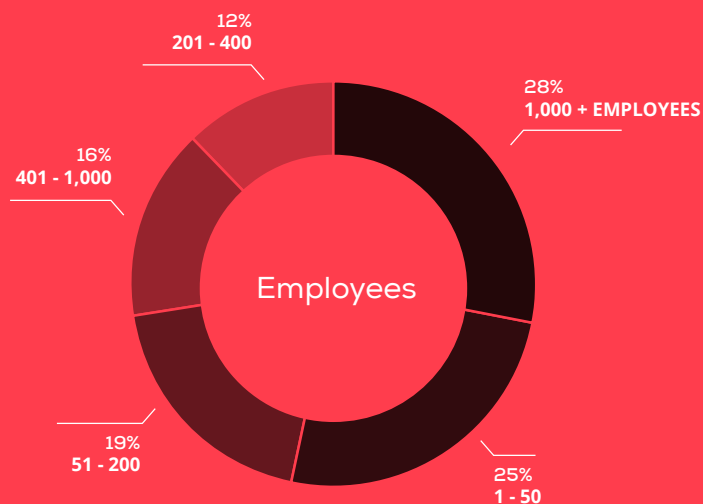


Demographics

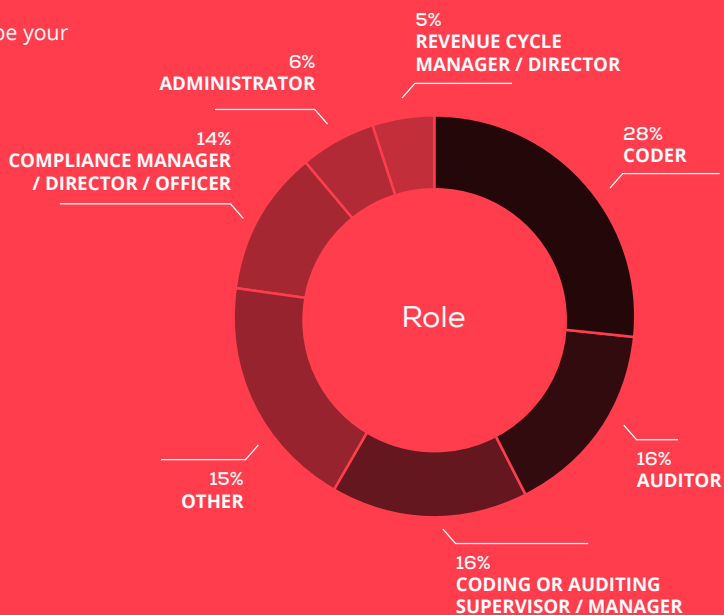
Which best describes your organization?



What is the size of your organization?



How would you best describe your current role / position?





Introduction

An effective compliance program is essential for every healthcare organization. Compliance programs not only meet legal and contractual requirements but also help ensure efficient operations and financial security. And yet, according to respondents, 88% of organizations have a formal compliance program in place. Additionally, you may be interested to know that 77% of surveyed Compliance Officers who plan on leaving their field reported being underfunded. And that most compliance programs only designate 10% of time to training efforts.

In this section you'll find an overview of the compliance landscape. The data was taken from the compliance-specific section of the survey that aimed to understand how compliance experts manage the resources available to their compliance programs.

Find answers to questions such as how frequently other compliance organizations conduct trainings and how often CCO's are meeting with their governing board. Then, use this insider knowledge to improve your own compliance program.

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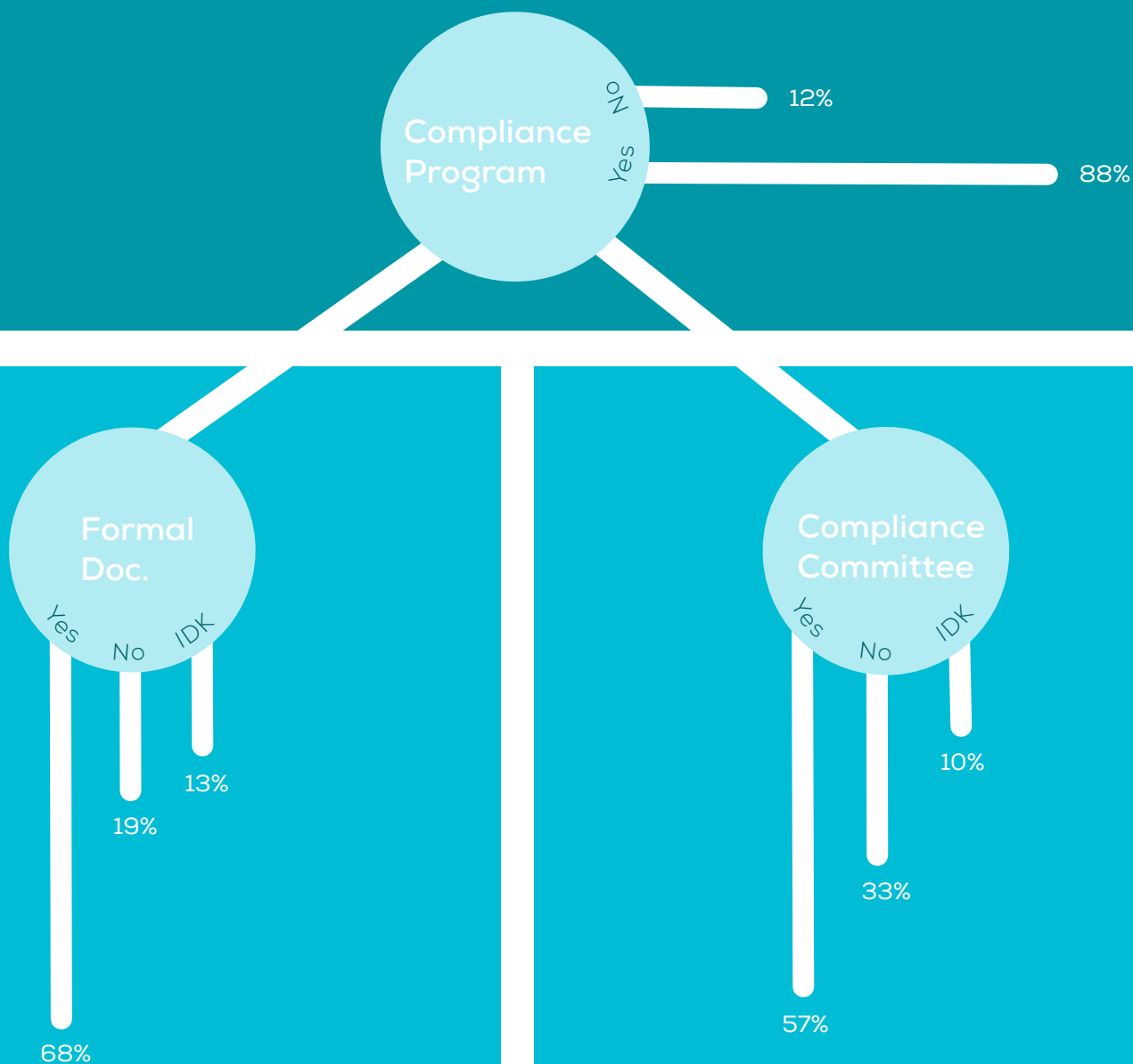
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Overview

1. Does your organization have a formal compliance program in place?



2. Does your compliance program require formal documentation / coding audits of your medical providers?

3. Does your organization have a designated compliance committee that oversees medical coding and auditing activities?

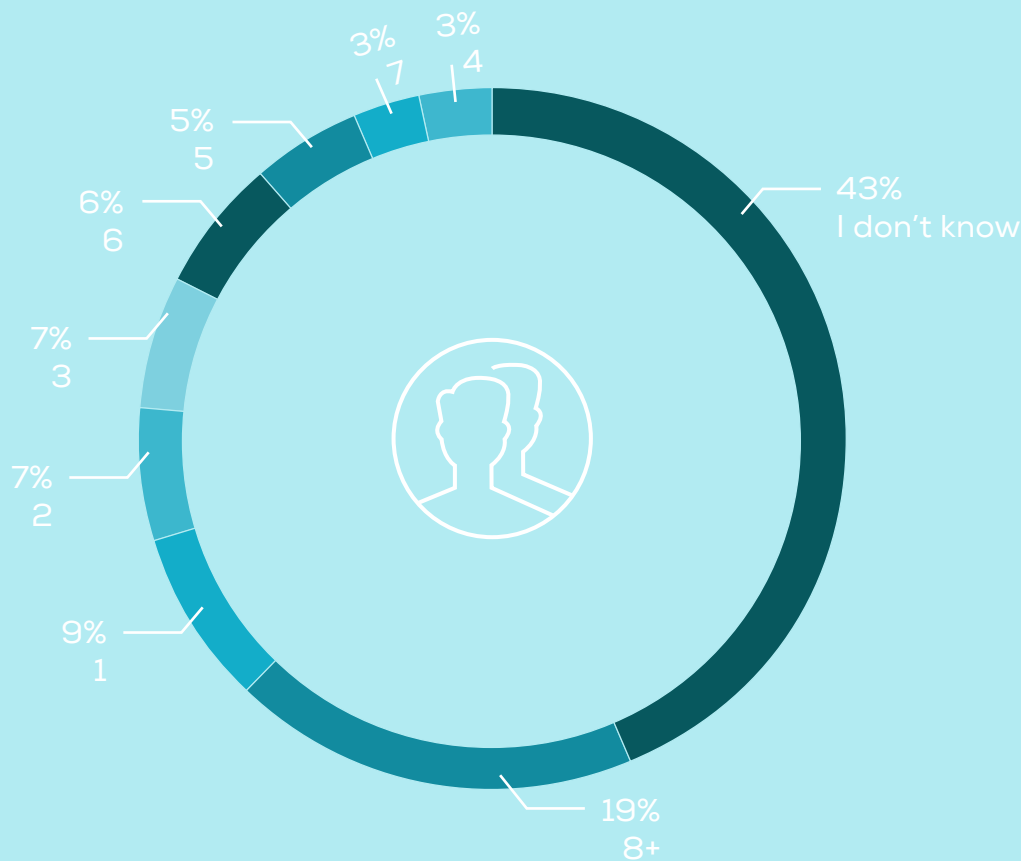


Industry Insights

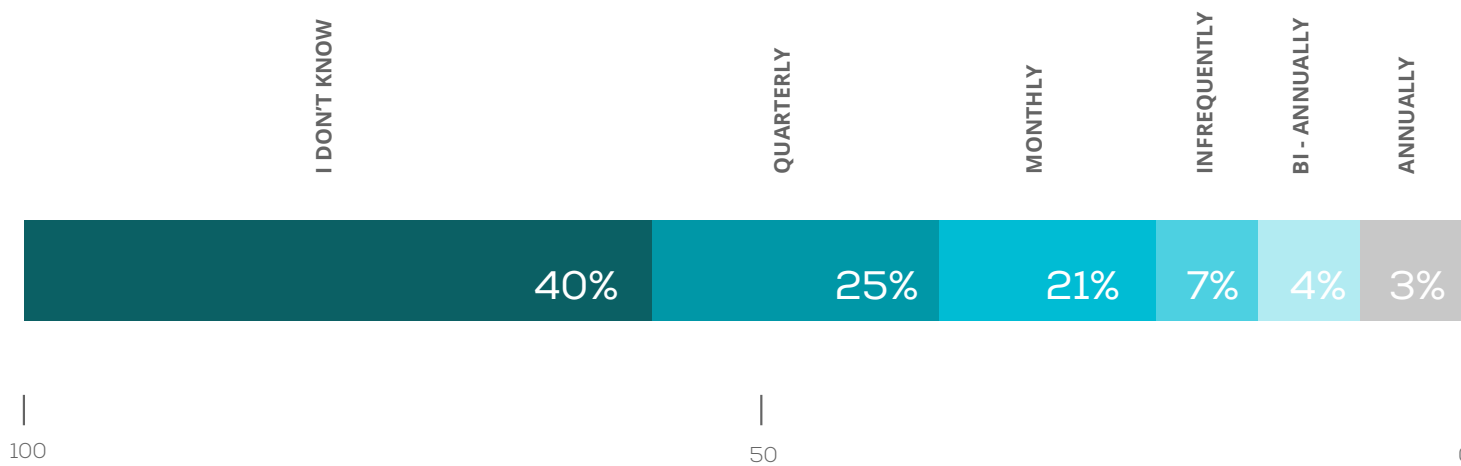
50% of those who answered "no" to having a formal compliance program are from a small physician practice (1-25 physicians). The OIG specifically published program guidelines for individual physicians and small group practices. Just because you're small doesn't mean you are not expected to have a formal program. Also, because you are small, the OIG guidelines allow for great flexibility.

Overview Continued

4. How many individuals are on the compliance committee?

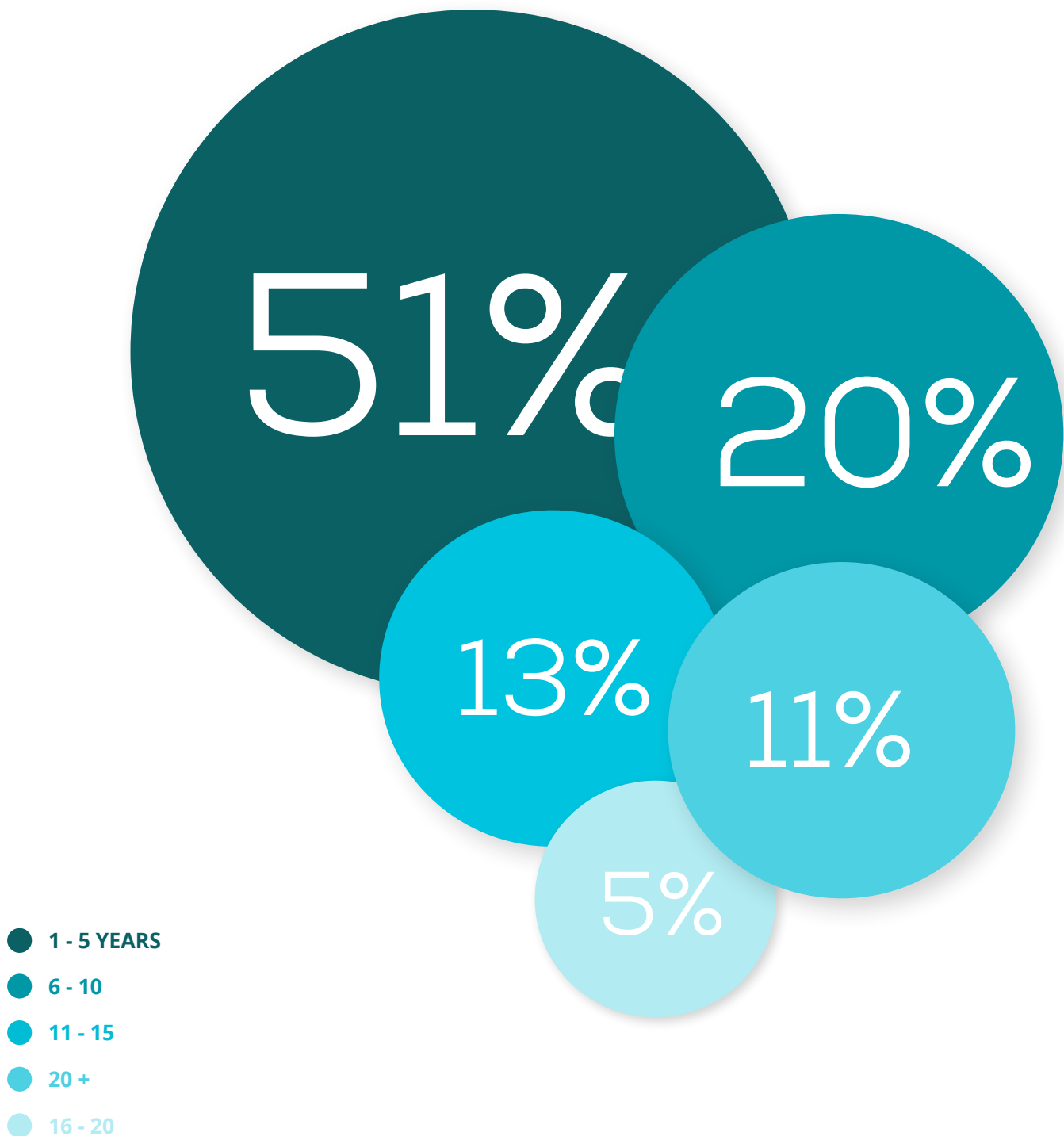


5. How often does the committee formally meet?



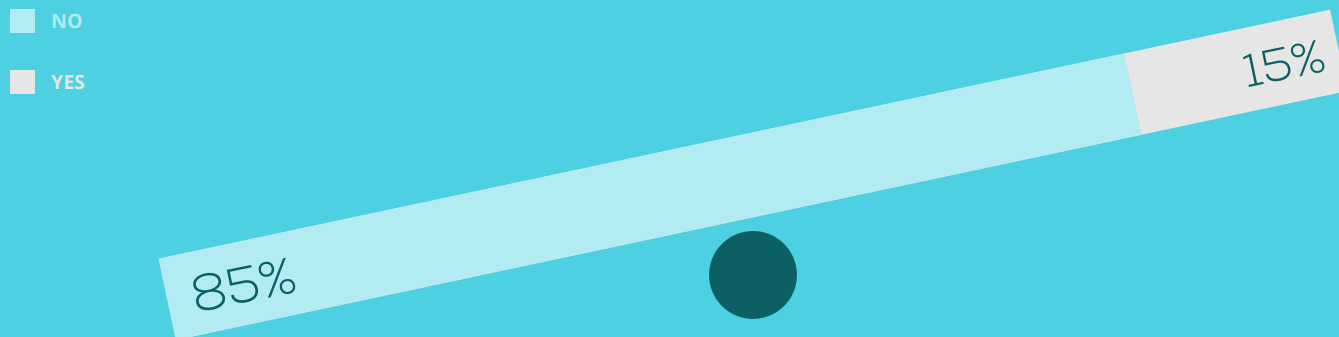
Assessment

6. How many years have you been with your current organization?



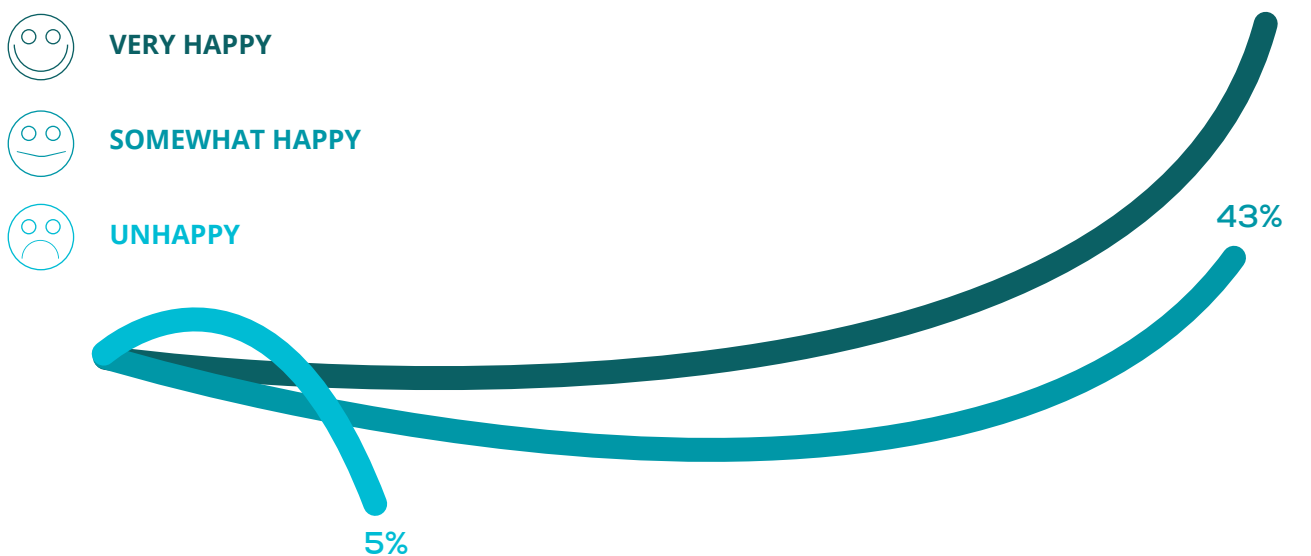
Assessment Continued

7. In 2017, do you anticipate leaving your current organization or its compliance department?



Of those who answered “yes,” 89% are either very happy or somewhat happy in the field of compliance. Additionally, 59% have been with their current organization 1-5 years. This may suggest that respondents who plan to leave their current organization or compliance department are newer employees who are happy in the field of compliance. Therefore, it can be inferred that they’d like to leave their job for career growth opportunities. For newer employees in your compliance department, keeping them happy and fulfilled might reduce turnover.

8. How happy are you working in the field of compliance?



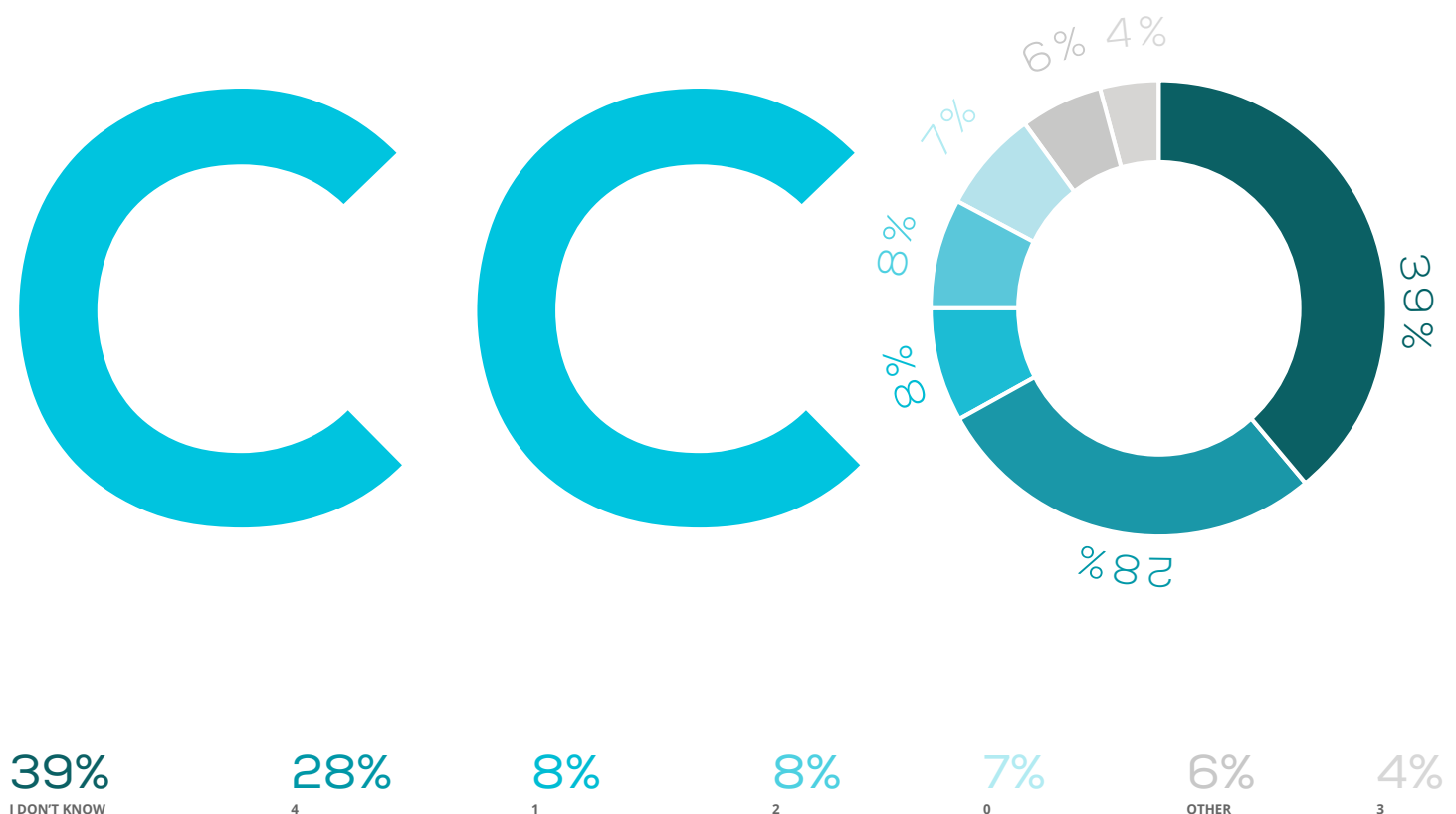
Drilldown

Length of time with an organization does not appear to affect how happy compliance professionals are. The trends for “unhappy, somewhat happy and very happy” seem to be consistent regardless of how many years an individual has been with an organization.

Operations

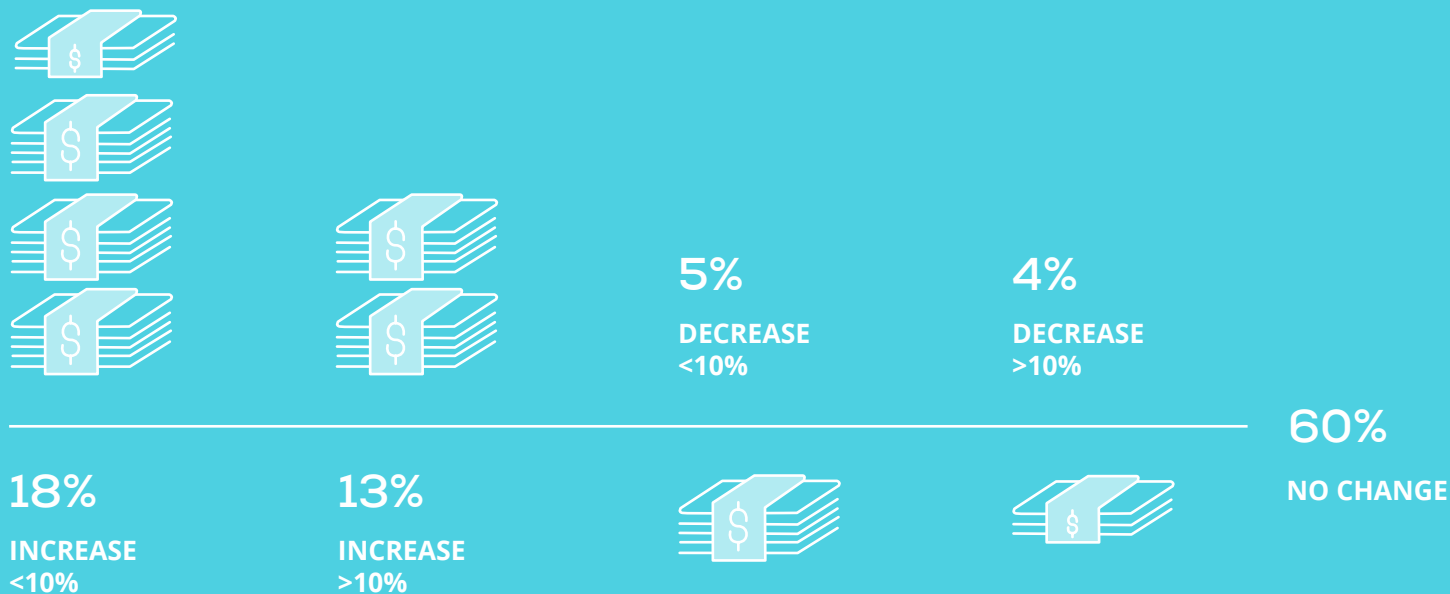
Managing a compliance program is no easy task. It's a challenge to stay current in an industry that is constantly evolving. In this section, you'll get a feel for how other compliance professionals stay on top of new regulations and rulings and what resources they turn to for their compliance information. You'll also see how frequently your peers interact with their governing board and how often organizations conduct compliance trainings.

11. In 2017, how many times do you anticipate your Chief Compliance Officer will meet with your organization's governing board or highest authority?



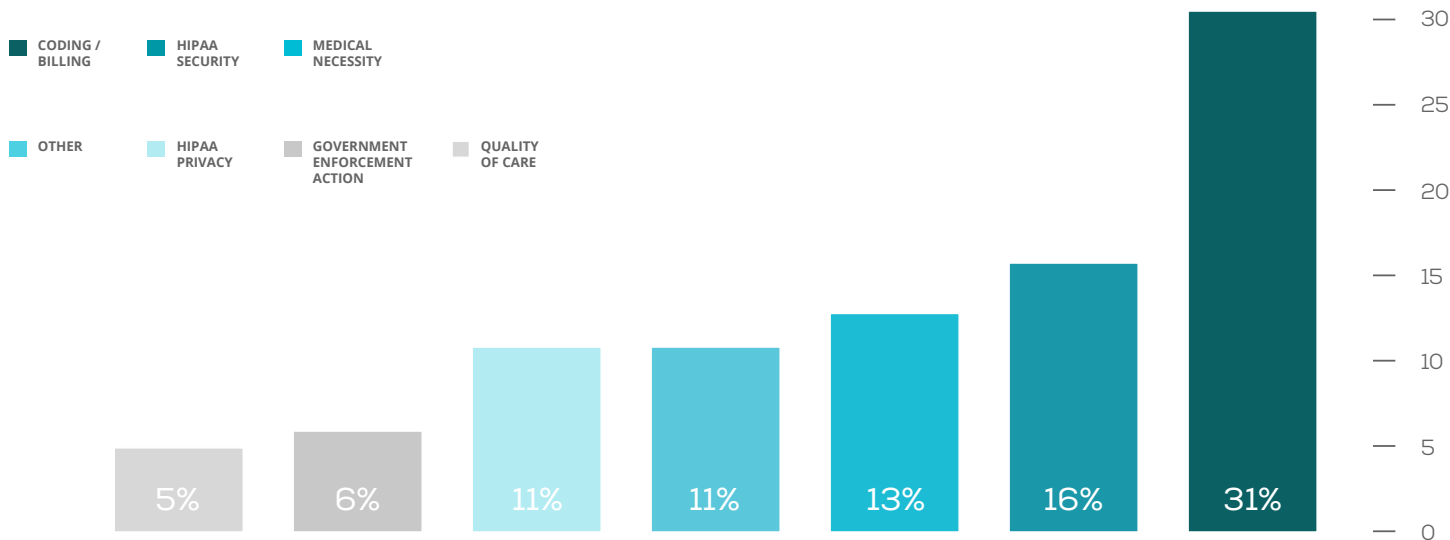
Operations Continued

9. In 2017, do you anticipate your organization's compliance budget will:



91% of respondents' compliance budgets will either stay the same or increase. This is a positive trend, suggesting that funding for compliance programs in general will not decrease.

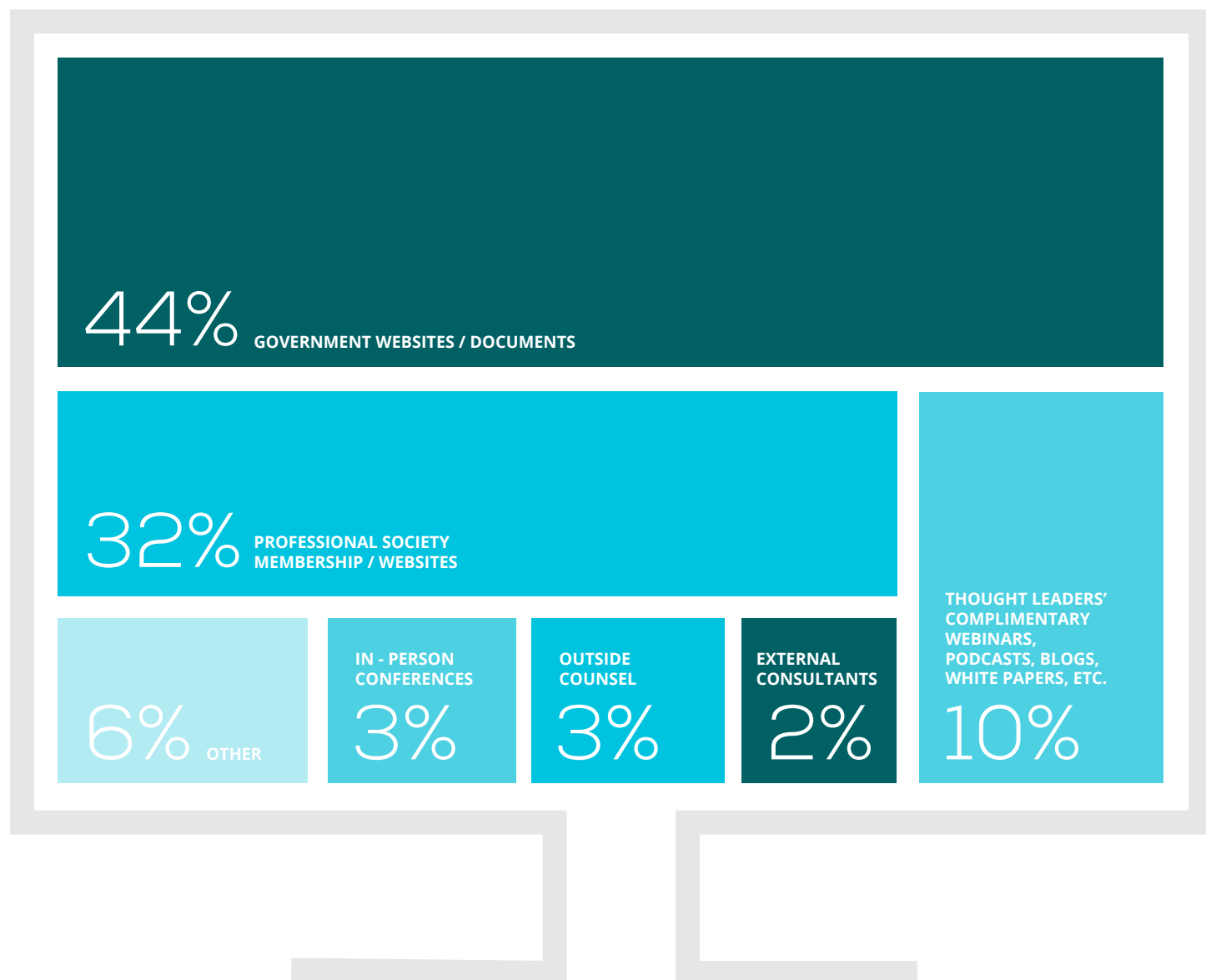
10. Which presents the greatest compliance risk to your organization this year?



Compliance risks are varied, so it's no surprise that the 4th greatest compliance risk was "other." The number 1 risk under "other" was "documentation," though the possibility of new legislation is also a contributing factor.

Operations Continued

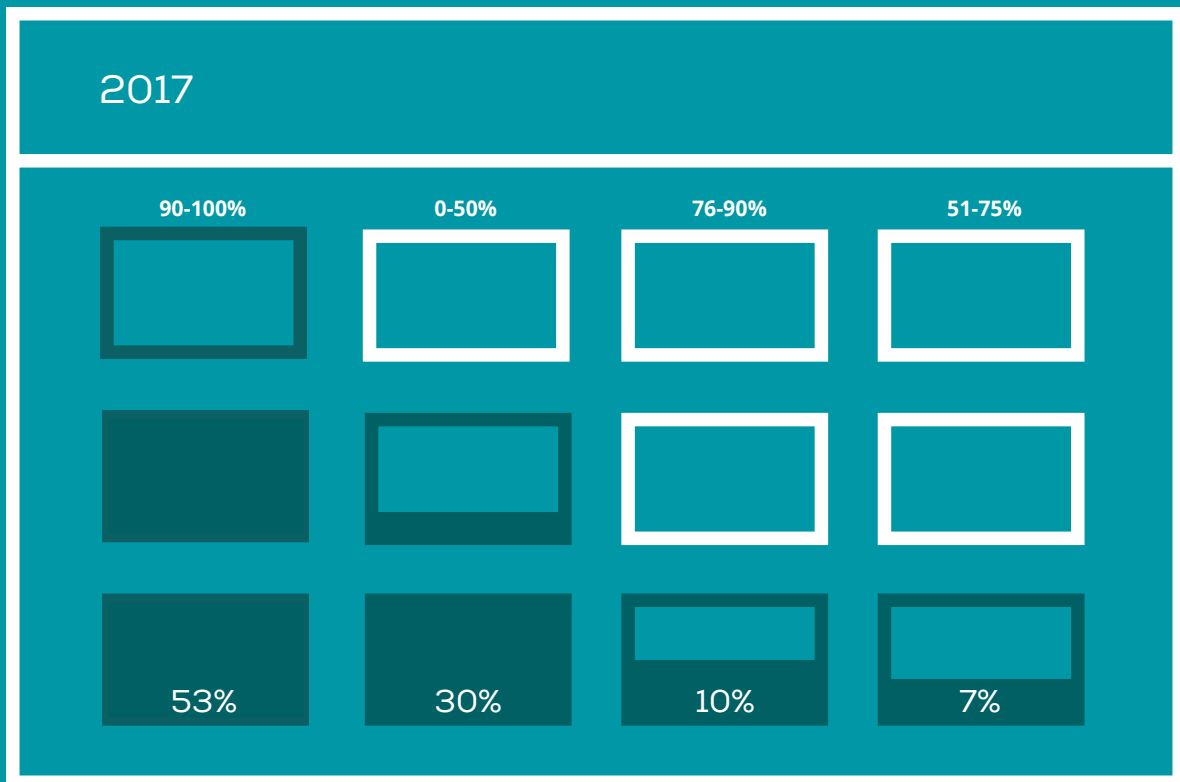
12. For 2017, which resource do you anticipate relying upon most for your compliance information:



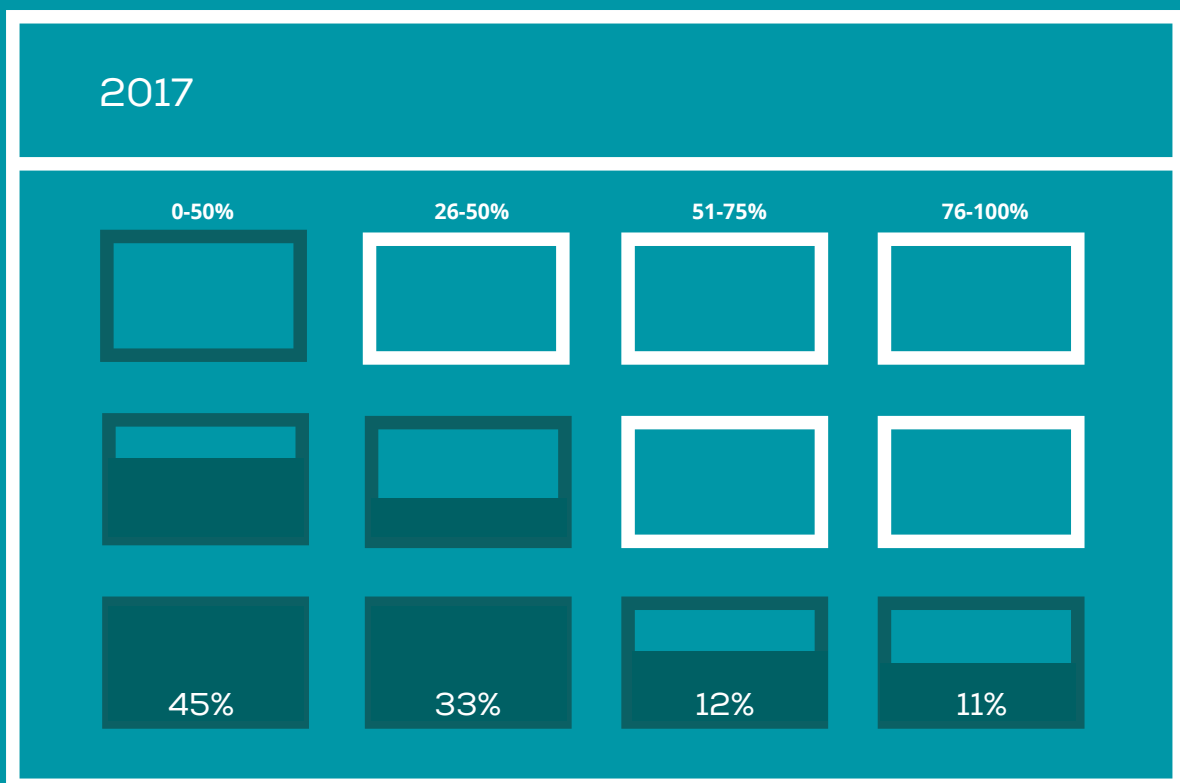
Industry Insights

The survey results suggest that the greatest challenge compliance programs will face in 2017 is keeping current with an ever-increasing volume of laws and regulations. Similarly, most answering the survey suggest government websites are their primary resource for compliance information. Some publications, such as OIG's Special Fraud Alerts, audit and inspection reports, and Advisory Opinions are readily available from the OIG and can provide a basis for educational courses and programs for physician practice employees.

13. About what percentage of your organization's workforce will complete at least 1 hour of accumulative compliance training for the year?

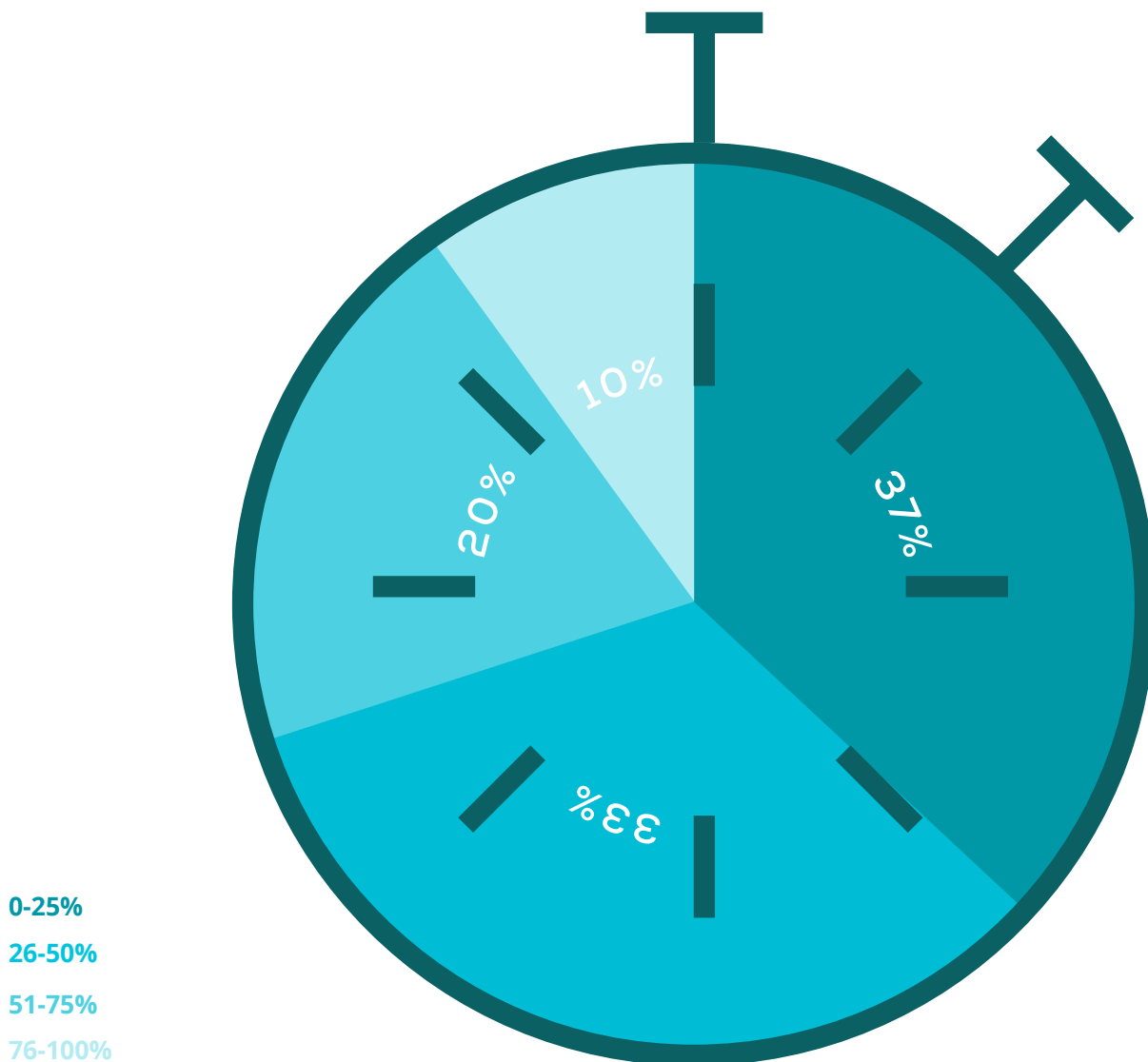


14. About what percentage of your organization's workforce will complete more than 1 hour of accumulative compliance training for the year?



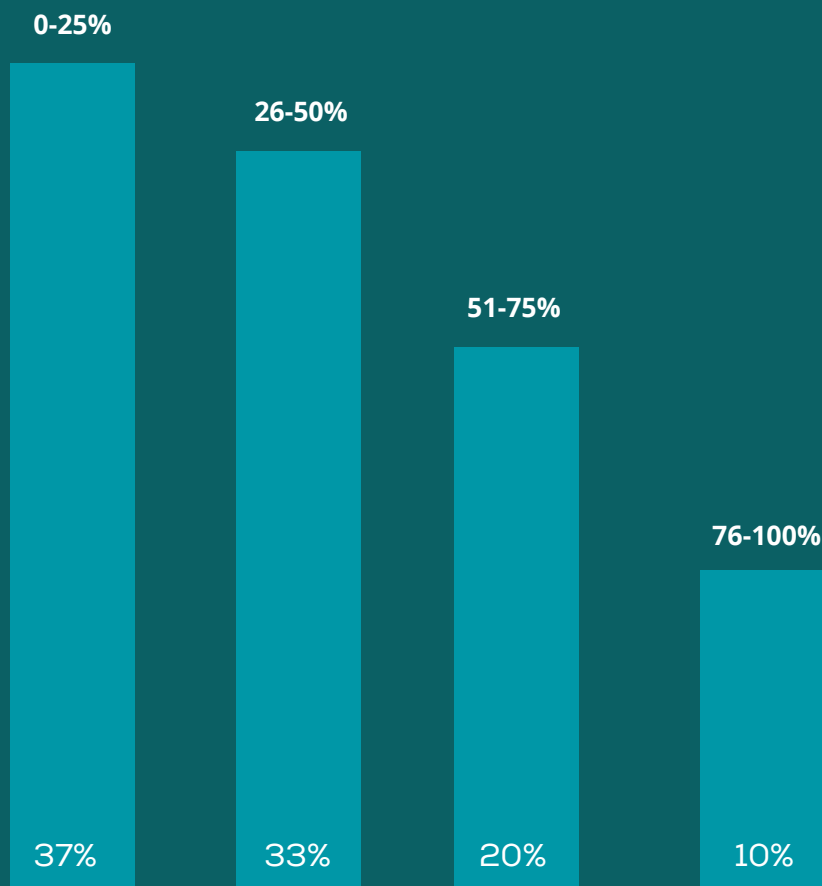
Operations Continued

15. What percentage of your compliance program's time do you anticipate will be devoted to training efforts?

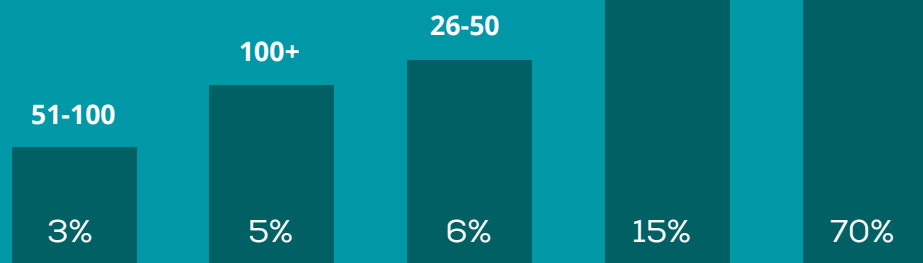


Monitoring

16. What percentage of your compliance program's time do you anticipate will be devoted to Auditing and Monitoring?

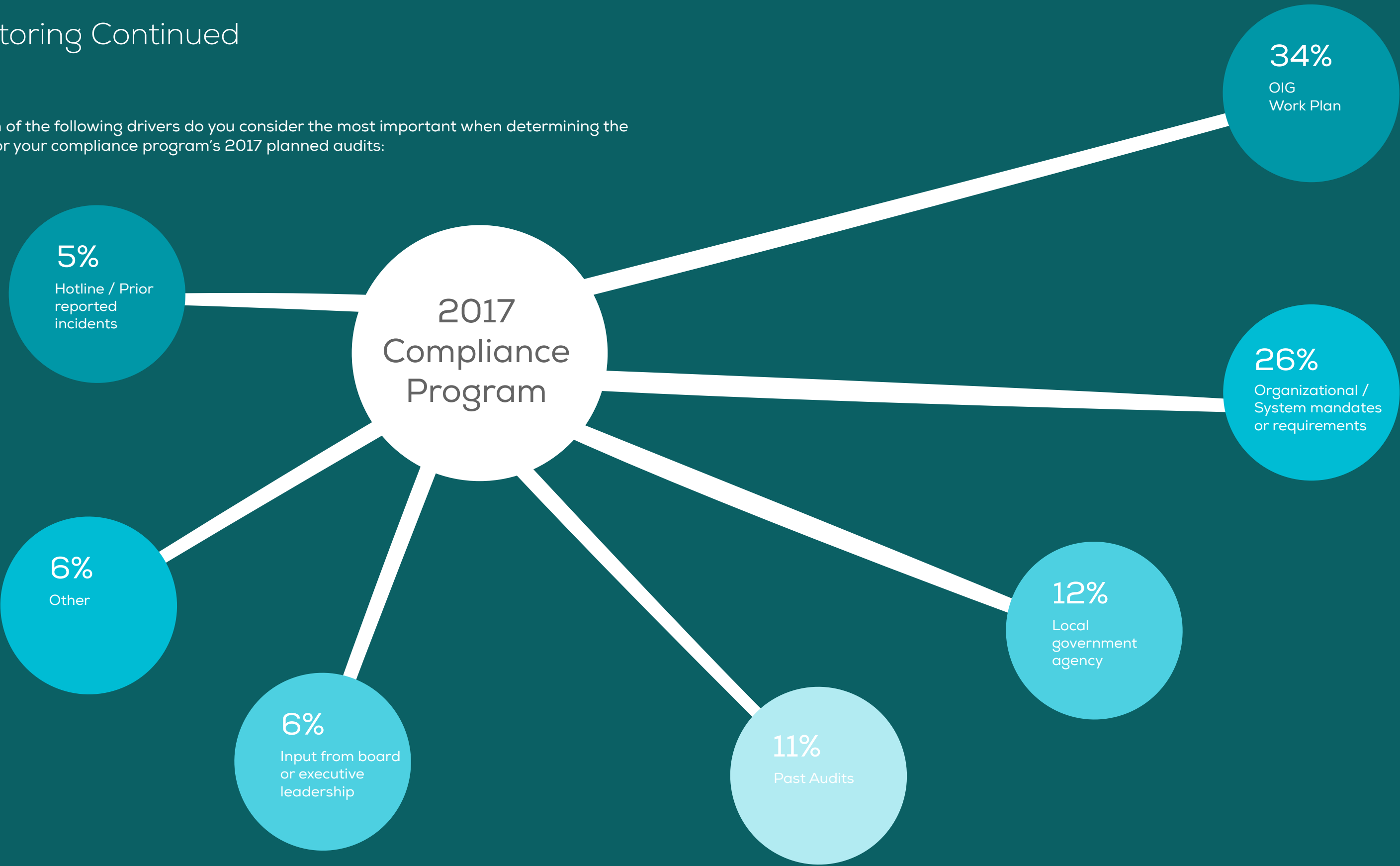


17. Based on previous years, how many incidents of non-compliance do you anticipate being reported to, or discovered by, your compliance program for 2017?



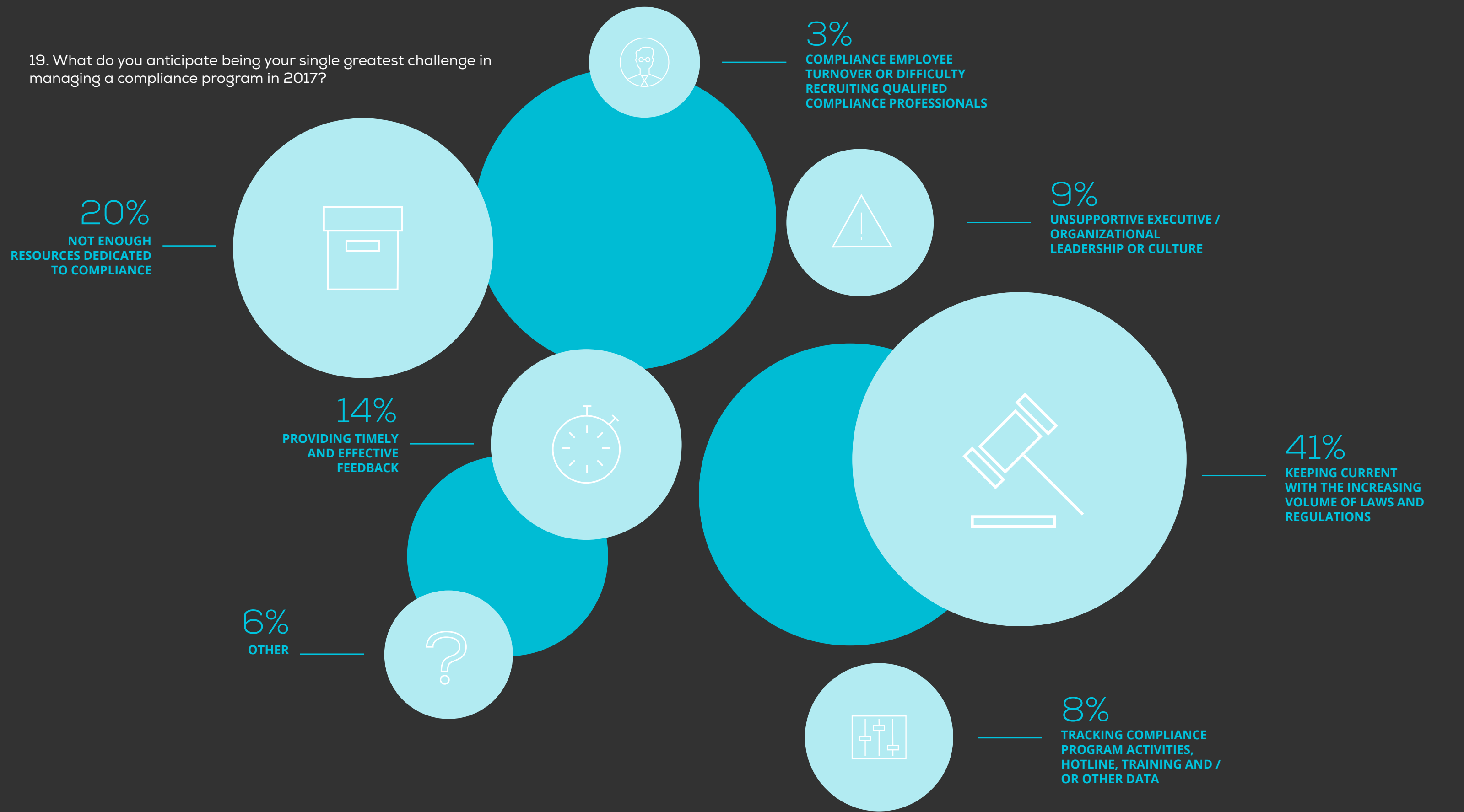
Monitoring Continued

18. Which of the following drivers do you consider the most important when determining the priority for your compliance program's 2017 planned audits:



Monitoring Continued

19. What do you anticipate being your single greatest challenge in managing a compliance program in 2017?





Introduction

Formal billing and coding compliance programs are implemented by organizations to establish and maintain standards of conduct, guidelines and procedures aimed at ensuring accurate submission of medical claims. While 88% of respondents indicated having implemented such a program, there still remains 12% of organizations who are non-compliant.

Despite finalization of the OIG Compliance Program for Individual and Small Group Physician Practices in October, 2000, only 80% of medical groups have implemented formal programs to address auditing and monitoring for billing and coding compliance. Despite the OIG programs being designed to be scalable and achievable for all medical practices, implementation also correlates with practice size where smaller practices are far less likely to implement billing compliance programs.

Formal Billing & Coding Compliance Programs

Percent of organizations who have implemented a formal billing / coding compliance program

Organization Type	Yes
Academic Medical Center	100%
Billing / Coding Company	89%
Hospital	96%
Long Term Care Facility	85%
Medical Practice	81%
Payer / Insurance Company	95%

Percent of medical group practices who have implemented a formal billing / coding compliance program

Medical Practices by Size	Yes
1 - 25 Providers	74%
26 - 50 Providers	86%
51 - 100 Providers	88%
101 - 200 Providers	100%
200 and Above	100%

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Governance

Oversight by committee remains the most common reporting and accountability structure for managing billing compliance programs. Billing Compliance Committees tend to meet on a frequent basis with 35% of organizations meeting monthly and 43% meeting quarterly.

1. Does your organization have a designated compliance committee that oversees medical coding and auditing activities?



Result by Organization Type	Yes
Academic Medical Center	95%
Billing / Coding Co.	60%
Home Health	56%
Hospital	74%
Long Term Care Facility	68%
Medical Practice	59%
Payer / Insurance Co.	89%

2. What is the frequency of your compliance committee meetings?

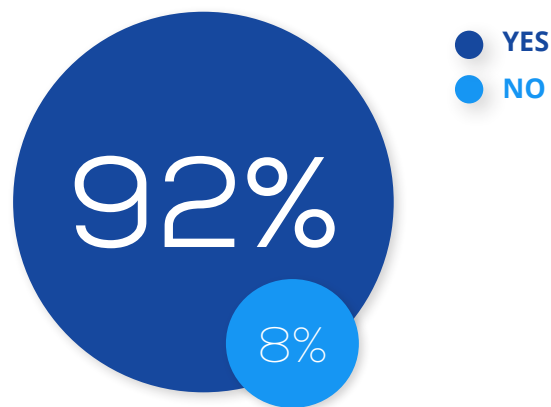
Annually	Bi-annually	Infrequently*	Monthly	Quarterly
4%	6%	12%	35%	43%

*less than annually

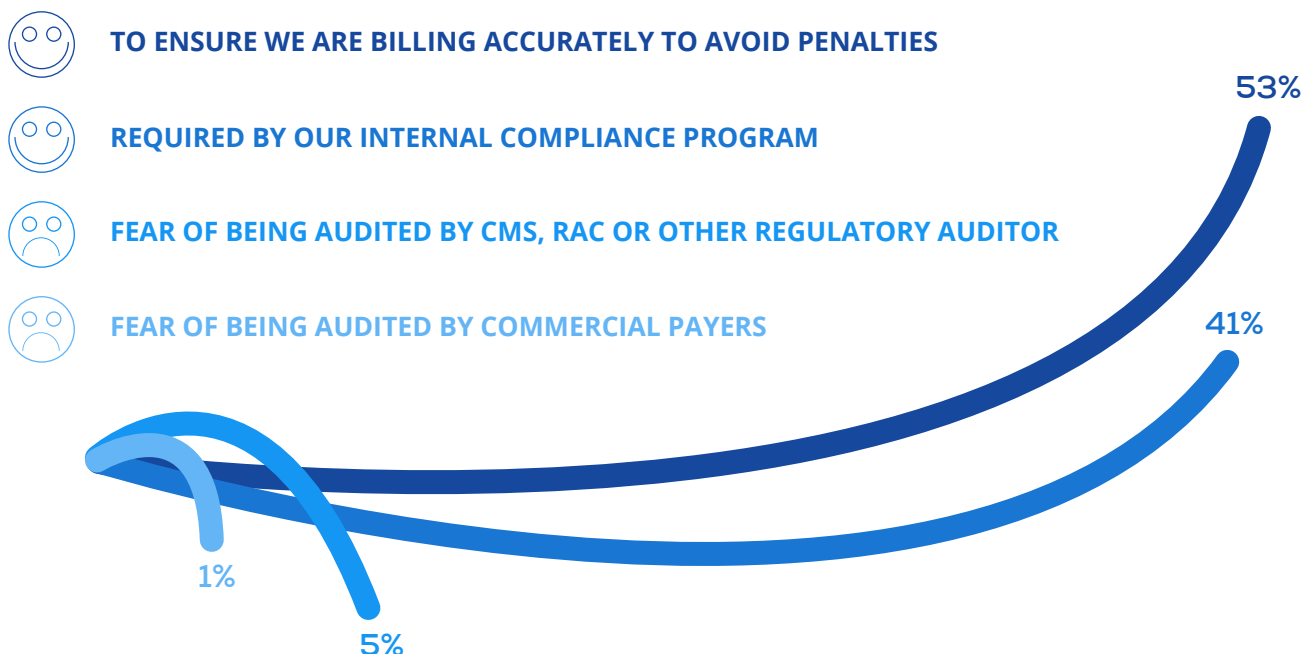
Auditing

Internal audit programs focused on assessing, correcting, and maintaining controls to promote compliance with applicable rules and regulations, is among the key elements of sound billing compliance programs outlined by the Department of Health and Human Services and Office of Inspector General (HHS-OIG). Industry-wide, approximately 92% of healthcare organizations with billing compliance programs indicated they conduct formal documentation & coding audits of their medical providers.

3. Does your compliance program require formal documentation / coding audits of your medical providers?

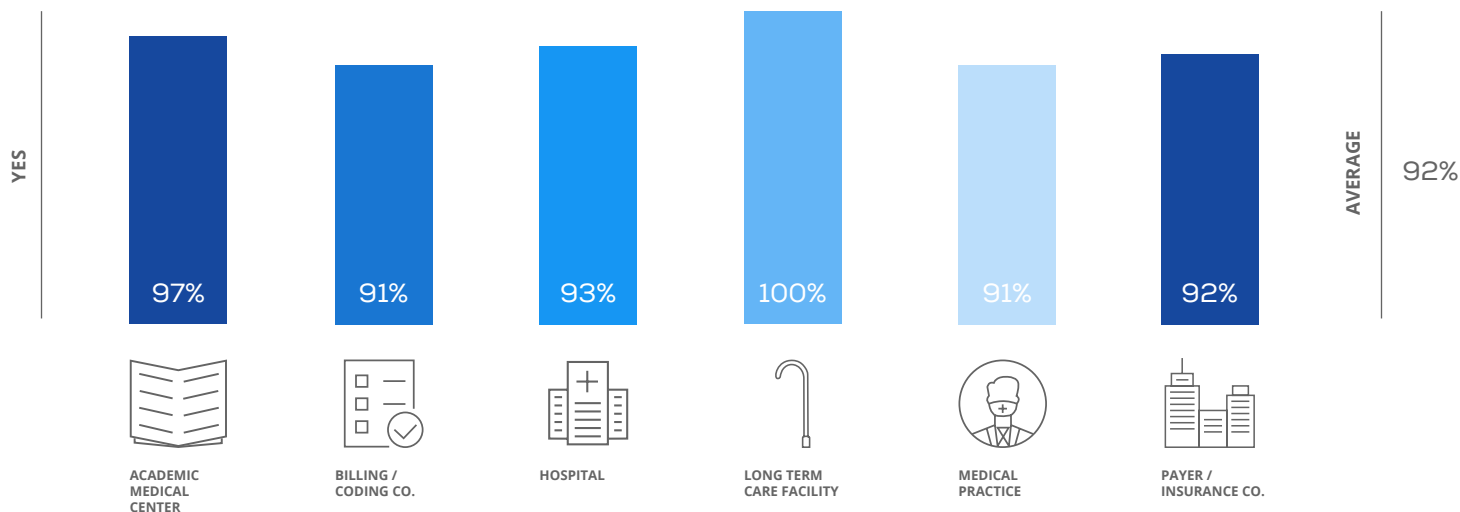


4. The primary reason your organization conducts formal documentation / coding audits.



Auditing Continued

5. Does your compliance program require formal documentation / coding audits of your medical providers?



Smaller organizations are less likely to conduct formal audits than those of larger size. Lack of resources, cost of compliance and a belief that being smaller makes you less likely to be scrutinized by regulatory agencies or payers were the most common reasons cited for not conducting reviews.

Medical Practices by Size	Yes
1 - 50 Employees	83%
51 - 200 Employees	90%
201 - 400 Employees	89%
401 - 1,000 Employees	94%
1,000 + Employees	97%



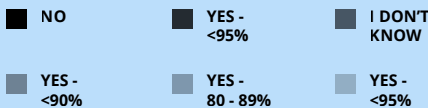
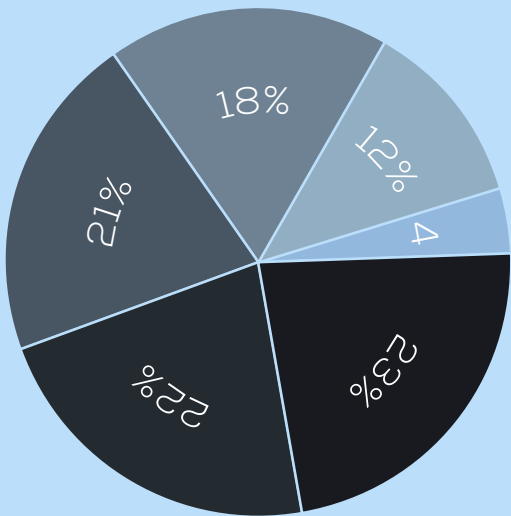
Industry Insights

Implementing a formal billing compliance program, either through committee or a compliance officer, establishes accountability for compliance oversight. Trends among high performance organizations:

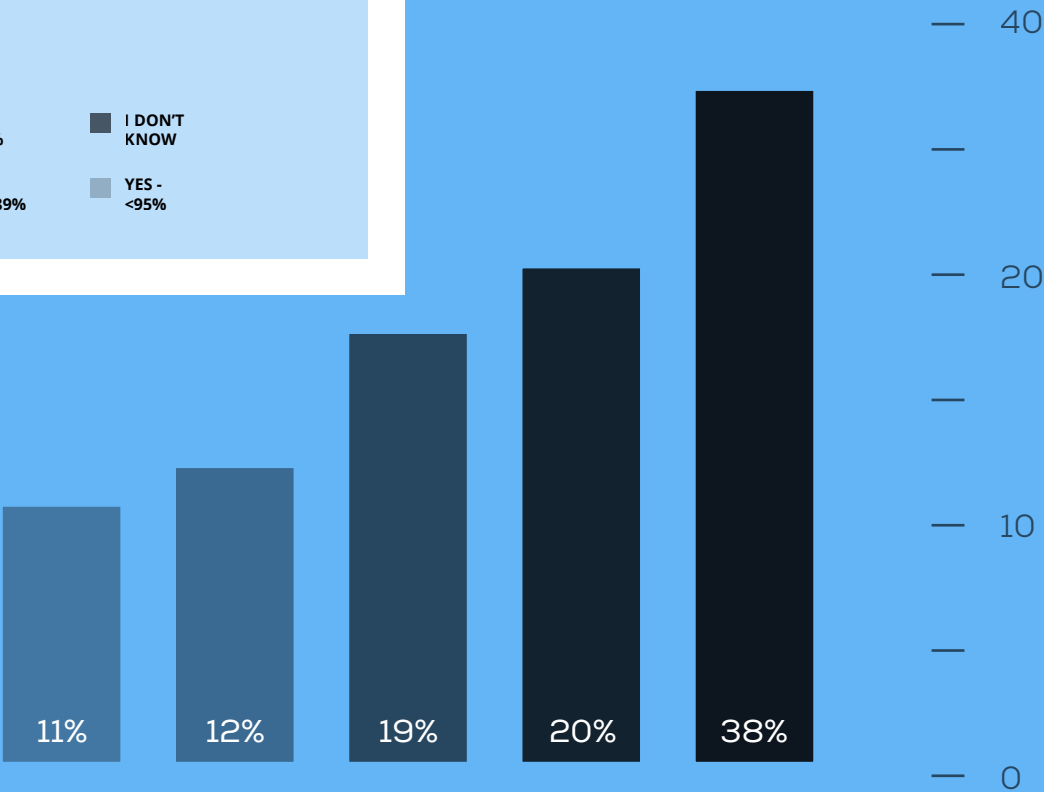
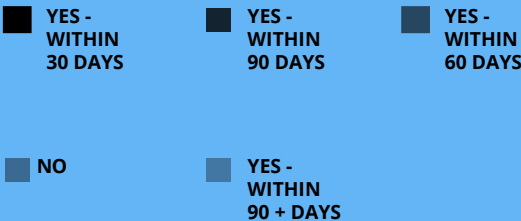
- Compliance and audit functions are independent of the operational areas they evaluate, allowing for proper lines of reporting, authority, and access to achieve independence and governance.
- The compliance committee or designated compliance officer occupies senior leadership levels with the authority to undertake and comply with the associated responsibilities of the role.
- Enacted minimum qualifications and process to select and appoint compliance committee members, or a compliance officer.
- Do not allow operational areas subject to auditing and monitoring activities to inappropriately influence functional administration and resource allocation for the compliance committee members or compliance officer.

Auditing Continued

6. Does your organization have a defined pass rate threshold that is used for passing or failing a provider on their audit?



7. If a provider fails an audit, does your organization require that provider to be re-audited?



Audits

8. Does your organization require provider education prior to a re-audit?

Re-Audits

Yes

IDK

No

10%

10%

80%

9. Does your organization conduct formal audits prospectively or retrospectively?

Formal Audits

56%

29%

15%

IDK

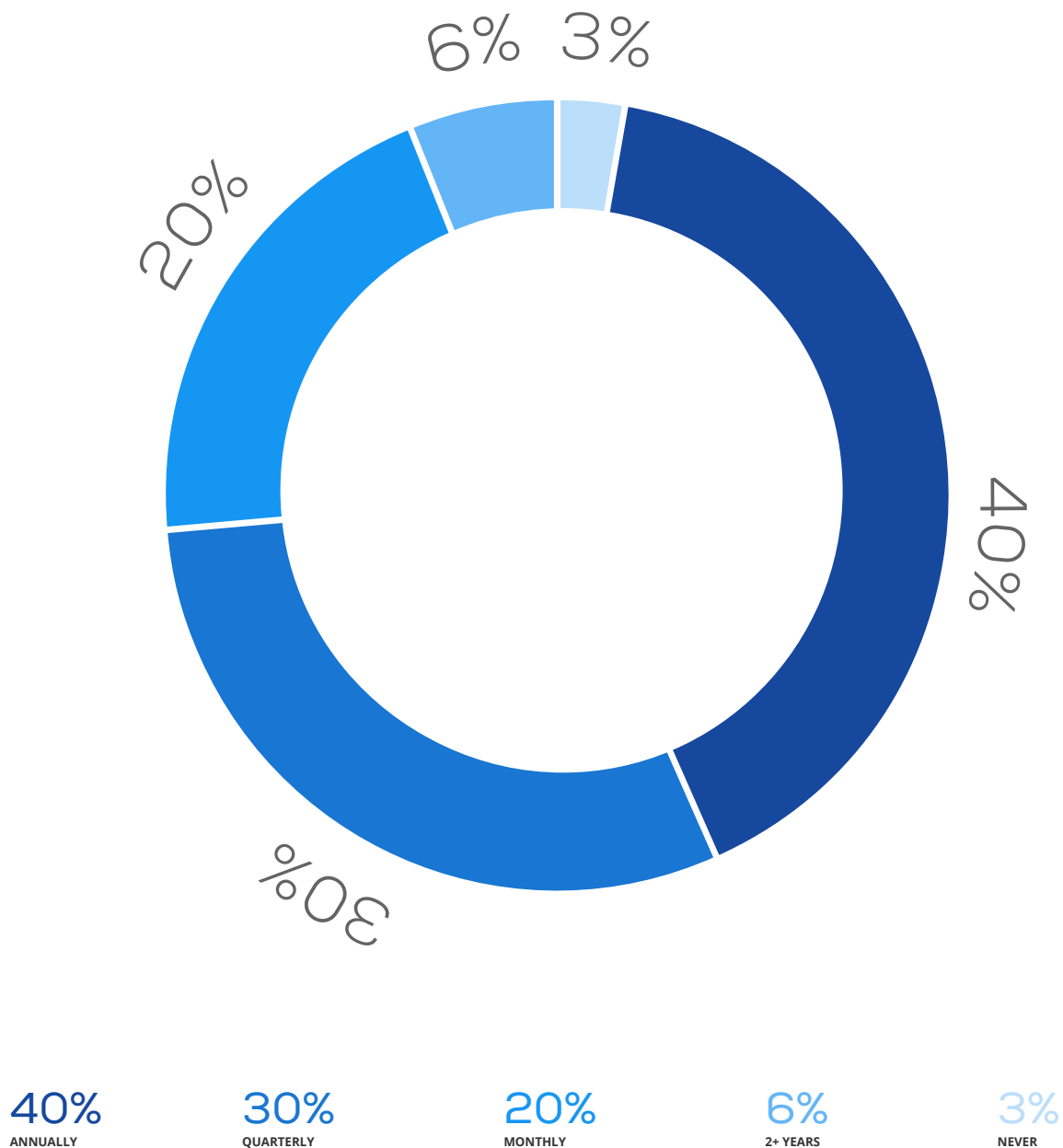
Prospectively

Retrospectively

Frequency of Formal Documentation / Coding Reviews

According to the Department of Health and Human Services and Office of Inspector General (HHS-OIG), medical claims should be reviewed regularly for compliance with applicable coding, billing and documentation requirements. While no specific standard has been mandated, HHS-OIG recommends that an internal formal review occur at least annually. Survey results suggest providers are implementing more stringent standards in order to monitor compliance, with 50% of organizations choosing to conduct formal audits at least quarterly or monthly.

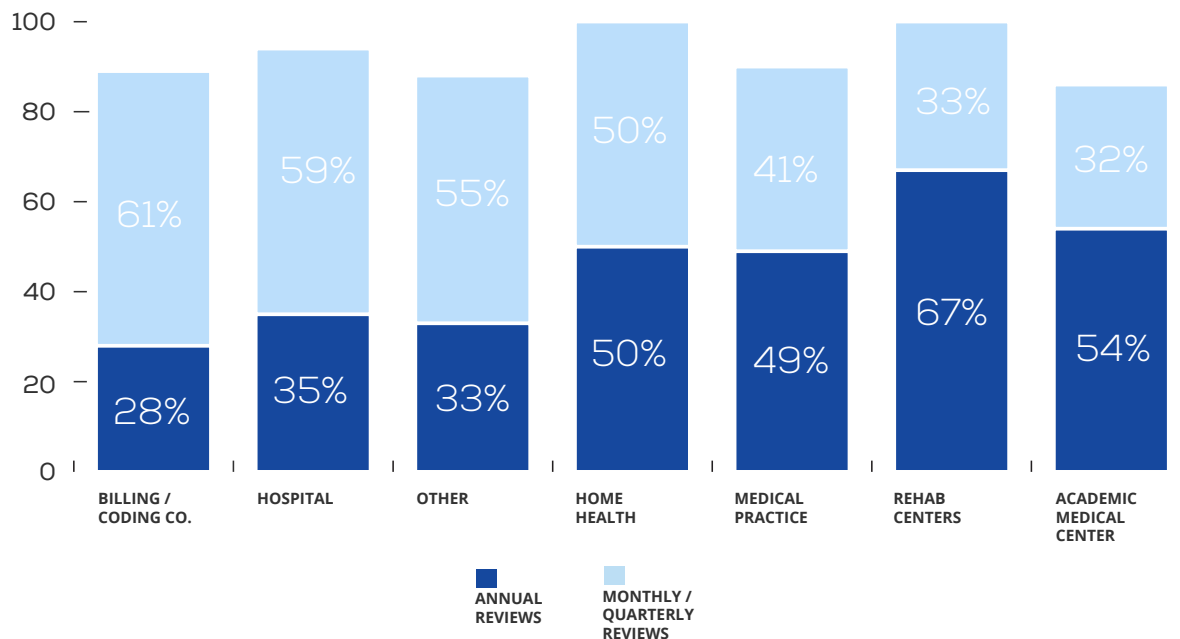
10. How Frequently Are Formal Documentation / Coding Audits Conducted on Your Providers?



Frequency of Formal Documentation / Coding Reviews Continued

Of the various provider organization types, hospitals and billing companies audit with the most frequency. Survey results showed that 60% of hospitals and 61% of billing companies conduct formal audits of their providers at least once per quarter.

11. Frequency of Formal Documentation / Coding Audits by Provider Type?



12. Frequency of formal documentation / coding audits by medical group size

Medical Practices	Annually	Quarterly	Monthly	Less Than Annually
1 - 25 Providers	31%	30%	24%	15%
26 - 50 Providers	46%	39%	9%	7%
51 - 100 Providers	47%	32%	17%	4%
101 - 200 Providers	60%	23%	12%	5%
201 - 300 Providers	55%	25%	15%	5%
301 - 400 Providers	55%	23%	19%	3%
401 - 500 Providers	55%	27%	18%	0%
500 + Providers	46%	27%	18%	8%
Overall	44%	29%	18%	9%

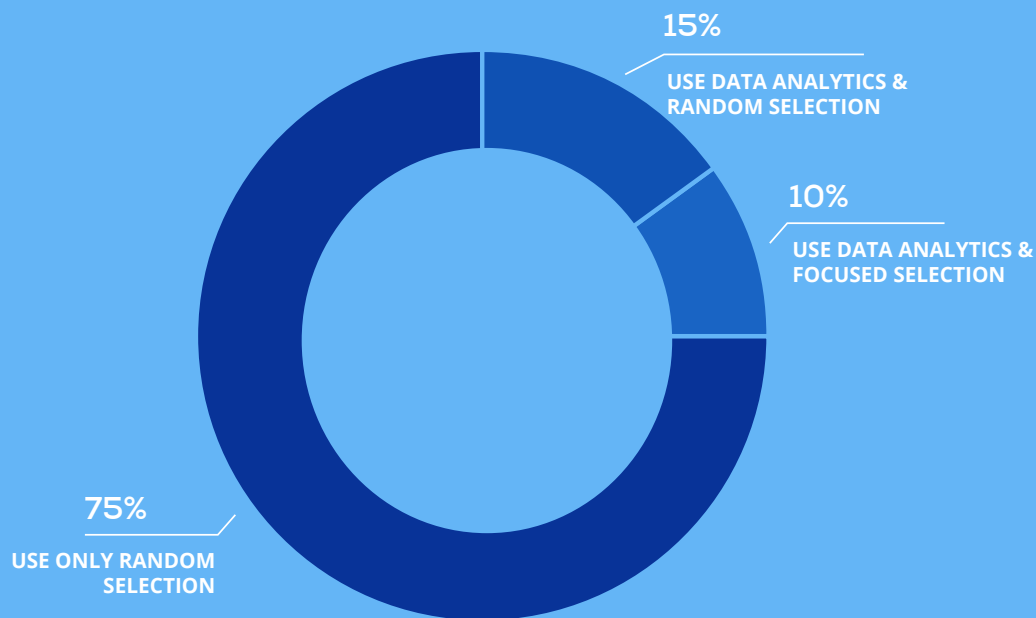


Drilldown: Smaller medical practices conduct audits more frequently than larger medical practices.

Selection Methodology

Despite advances in technology and data analytics tools, most providers still prefer to rely on arbitrary random sampling methods for their compliance audits. Survey results revealed that 75% of organizations continue to rely solely on random sampling methods for chart selection. However, the use of more sophisticated sampling methods is growing, with 25% of organizations indicating they have adopted the use of data analytics to assist in determining chart selections.

13. Audit Sample Selection by Methodology Type:



Industry Insights

Industry-accepted best practice for conducting compliance audits has been to utilize a random sampling of medical records. However, given more recent advances in technology and data analytics, it begs the question if providers are falling behind the times. With an increasing focus on fraud, waste and abuse, many regulatory agencies and payer organizations are increasingly adopting analytic and detection software tools to monitor medical claims. For the vast majority of provider organizations still using random sampling, this could become an outdated method that puts them at risk.

Even for those organizations using data analytics, we found that the majority of them are only using the information to help identify broad areas to target for review while still relying on randomized selections. [For example, organizations might use software to help analyze utilization patterns of providers and identify those providers with high patterns of 99214 or 99215 code types. But then conduct a random sampling of those codes for audit instead of leveraging technology to drill down deeper and identify specific claims for focused review.]

In order to keep pace with payers and audit agencies, providers need to consider changing old standards and begin incorporating more sophisticated practices that can be surprisingly easy, given the right tools.

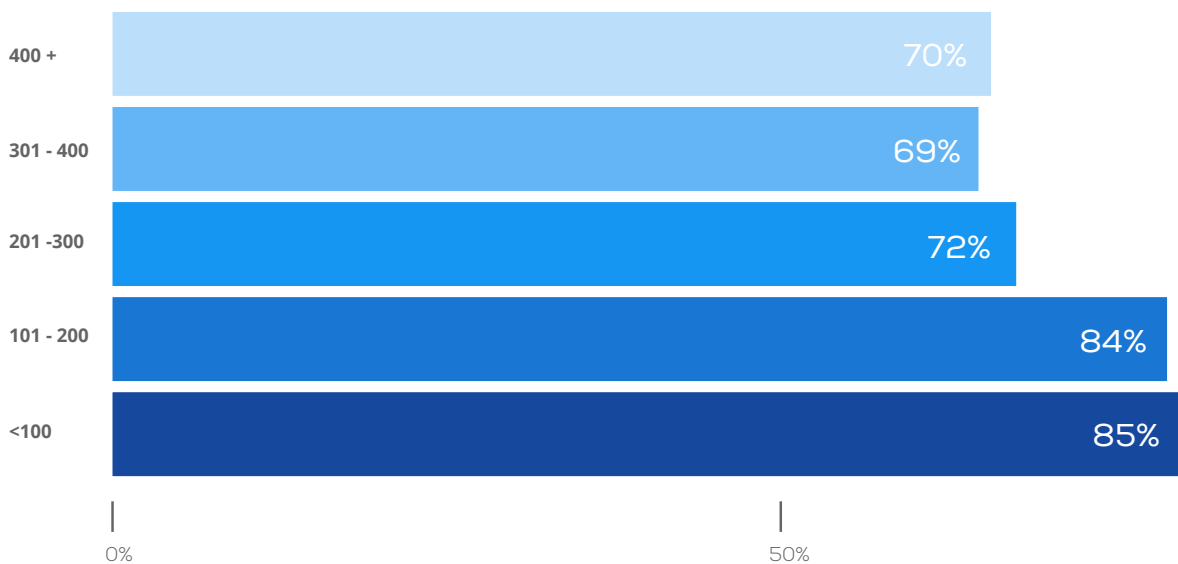
Selection Methodology Continued

Breakdown by the Numbers

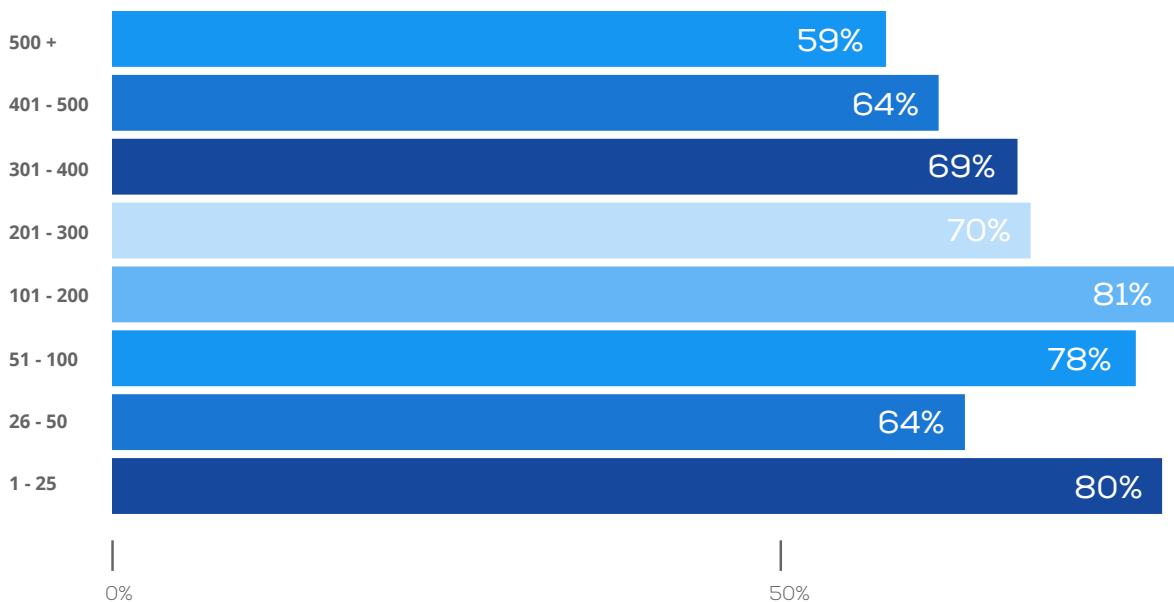
Both hospitals and medical groups of larger size tend to utilize more sophisticated sampling methods for conducting compliance chart audits.

- 85% of hospitals with 200 beds or fewer utilize random sampling as their only method for conducting audits, compared to 70% of hospitals with 200 beds or more.
- 80% of medical practices with 200 providers or less utilize random sampling as their only method for conducting audits, compared to 66% of practices with 200 physicians or more.

14. % of Providers Using Random Sampling as Only Selection Method: Hospital Size by Bed Count



15. % of Providers Using Random Sampling as Only Selection Method: Medical Practice by Provider Count



Sampling Size

Use of statistically valid sample sizes helps ensure confidence and accuracy in one's audit results. Conversely, the consequences of using too few samples can undermine the reliability of the audit and impacts acceptance of the results. Despite this, use of statistically valid sampling is almost non-existent in compliance audits. Rather, cost and availability of resources are cited as the most common drivers for determining sample size. The most common sample size for coding/documentation audits was 10-15 records per provider.

16. Audit sample size by organization type

Organization Type	< 10	10 - 15	16 - 20	21 - 25	25 +
Academic Medical Center	23%	53%	0%	7%	17%
Ambulatory Surgery Center	67%	33%	0%	0%	0%
Billing / Coding Company	29%	42%	5%	8%	16%
Home Health	20%	40%	20%	0%	20%
Hospital	23%	49%	11%	6%	11%
Long Term Care Facility	40%	0%	0%	20%	40%
Medical Practice	25%	52%	10%	6%	7%
Payer / Insurance Co.	26%	46%	9%	6%	13%
Grand Total	26%	46%	9%	6%	13%



Industry Insights

Consider the impact sample size plays on your audits:

- Keep in mind the effect your sample size can have on your pass rate using such a combination. A common combination of sample size and pass rates was found to be a 10-chart review with a 95% pass rate. If your pass rate is calculated on the number of correct charts versus incorrect, then you have made it mathematically impossible for the provider to pass the audit unless they have 100% accuracy. Consider setting your pass rates first. Then either use a weighted scoring of the charts or increase your sample size to allow for a reasonable margin of mistakes.
- Organizations are starting to tie audit results to physician compensation. The consequences of using too few samples is leaving favorable or negative audit results to chance simply by the nature of the selection process. When compensation is at stake, keep in mind physicians will tend to strongly resist poor results, negating their accuracy based on "luck of the draw." When tying punitive action or rewards to audit results, remember to consider the importance of utilizing appropriate sample sizes.

Feedback

88% of organizations use audit reports to capture the results of each audit conducted. Analyzing and reporting on audit findings for each practitioner within the organization is a critical step in effectively monitoring coding and billing compliance. At the completion of every audit, generate reports to review coding patterns, utilization, deficiencies, and areas needing improvement. Audit results should be reported in an organized format that allows the viewer to easily draw conclusions.

17. Do the audits include a written report of results and findings?



Industry Insights

Providers' most common complaints about audit reports:

- Providers like to see if they improved or got worse but reported that their audit results typically do not show trending information from prior audits.
- Audit reports don't provide enough meaningful feedback and/or recommendations.
- Audit reports' format / structure is too busy. Takes too long to find the pertinent information.

18. Do the audits include a formal written report of results and findings?

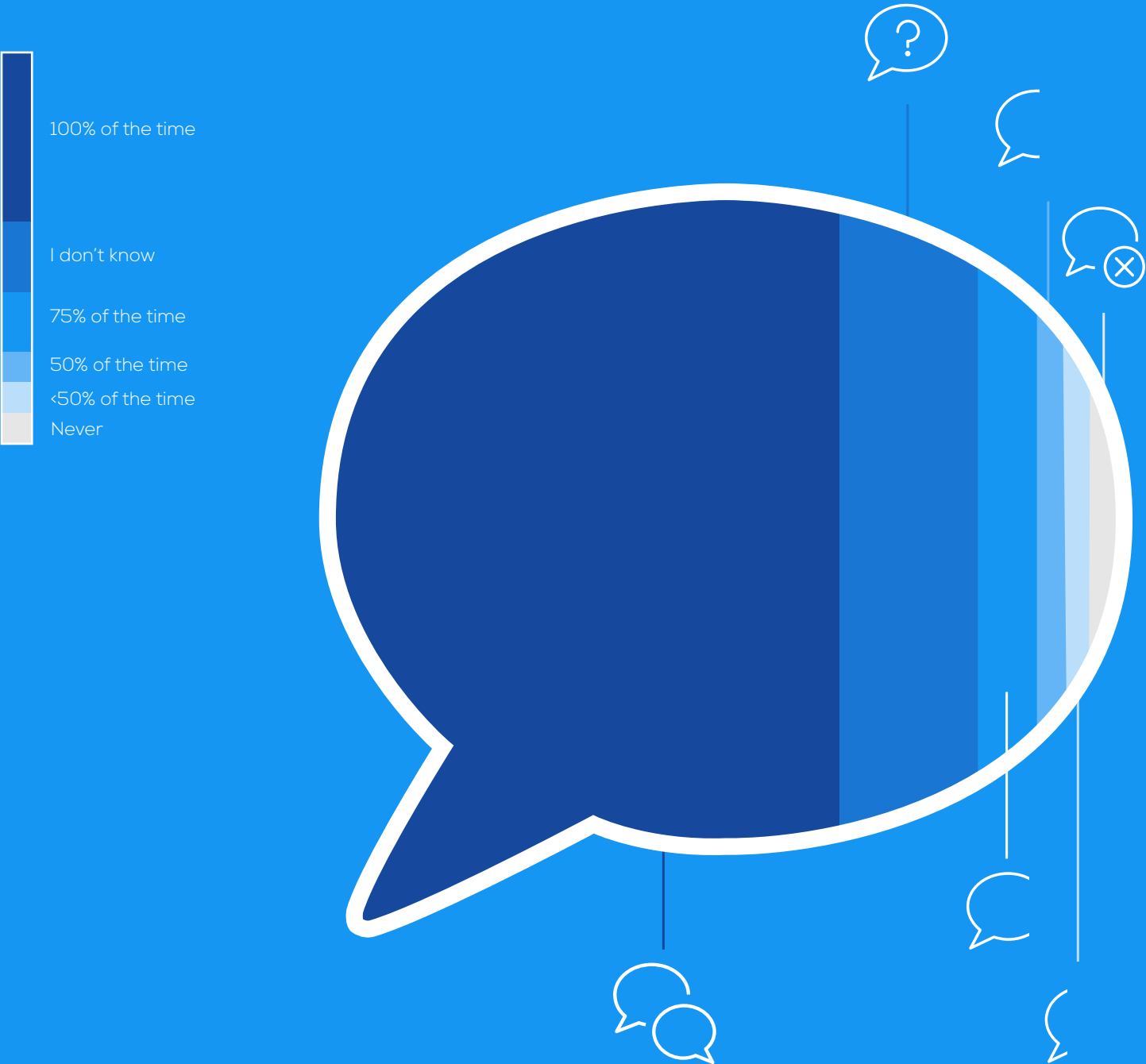
Organization Type	Yes
Academic Medical Center	97%
Ambulatory Surgery Center	100%
Billing / Coding Co.	88%
Home Health	100%
Grand Total	88%

Organization Type	Yes
Hospital	97%
Long Term Care Facility	80%
Medical Practice	84%
Payer / Insurance Co.	77%
Rehab Center	75%
Grand Total	88%

Feedback Continued

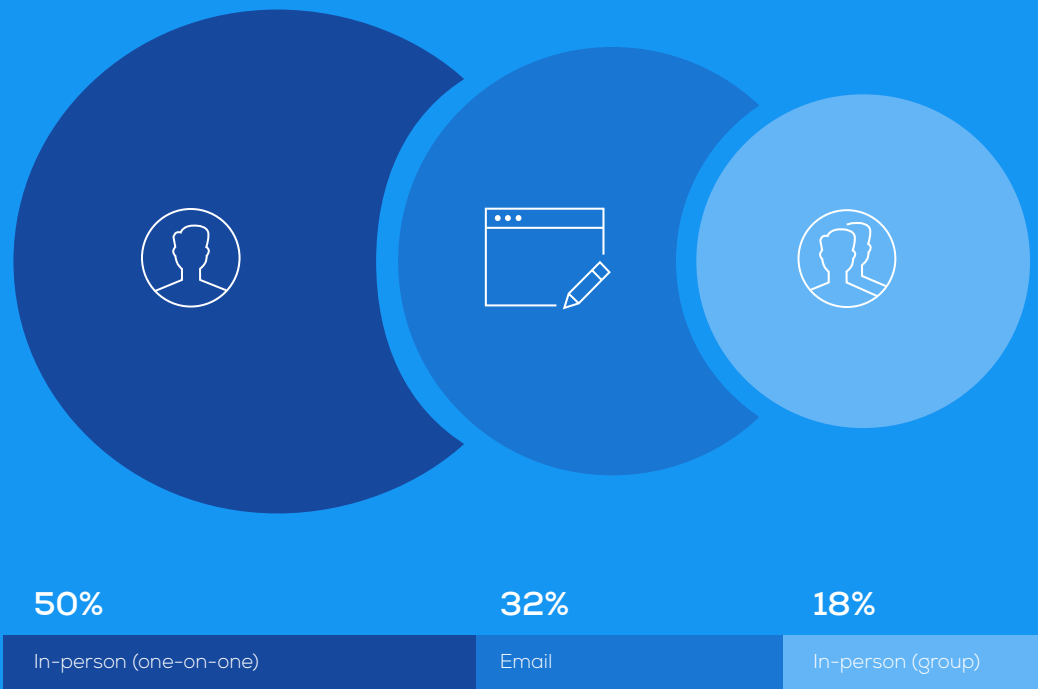
84% of respondents indicate audit results are communicated back to providers 100% of the time. Post-audit feedback should be conducted at the completion of each audit to ensure compliance with regulatory standards. Post-audit training is a critical component to address issues or trends that are identified through the monitoring process. The ideal standard for communicating results is through one-on-one interaction between the auditor and provider. 50% of organizations reported in-person feedback was their primary method of conducting post-audit reviews, followed by email.

19. How often are audit results communicated back to the providers?



Feedback Continued

20. How are audit results typically communicated back to the providers?



The most common reason for not communicating audit results back to providers was due to lack of staffing, followed by providers being too busy to make time.

Not Required	15%
Not Enough Resources / Staff	32%
Providers Too Busy	25%
Providers Are Not Interested	15%
Other	13%

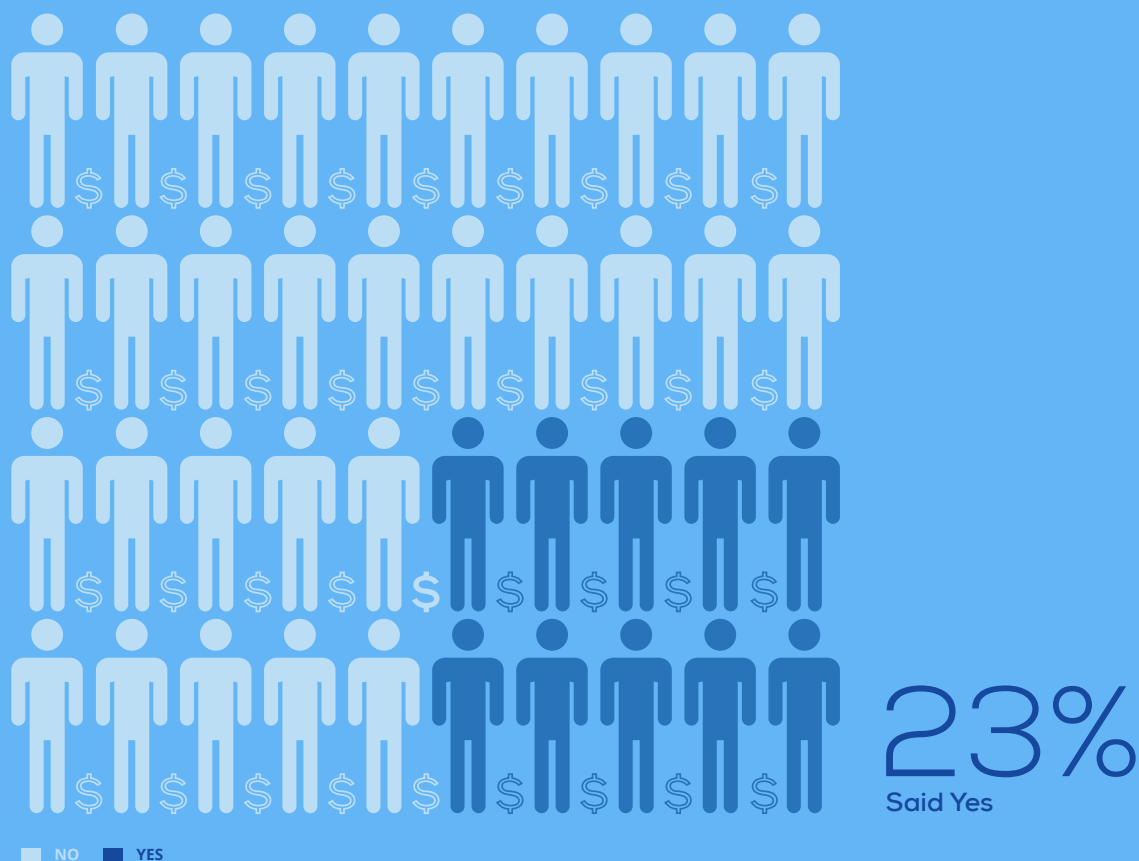


Industry Insight

The auditor-to-provider staffing ratio needs to be sufficient to enable the auditor to carry out the audit requirements specified within the organization's audit/compliance program. The recommended auditor-to-provider ratio should not exceed 100 providers per auditor. This ratio may vary depending on the scope and frequency outlined within the organization's audit/compliance program requirements.

Linking Compensation & Performance

21. Does your organization tie any of your providers' compensation to the results of their audits?



Many organizations have evaluated various ways in which to encourage physician engagement around documentation and coding compliance. Methods such as tying compensation in the form of bonuses or other monetary rewards have been adopted by the industry. According to the survey results, 23% of organizations reported tying compensation to audit results.

Organization Type	Yes
Academic Medical Center	22%
Ambulatory Surgery Center	0%
Hospital	28%
Long Term Care Facility	25%
Medical Practice	18%
Payer / Insurance Company	41%
Rehab Center	0%
Grand Total	23%

Case Study



SIZE

1,000 + Providers



GROUP TYPE

Multi-Specialty Medical Group



CHALLENGES

Provider Accuracy



ANSWER

Audit Services

In an effort to improve documentation and coding compliance, this medical group implemented a pilot incentive program which tied the providers' compensation to their audit results. In order to qualify for the bonus payment, providers were required to meet or exceed a specified accuracy rate on their audit results. Bonus payments were in the form of cash compensation, in addition to providers' regular earnings. The program was intended to reward excellence and incentivize providers to be engaged in the audit process.

Lessons Learned

- In some cases, the incentive eventually led to an "adversarial" atmosphere between auditors and physicians rather than a collaborative one. A perception began to develop among physicians that auditors had lost their objectivity because of pressure from management who wanted to avoid paying bonuses.
- The program resulted in the workforce (not just physicians) being hesitant to report other compliance issues/concerns due to concerns it might impact a provider's bonus.
- Overall the audit focus changed to 'doing audits to get a bonus or not getting a bonus' rather than to help identify areas of risk or improvement opportunities.
- Auditors' workloads increased significantly as they were having to provide more information in their reports and spend more time with physicians to defend their results. This also led to higher requests for re-audits by providers looking to achieve better scores.
- The pilot program was successful from the standpoint that the providers were more engaged in the process and it led to changes in documentation and coding behavior. However, the unintended consequences of the negative environment it created, pressure on auditors and increased cost of auditing, outweighed the benefit of the program.



Results

What they are doing now

In light of the lessons learned from their initial pilot program the organization has since made fundamental changes to their program. Results are no longer tied to compensation, rather the organization identified alternative means of recognizing providers with outstanding audit results. Additionally, the organization chose to focus on incentivizing physicians for periodically completing educational courses intended to improve documentation and coding.

Outsourcing & Technology

Software

Audit Software

Yes No

69%

31%

22. Does your organization use any type of audit software to assist with conducting your audits?

CAC Software

No Yes

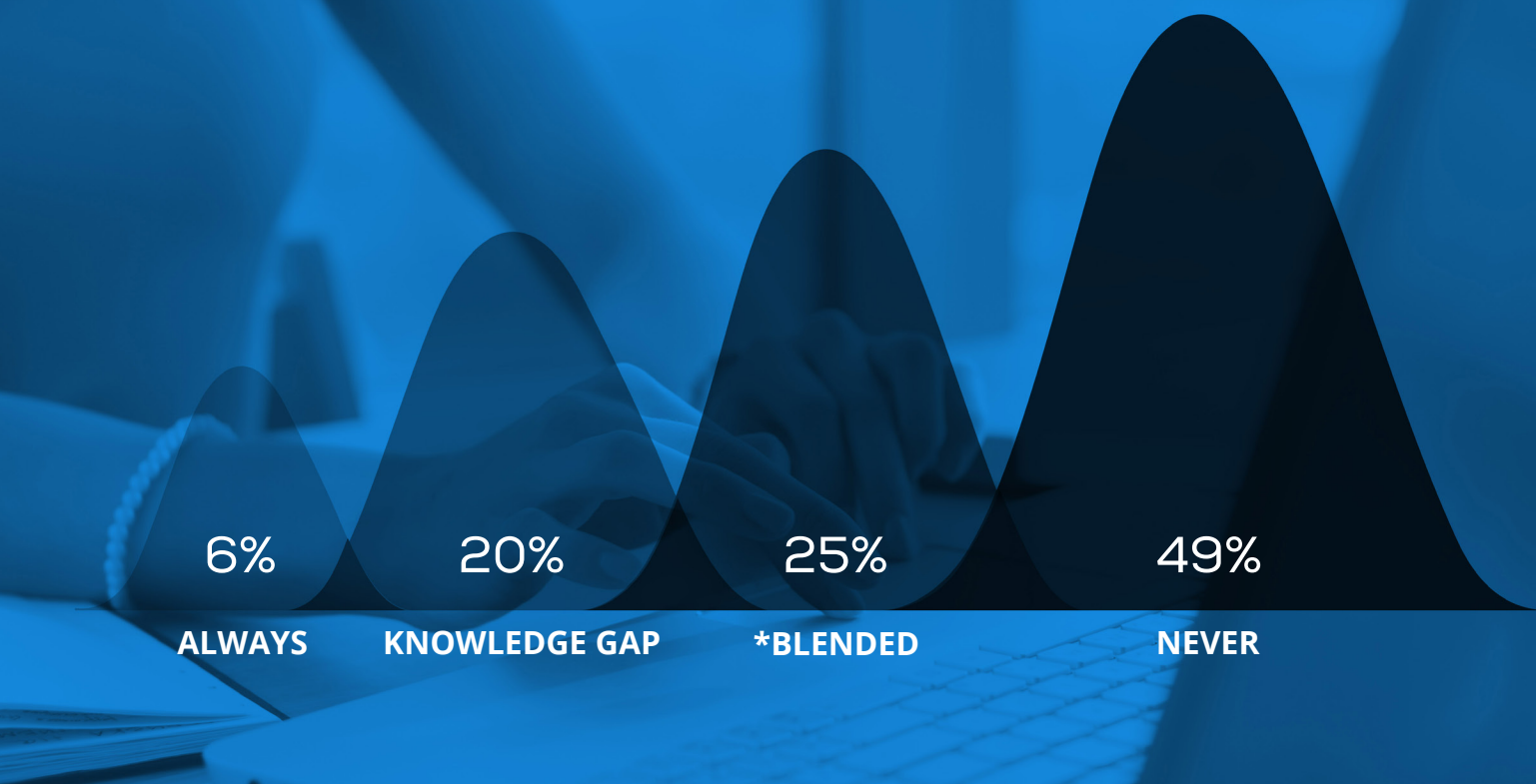
57%

43%

23. Does your organization utilize Computer Assisted Coding (CAC) Software?

Outsourcing & Technology Continued

24. Does your organization use third-party auditors for coding / documentation audits?



*Blended Model utilizes a consistent mix of both internal and external audits to complete work.



Point of View:

Organizations who utilize third-party vendors to assist with coding/documentation audits discussed the benefits.

- Frees up internal resources to be reallocated to other activities, such as post-audit training.
- Organizations reported experiencing less resistance from providers and greater acceptance of audit findings when seen as coming from an independent source.
- Increased ability to fill knowledge gaps where vendors may have access to a larger pool of specialty specific expertise.
- Allows for better cost control by limiting fixed costs expenses and being able to staff up or down your resources during audit projects.

See a breakdown of the results by organizational type on the next page >>

Outsourcing and Technology Continued

25. Use of third-party auditors for coding / documentation audits

Organization Type	100% Outsource	*Blended Model	Never	Only to Fill Knowledge Gap
Academic Medical Center	3%	10%	53%	33%
Ambulatory Surgery Center	0%	33%	50%	17%
Billing / Coding Co.	9%	29%	50%	12%
Home Health	0%	40%	40%	20%
Hospital	8%	25%	40%	27%
Long Term Care Facility	0%	0%	100%	0%
Medical Practice	4%	23%	55%	18%
Payer / Insurance Co.	5%	39%	37%	18%
Rehab Center	0%	50%	50%	0%
Grand Total	6%	25%	49%	20%

*Blended Model utilizes a consistent mix of both internal and external audits to complete work.



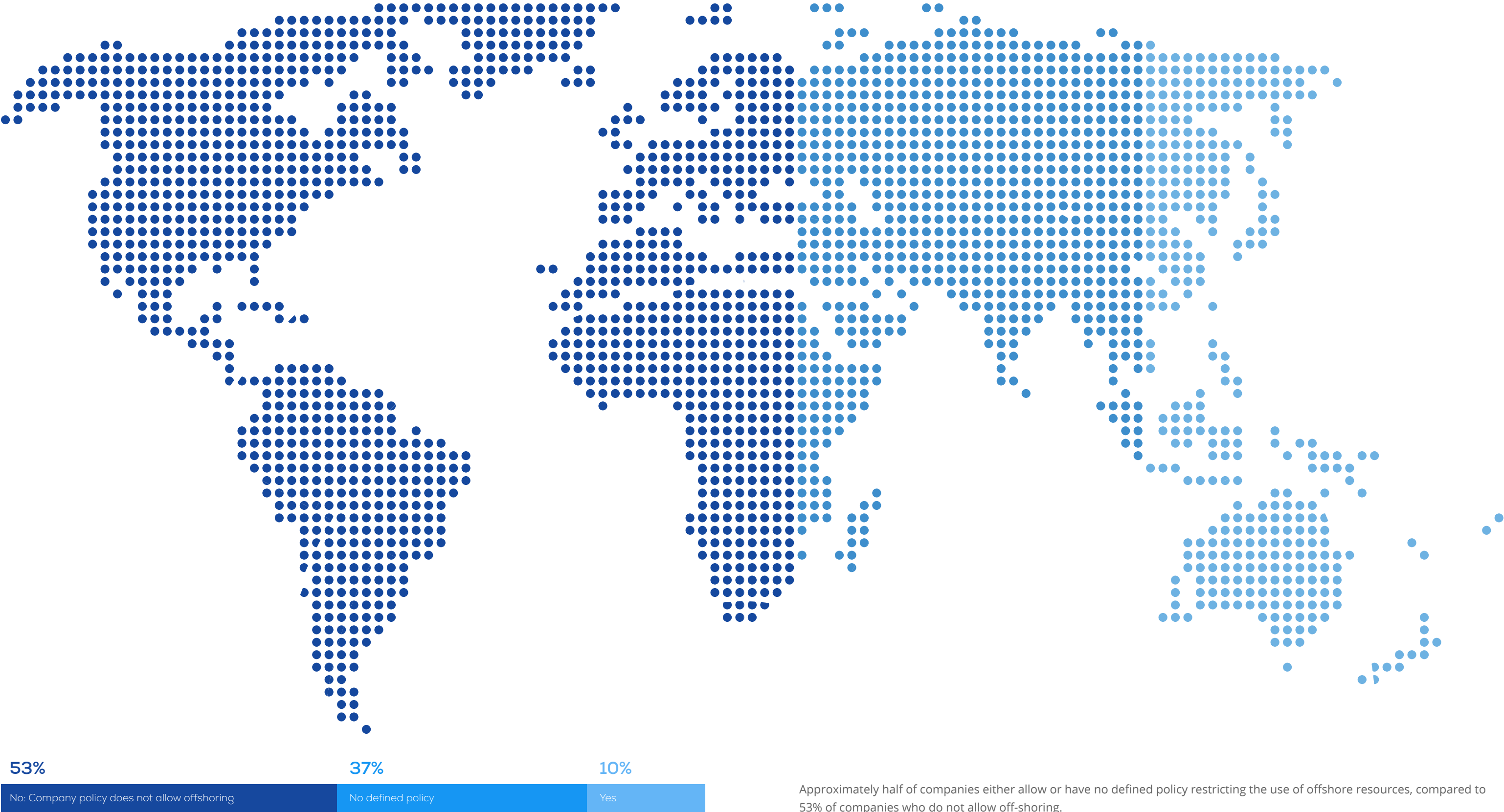
Drilldown:

Organizations who utilize third-party vendors to assist with audit work identified the most important "Selection Criteria When Evaluating using a Vendors." Results are ranked in order of Most to Least Important:

Quality / Accuracy of Work	18%
Use of Certified Staff	15%
Reputation of Organization	14%
Pricing	14%
Report Details	12%
HIPAA Security	11%
Turnaround Time	8%
Geographic Location	3%
Provide Offshore Resources	1%

Outsourcing and Technology Continued

26. Does your company allow the use of offshore resources to conduct medical coding or audit related services?



Qualifications

Qualified and competent subject matter experts should be utilized to conduct audits. Auditors should be credentialed professionals, qualified by advanced training and audit experience to ensure they are qualified to review claims in the practice's specialties. While 92% of organizations require their auditors to have a general medical coding certification (e.g. CPC, RHIT), industry adoption of more advanced certifications is growing with 35% of organizations requiring audit specific certifications (e.g. CPMA).

27. Does your organization require auditors to have a current coding certification from a reputable certifying body?



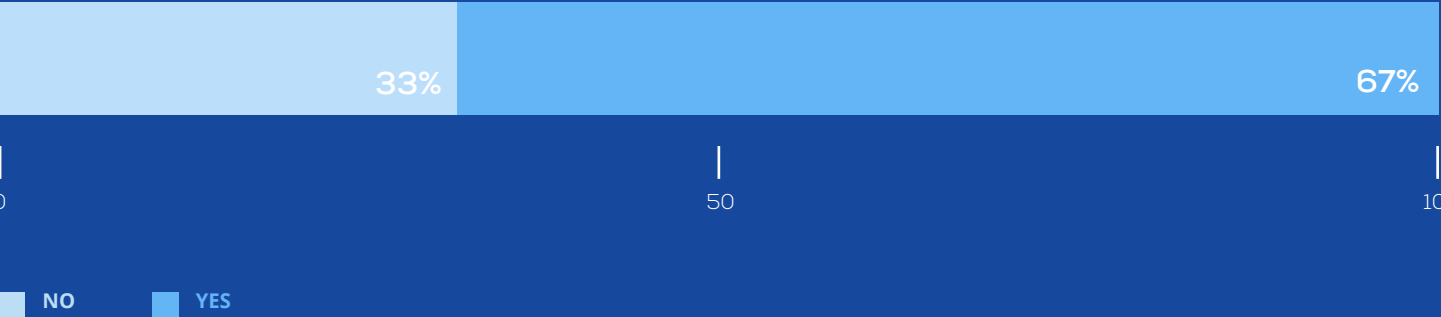
28. Does your organization require auditors to have an audit-specific certification?



Qualifications Continued

Only 67% of organizations regularly screen their auditors against the HHS-OIG’s List of Excluded Individuals and Entities, and the General Services Administration’s (GSA’s) list of Parties Debarred from federal programs.

29. Does your organization regularly screen your auditors to ensure they are not on the OIG or CMS exclusion databases?



Industry Insight

The Office of Inspector General has given guidance regarding healthcare providers employing or contracting with individuals who have been excluded from participating in federal healthcare programs. The excluded individual rule prohibits any direct or indirect involvement by an excluded individual in providing services billed to Medicare. This not only includes physicians and nursing staff but extends to administrative and support stuff, such as a coder and auditor.

Industry standard is to conduct a pre-employment background check of the exclusion list to confirm an applicant is not on the exclusion list for unethical or illegal dealings with Medicare and Medicaid. However, this is not enough. There is a legal doctrine called ‘negligent retention.’ The Affordable Care Act Section 6501 can hold an employer liable for negligent hiring or negligent retaining an excluded individual. The OIG may impose Civil Monetary Penalties of up to \$10,000 for each item or service furnished by the excluded person for which federal program payment is sought, as well as an assessment of up to three times the amount claimed.

If a healthcare employer is only conducting pre-employment OIG background checks, then they are exposing the company to possible risk of continuing to bill CMS for an existing employee items or services in its claims to CMS. Considering the sizable liabilities tacked on for employing just one excluded individual, it’s easy to see why an effective compliance policy incorporates regular searches of the OIG exclusion list. Best practice is to check the exclusion list monthly as that is how frequently the OIG updates the list.

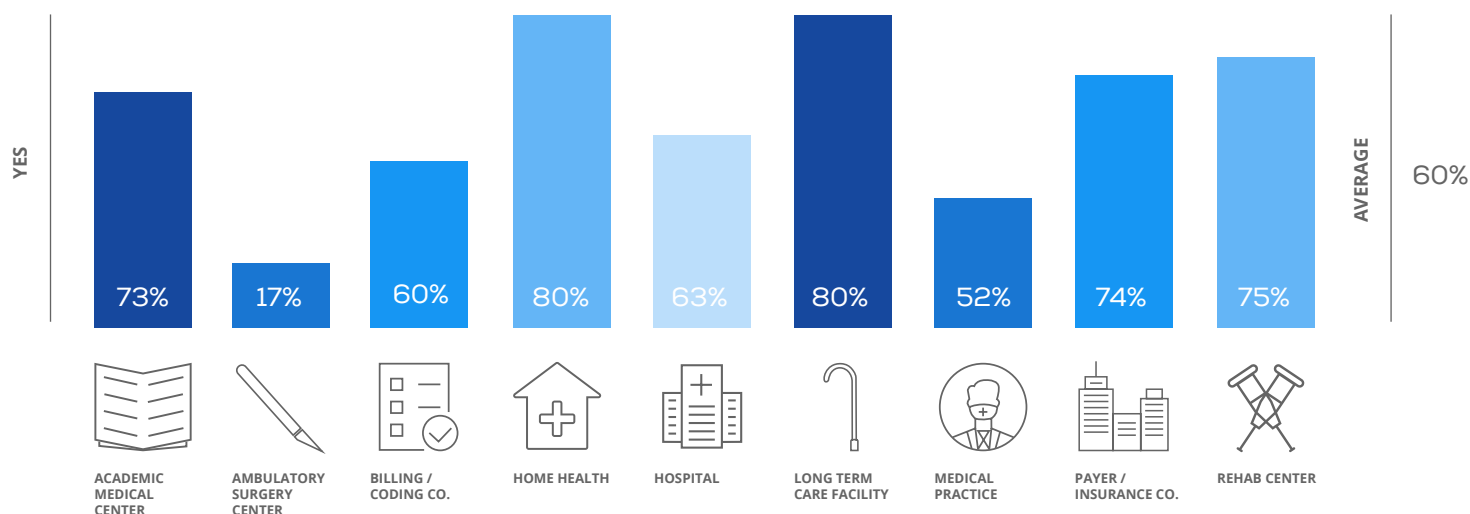
<http://exclusions.oig.hhs.gov>

Organization Type	Yes
Academic Medical Center	75%
Billing / Coding Co.	66%
Hospital	69%
Medical Practice	52%
Payer / Insurance Co.	70%
Grand Total	67%

Qualifications Continued

Standard practice of quality assurance should include enacting programs to monitor, assess, and measure auditors' performance and quality. However, only 60% of the organizations surveyed indicated they scrutinize the work of their auditors to verify accuracy and quality.

30. Does your organization audit the work of your auditors to verify quality and accuracy?



31. Percentage of organizations using external vs. internal QA

Organization Type	External Vendor	Internal QA
Academic Medical Center	9%	91%
Ambulatory Surgery Center	0%	100%
Billing / Coding Co.	8%	92%
Home Health	0%	100%
Hospital	10%	90%
Long Term Care Facility	0%	100%
Medical Practice	14%	86%
Payer / Insurance Co.	4%	96%
Rehab Center	0%	100%
Grand Total	11%	89%



Drilldown: External Vs Internal QA Review

Of those organizations who do conduct QA of their auditors, 89% use internal resources, compared to 11% who use independent external resources. Industry best practice suggests using qualified third-party vendors to validate internal findings, and the quality and accuracy of internal auditors, at least once per year. External validation can help mitigate the risk of subjective influences that can often occur within organizations.

Thank You

We hope you found our first annual report to be an informative, insightful, and, with any luck, fun read. Whether you identified areas for improvement or areas where you already excel (or a bit of both), know that just by being informed you're staying ahead of the curve.

A special thanks to those of you who participated in the survey and made this report possible. Because of your participation we've had the opportunity to share so much important knowledge with so many. We're already excited to get started on next year's report.

Credits

In order to bring you this report, Healthcity teamed up with AAPC to survey over 1,200 coding, auditing, compliance, and healthcare executives in the United States. All data was collected during the final quarter of 2016. Questions and Insights written by Daniel Schwebach and CJ Wolf.



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