



CLINICAL AUDIT



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Outline

- Clinical Audit Concept
- Challenges
- Personnel & Tools
- Key Findings
- Recommendations
- Actions & Cost Recovery



Reasons for Audit

- Compliance with standards:
 - Standard Treatment Guidelines
 - Tariff manual
 - NHIS Medicines List



Reasons for Audit

- Increasing cost of claims
- Increasing percentage cost of medicines
- Number of schemes filing for re-insurance
- High levels of indebtedness to providers
- Levels of fraud & abuse in the system



Cost of Claims

<u>YEAR</u>	<u>CLAIMS</u>	<u>COST</u>	<u>PER CLAIM</u>
2005	483,577	2,609,444	5.40
2006	3,711,123	19,219,447	5.18
2007	8,192,872	73,648,597	8.99
2008	11,025,806	125,226,831	11.36
2009	22,731,827	331,558,249.12	14.58



Cost of medicines

<u>YEAR</u>	<u>DRUGS</u>	<u>TOTAL</u>	<u>%DRUGS</u>
2005	505,656	2,609,444	19.40%
2006	4,885,823	19,219.447	25.42%
2007	31,164,713	73,648,597	42.32%
2008	57,440,315	125,226,831	45.87%
2009	177,085,260	331,558,249	53.41 %



Challenges

❖ Misconceptions about NHIS

- Victimless crime
- Unlimited piles of money
- Will not last so make money whilst you can

❖ Lack of capacity at Scheme level has led to perpetuation of errors making cost recovery problematic



Challenges

Exploitation of existing loopholes:

- All –inclusive and unbundled tariffs
- 3 visits within 2 weeks
- Gate-keeper system abuse
- Mass accreditation
- Conflict of interest – Public Health Care Practitioners owning/supervising private facilities
- Open Medicines List- no prescribing levels



PERSONNEL & TOOLS

- 3 – person team made up of doctors, pharmacists, midwives, medical assistants, dispensing technicians, hospital administrators.
- Includes staff from the NHIA , Schemes and external members from GHS, CHAG,GAQGHI, Private sector
- Joined by staff from District Directorate of Health when available



PERSONNEL & TOOLS

- Plan audit one month prior to execution
- Audit Manual, Scheme checklist & Provider checklist developed
- Notice to auditees 2 weeks prior to audit
- List of sampled folders sent to facility 24 hours before visit to facilitate retrieval
- Entrance and exit conferences done at Scheme office and all facilities visited.



KEY FINDINGS - SCHEMES

- Inadequate or no vetting of claims
- Claims Module not being used
- Items not on Medicines List being paid for e.g. Lucozade, Glucose powder
- Wrong prices of medicines being paid for
- Selective payment of providers
- Wrong tariffs given to providers



KEY FINDINGS - LOGISTICS

- Unqualified staff as prescribers at facilities
- Inappropriate staff at the facility for the services being given
- Inadequate infrastructure e.g. patients asked to use pit latrines
- Lack of equipment e.g. no thermometers
- Lack of personnel to fill in claims forms



KEY FINDINGS - ERRORS

- Charging in-patient tariffs for detention cases.
- Using the wrong G-DRG and therefore getting a higher tariff.
- Using the wrong prices for medicines e.g. Multivites, Folic Acid
- Charging for multiple visits that did not occur – misunderstanding about 3 visits in 2 weeks.
- Wrong Tariff being supplied by the Scheme to Providers leading to over-charging



KEY FINDINGS - ABUSE

- Provider shopping – the same patient visits 3 different providers in one week with the same complaint
- Patients collecting prescriptions and selling them to pharmacies and chemical sellers
- Manipulating formulations & dosages to attract higher cost
- Co-payment – patients are asked to pay in addition to what the NHIS pays.



KEY FINDINGS - FRAUD

- Insertion of medicines – a medicine not prescribed but billed for
- Substitution of medicines e.g. Amoxicillin is prescribed but Azithromycin is billed for
- Prescriptions served at pharmacies/chemical sellers with no clinical visit at the corresponding hospital
- Diagnostic centers billing for investigations not authorised by a clinician



KEY FINDINGS – QUALITY OF CARE

- Irrational prescribing – e.g. all patients given IV Cefuroxime at OPD visits
- ANC routine drugs – these now include 30 tabs Paracetamol, 10 tabs Diazepam
- Inappropriate malaria treatment so patient keeps coming back eg Fansidar
- Poor surgical techniques and poor post-op care so high incidence of wound infection



RECOMMENDATIONS

- Adherence to NHIS Medicines List – by the prescribers, dispensers and the Schemes
- Enforcement of MOH prescribing and dispensing levels – copies should be made available to Providers and Schemes
- Widespread use of Standard Treatment Guidelines



RECOMMENDATIONS

- Schemes should not enter into private arrangements with providers with regards to claims
- Engage regulatory bodies and associations in clinical audit process
- Share findings at quarterly stakeholder meetings



RECOMMENDATIONS

- A robust ICT platform to monitor patient eligibility and patient attendance
- Efficient claims processing that detects anomalies before claims are paid
- Public Education to reduce moral hazard and fraud
- Increased training for providers on correct submission of claims



RECOMMENDATIONS

- Strengthen capacity of Schemes to detect fraud and abuse in the early stages
- Strengthen capacity of the Regional Offices to monitor effectively
- Collaboration with the MOH, Regulatory Bodies and Associations to educate and “police” the sector.



ACTIONS

- Cost Recovery – based on the amount of over-billing and over-payment
- Sanctions- suspension or disaccreditation of facilities when quality of care is compromised
- Education – to providers and scheme staff on some of the errors
- Prosecution – when there is fraud



COST RECOVERY

<u>REGION</u>	<u>DISTRICTS</u>	<u>DEDUCTIONS</u>
ASHANTI	10	4,356,426.29
BRONG-AHAFO	5	357,967.82
CENTRAL	3	254,427.97
EASTERN	11	2,361,755.36
GREATER ACCRA	3	452,867.53
NORTHERN	6	1,100,118.70



COST RECOVERY

<u>REGION</u>	<u>DISTRICTS</u>	<u>DEDUCTIONS</u>
UPPER EAST	0	0.00
UPPER WEST	1	500,310.94
VOLTA	1	346,949.83
WESTERN	7	2,891,740.90
TOTAL	47	12,622,565.34



Together, we can sustain the NHIS

Can we?

Yes, we can!

THANK YOU