The Private Payer E/M Audit
How to Stay S.M.A.R.T.

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The Practice of Medicine

• Practice of Medicine has undergone a significant transformation due to:
  – Federal regulations
  – Coding
  – Reimbursement
• Medical Coding is a language all its own
  – Coding is not an exact science
  – Documentation and Medical Necessity must be supported in the medical record
  – Coding is subject to intense review by insurance industry
• Insurance industry uses statistical analysis to recover dollars spent for fraud, waste, and abuse
The Climate

• All of healthcare, including Medicare and private health plans, are watching!
• The search for healthcare fraud and abuse has risen to new heights
• Reason:
  – Studies identify high rates of errors and omissions among claims
  – Innocent recurrent billing errors might be viewed as fraud
• Most providers don’t set out to commit fraud or abuse
  – Most don’t understand or fail to learn coding guidelines and carrier regulations

Analysis of Physician Billing

• Health care providers should know:
  – Coding and billing requirements for health care services rendered
    • To ensure that documentation satisfies level and scope of services provided
  – Insurance companies recoup millions of dollars in refunds from providers unable to justify care
• Insurer’s fundamental existence and financial success requires:
  – Detailed analysis of provider’s practice patterns using information management systems
    • To identify over-utilization of services
    • Extensive data banks provide frequency reports for a CPT code and compares based on percentage of services billed
      – By same specialty
      – Similar patient population
WHAT TRIGGERS AN AUDIT?

• A retrospective audit
  – Cost containment mechanism that health plans use to determine whether overpayment on claims have been made to a particular physician, practitioner, or hospital
• In today’s regulatory environment, it is not if, but when you practice will receive a letter from the insurance carrier, either asking for medical records, or a planned visit to your practice

Audit Triggers

Examples
• Reporting the same level of service for an evaluation and management service
• Reporting high levels of E/M service outside the “bell curve”
  – Many insurance carriers are concerned with the constant use of level four and five visits because reimbursement is higher for these services
  – Performance of diagnostic procedures in the medical office as “routine”
  – For example, if the cardiologist orders a stress test on every new patient, the pattern might draw attention to the insurance carrier who will investigate for medical necessity
How Claims are Selected

- Automated (no medical record)
  - Based on utilization or “Data Mining”
- Complex (medical records)
  - Medical records are requested, or the auditor audits the records at the providers office
    - Can be a random sampling
    - Focused review-specific number of medical records

How Data is Gathered

- Data Mining
- Insurance carrier generate profiles
  - Gathers data for utilization
    - How often a procedure is performed
    - Where the procedure is performed
    - What CPT code is reported
  - Individual physician’s profile is compared to other provider
How Data is Gathered

- **Data Mining**
  - Insurance carrier maintains data banks for comparison:
    - When a provider orders laboratory tests
    - What test are ordered
    - What procedure and diagnosis codes are reported
    - Diagnosis code reporting frequency and medical necessity
    - Frequency of E/M levels
  - Insurance carrier generates provider profiles and compares information across specialty areas

Audit or Investigation

- When data mining has been completed, and coding pattern of a provider or group of providers has been identified
  - An audit or investigation might be implemented (request of documentation)
  - Request for repayment based on claims data
- Request for repayment of previously paid claims without a review of the medical record(s) is called a Payback
  - Request can be in the form of a written request for repayment
  - Insurance carrier takes the money back by deducting future payments without requesting the return of money
- Another problem that can occur based on data mining
  - Insurance carrier will down code a level of service such as an evaluation and management service (E/M) to a lower level
    - Reducing expected reimbursement
The Insurance Audit

• Types of Audits:
  – Prepayment (prospective)
    • Prior to payment dispersed to provider
    • Medical record documentation is requested and reviewed
  – Retrospective
    • After payment has been rendered
    • May ask for medical records or perform audit on site
    • May be random sampling or a focused review
      – Asking for a specific number of medical records
      – Typically over 15, average is 30-40 or more for many carriers
      – They have found a pattern based on utilization, data mining, other data, or patient complaints

Areas of Concern

• High Volume of services
  – Over utilization or frequency of services that may be identified by specialty, size of practice, patient population, or other factors that affect a practitioners billing practice
• Coding
  – Reporting high levels of evaluation and management service levels is consistently on insurance carriers’ radar
  • Because patient encounters vary in complexity, insurance carriers expect the leveling of these services will vary
Areas of Concern

• Practitioners who consistently bill higher levels of service will more likely be audited
  – The insurance carrier takes into account the patient population, as well as specialty, when making this determination
  – Utilization patterns will be identified. If the practitioner is an “outlier”—meaning higher levels of service than within his specialty within a specific region—documentation likely will be requested

Areas of Concern

• Overuse of modifier 25 and 59 might trigger a retrospective audit from an insurance carrier
  – A high volume of evaluation and management services with modifier 25 appended will, in many cases, alert the carrier that an audit is indicated
  • Carrier will review the documentation to determine whether additionally-reported services were above and beyond the service performed during the visit, based on the insurance carrier’s medical payment policy
Areas of Concern

- Modifier 59 has been slated by the Office of the Inspector General, the Centers for Medicare and Medicaid Services and the American Medical Association as the “Modifier of last resort”
  - This modifier should be used only when a procedure or service is bundled and the service is separate and distinct from the primary procedure performed
  - This modifier is often misused and should only be reported if the procedure is a National Correct Coding Initiative edit and the modifier is allowed to bypass the edit, when all criteria is met

Areas of Concern

- Other reasons
  - a practitioner might be selected for a retrospective audit for various reasons, including previous noncompliance with insurance carrier policies

Audit Dr. Smith today
Over utilization of consultations
## Audit Triggers

- Inconsistent coding among partners within a group
- Coding high levels of evaluation and management services for a new patient, or reporting a consultation for every new patient
- Upcoding evaluation and management services
- Unbundling procedures and services
- Improper use of modifiers
- Inadequate documentation
- Submitting “unspecified diagnoses” consistently
- Patient and/or provider complaints

## Audit Triggers

- Billing for goods and services not rendered
- Billing for phantom patients
- Upcoding or billing for more time than the duration of the actual service
- Charging Medicare patients more than non-Medicare patients for the same services
- Paying kickbacks in exchange for referrals
- Misrepresenting non-covered services as covered
- Billing for medically unnecessary tests
- Misrepresenting the quality of care provided
- Double billing
- Billing incident to services when the physician is not present
Surviving an Audit

• A chart audit is an examination of medical records, to determine what procedure or service is:
  – Performed and correctly coded, and to determine if the documentation is compliant and all charges are captured
  – Most insurance carriers are expected to audit a certain number of paid claims per year, as well as to conduct prepayment review of unusual billing patterns from a practitioner who raises suspicion or is considered an “outlier”

• Definition of outlier — “A value far from most others in a set of data”

Surviving an Audit

• Best defense:
  – Good documentation
  – Accurate and precise coding
  – E/M levels support both key components and medical necessity
  – Compliance Plan
  – Regular internal auditing and monitoring
  – Ongoing education and training
S.M.A.R.T. REACTION

Shhhhhhh...

• Don’t say things you will regret

The Insurance Audit

Insurance carrier will:
   - Contact provider in writing requesting records or site visit

If participating, physician must:
   - Comply with audit pursuant to provider agreement

Even if not part of network or participating, physician may be subject to claim review based on Federal and State Laws
The Insurance Audit

- Insurance Carrier must provide authorization if provider or group is non-participating or does not have a contract
- When the insurance carrier alleges fraud:
  - May report provider to the Office of Professional Medical Conduct in his/her state
    - Investigation could affect medical license
  - Imposes specific obligations to insurance carriers when conducting an audit
  - Each individual provider should check with both Federal and State laws regarding potential repercussions of an audit

The Insurance Audit

- Sometimes a carrier will send the provider a letter several months before auditing, making him/her aware that he or she is an “outlier”
  - Warning to a provider to begin an internal review of his/her coding practices and documentation to ensure he/she can withstand carrier scrutiny.
  - If errors are found this gives the provider time to:
    - Make changes to documentation patterns
    - Change coding patterns
    - Self-disclose coding or billing errors
    - Refund any overpayments to the insurance company
The Audit Investigation

• Begins when:
  – Insurance carriers requests documentation that might include:
    • Medical record
    • Specific date of service
    • Other supporting documentation
      – Labs
      – Radiology reports
      – tests
      – other

S.M.A.R.T. REACTION

• Don’t say things you will regret
  • Make sure you keep the process formal
  • Get everything in writing
  • Do not disclose information not requested either verbally or in writing
    • Do include supporting documentation or reports applicable to the record request
S.M.A.R.T. REACTION

Manage...

• Assign the right person to oversee the process.
  • Familiar and Comfortable with:
    • The Rights of the Provider in your State
    • The DGs and E/M CPT logics

• Assign a point person who handles audit requests on a routine basis
  • Make sure the physician reviews documents that the insurance carrier will review
  • The physician may want to include a cover letter explaining unusual circumstances
S.M.A.R.T. REACTION

Manage...

- Familiar and Comfortable with:
  - The Rights of the Provider in your State
  - Make sure the health plan complies with state laws pertaining to insurance transactions
    - Specifically retrospective audits
    - May want to retain a health care lawyer to assist
    - Coding Expert to review documentation

S.M.A.R.T. REACTION

Manage...

- The DGs and E/M CPT logics
  - Find out what the carrier E/M logic is
    - Do they use CMS’s guidelines
    - CPT guidelines
    - Other guidelines
    - How do they determine medical necessity
    - Marshfield Clinic tool?
    - Other mechanism?
S.M.A.R.T. REACTION

Ask...

- Why was I selected?
- What is the deadline?
- What DGs are used?
- Appeal rights?
- Handling of the Medical Record?
- What will you do with the results?
- Reviewer Credentials?
- Will I get the results?
- What if I don’t respond?
- How are peers used?
- Can I speak with the reviewer?
- What if reviewer can’t read it?
  - Can the physician dictate the notes?
    - Most carriers allow this

Responding to the Audit Request

- Should be well thought out, planned, and implemented
- Response depends on three factors
  1. Type of audit
  2. Scope of audit
  3. Duration of the audit
- Some requests for an audit will be in the form of a letter requesting specific medical records and/or documentation for specific dates of service
  - You should also include any supporting documentation, such as lab reports, radiology reports, etc. if it will help support the service provided
Responding to the Audit Request

- Many insurance auditors will make a site visit to the medical practice
  - The insurance carrier will request specific records, typically by patient name and identification number
  - They will request a quiet place to work, and access to the medical records
  - Make sure before you allow them access to your medical records; check their identification and authorization to the medical records before relinquishing these files
  - An audit investigation might include your practice’s sign-in sheet, superbills or charge tickets, daily appointment schedules, or other supporting evidence the carrier requests

Responding to the Audit Request

- Any information provided to the insurance company’s auditor or investigator during the initial contact will be added to his/her file, log, or note pad and used to compare against information already received
  - Some information might come from a patient interview, which typically confirms types of treatment, duration, and times of appointments
- The initial contact should not be taken lightly
  - It is crucial to understand the significance of a “formal” approach in responding to any audit investigation because the insurance carriers rely heavily on data-mining software, coordination with law enforcement, and potential civil litigation.
Responding to the Audit Request

• The time frame of the audit is critical
  – If the insurance carrier wants 50 records in a week, is that reasonable?
  – Make sure you understand the timeframe of the request.
  – If the time is not sufficient
    • Ask for an extension to comply
    • Do not ignore the request
      – You will be considered non-compliant
  – Every communication with the insurance carrier must be in writing!

What Information Do You Provide?

Documentation may include:
• Office records including progress notes, H&P, treatment plan
• Identity and professional status of provider
• Laboratory & Radiology Reports
• Comprehensive Problem List
• Current list of prescribed medications
• Progress notes for each visit that demonstrates patient response to prescribed treatment
Responding to an Audit Request

- **TIP #1**: Send in as much documentation as you have, keeping photocopies for yourself.
  - Practices often forget to include information pertinent to a medical record
  - Don’t just send a copy of the progress note for that day, forgetting that there was a flow sheet updated too, with a change of medication, or a review of systems update
  - Perhaps the medical necessity for that test was documented in a prior note?
  - Provide this supporting information even if the auditor doesn’t ask for it

Responding to an Audit Request

- **TIP #2**: Never, *ever* change any charts or records you submit
  - Auditors can spot an altered chart in a heartbeat
  - If you feel handwritten notes may be illegible, have a transcript typed, but make it *exact*
  - Spelling mistakes (and other errors) have to stay
- Send in both the handwritten note and dictation
- Make sure the typed note is signed
Responding to an Audit Request

• **TIP #3**: Don’t delay in sending back the records to the auditor
  – Typically, you have a relatively short time frame of 30 days
  – What if the auditor wants records that are harder to collect, such as hospital-based records?
    • If you have to collect this kind of documentation, start working the day you get the audit letter
  – If the auditor wants office-based records, and your records are well organized; collect, copy, and mail the files as soon as you have a chance to review them against what was billed

Responding to an Audit Request

• **TIP #4**: Try to figure out what the auditor may be concerned about
  – Do the files requested share a date of service, a type of service, a diagnosis?
    • An example of a common audit target is excessive billing of higher-level E/M codes
  – This information could help you mount a more targeted and effective response
  – A professional coder could also help spot these patterns
Responding to an Audit Request

- Receipt required (send to street address)
- Cover letter
  - Explain any unusual circumstances
- Attach patient information in the order of the listing received
  - Don’t forget any addendums
- Keep an exact copy for your files!
- Contact the auditor who signed the Audit Review letter

S.M.A.R.T. REACTION

Review...

- Know what to expect
  - Have a qualified reviewer audit the documents ahead of time.
  - Respond appropriately to errors
    - Develop corrective action plans before the payer does
      - Does your practice have a compliance plan?
Review

- Allow the practitioner under investigation to review the documentation prior to the audit
  - Have a coding expert review what the auditor will review, if possible
    - The coding expert might find problematic areas that can be addressed in a cover letter sent with the records, or determine if a site visit can clarify with the auditor
    - Documentation may not be altered. However, if the practitioner’s handwriting is illegible, dictating the documentation is allowed by most carriers—if in doubt, contact the auditor and make the request and include the original handwritten notes
    - A letter to accompany the record explaining any unusual or complex procedures or patient conditions is helpful to support medical necessity

S.M.A.R.T. REACTION

Track your Trail

- From your prior review, produce a detailed audit report
  - Powerful tool to “even the playing field”
  - Should be submitted with the documentation
  - Many companies/consultants can help
  - Should repay overpayments
PHYSICIAN MEDICAL RECORD REVIEW
PLEASANT HILL FAMILY PHYSICIANS
SUMMARY REPORT

Physician: Harold Smith, MD

Reviewer: Mary Smith, CPC

Date of Review: 4/2/20xx

Number of Charts Reviewed: 10

One service date was reviewed for each chart reviewed for appropriate coding and supporting documentation.

Each chart was reviewed in detail for completeness.

E/M documentation in the record appeared to support service billed:
- 4
E/M documentation in the record appears to support a lower level of service than billed:
- 6
E/M documentation in the record appears to support a higher level of service than billed:
- 0

Other documentation coding issues:

1. The provider signed all documentation in the medical record.
2. The documentation was handwritten and/or dictated and appeared easy to read.
3. For five dates of service, the provider billed Level 5 established patient visits, which did not appear to support the level of service billed based on the documentation.
4. For one date of service, the provider billed Level 4 established patient visit but the documentation did not appear to contain a history of present illness.

RECOMMENDATIONS

1. Review problem areas with provider.
2. Review E/M guidelines with provider including the documentation of the required elements in the history and examination.
3. Review pattern of reporting higher levels of service.
4. Review medical necessity with provider.
5. Perform a follow-up review in 4-6 months.

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Progressive Corrective Action by Insurance Carrier

Corrective action based on results of audit review

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<td>• Initiation of high level of pre-payment review and/or</td>
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<td>• Statistically valid random sample</td>
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<td>• Payment suspension</td>
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<td>• Referral to Fraud Department</td>
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Request for Refund

• Tip #1
  – Review the provider contracts to determine how to respond to the refund request
    • Provider contracts should outline claim and utilization review process

• Tip #2
  – If contract does not outline time frame for refund requests
    • Renegotiate contract to include an amendment setting a time limit insurance carrier has to request a refund
    • One rule of thumb for negotiation is that the carrier should have the same amount of time to recoup as you have to file the claim.
Request for Refund

**Tip #3**
- Provider contracts should be reviewed for mention of "offset" provisions allowing carriers to deduct from future reimbursement
  - If such a clause exists, it may be wise to have it eliminated during your contract negotiations

**Tip #4**
- If you are not a participating provider with the carrier requesting the refund, and your state law does not have specific guidance
  - You may contest the request because you may not be contractually bound to abide by the carrier's claims and payment policy

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Request for Refund

**Tip #5**
- If the request for the refund was made within the appropriate time frame
  - The request must be investigated, and if possible appealed

**Tip #6**
- Beneficial to review the patient’s policy and review the language for covered benefits and exclusions
Request for Refund

• **Tip #7**
  – For high cost procedures or services
    • Make sure there is documentation that benefits were verified prior to surgery, either in writing or with name, date, and time of phone verification
    • If patient was not covered at the time of service, or the procedure is excluded from the patient’s benefits, it is reasonable for the insurance carrier to recover payment from the provider and/or patient.

• **Tip #8**
  – The request for a refund may be warranted if the carrier’s post-payment audit found the procedure to be not medically necessary or billed incorrectly

• **Tip #9**
  – If procedure was medically necessary
    • A letter, including supporting documentation, should be sent to the carrier disputing the refund
    • Practitioner has the right to question the plan’s clinical criteria used to determine medical necessity

• **Tip #10**
  – If audited due to…
    • High volume or frequency of services
    • Inappropriate or repeated use of procedure or service
      – Complete and accurate documentation is the best defense
      » Incomplete documentation will not provide the support required to defend a retrospective audit
Request for Refund

• Tip #11
  – HIPAA Privacy Rule requires physicians to only release "minimum necessary" information when requested
  – If carriers request for information exceeds the minimum necessary standard
    • the physician may inform the carrier of his or her position

• Tip #12
  – Other factors prompting the refund request might be issue
    • carrier issues concerning the plan's credentialing/re-credentialing process
    • request is tied to a problem identified by the government (i.e. the OIG Work Plan, improper or duplicative billing; or inappropriate use of modifiers).
      – It is wise to create a mechanism within the practice to capture insurance carrier trends or to track utilization review decisions through claim denials.
Request for Refund

• **Tip #13**
  – Insurance carrier’s request for a refund should not be ignored
    • Many States have enacted legislation limiting the time in which carriers can pursue refunds.
    • Such legislation may also place time limits for you to respond, as well as allow interest to be charged
      – It is imperative to familiarize yourself with your State's Insurance Codes

• **Tip #14**
  – If dispute cannot be resolved satisfactorily through the plan's internal and external review processes
    • Further appeals through an arbitrator or the court may be required

• **Tip #15**
  – Insurance carriers may refuse to withdraw their demand for repayment, or refuse to settle the case on terms agreeable to the provider
    • Dispute may go to arbitration if the provider agreement includes an arbitration clause in participation agreement
      – Otherwise, litigation may be initiated
A Shot at Prevention
“AUDITING AND MONITORING”

Prevention

- How do you take a proactive approach and give your practice a “shot” of prevention?
  - A comprehensive Compliance Plan should be the foundation of every medical practice
  - Perform compliance audits and continue to monitor problem areas so there are no surprises when any insurance carrier audits your claims
    - Not only should you audit claims data...
      - ensuring claims are submitted correctly with the correct dates of service
        » correct practitioner,
        » appropriate modifiers
        » correct procedures and diagnosis codes to support medical necessity.
    - Education should be a staple in your medical practice following each and every internal audit
I Haven’t Been Audited Yet

Make sure documentation can pass auditor’s scrutiny
Carrier’s are obligated to check random claims
    No one is protected from likelihood for review
    Certain billing practice can send up “red flags”
    Falling outside of the regular “curve” of coding can trigger an audit

Internal Auditing & Monitoring

- Reduces the risk of an audit by third party payers
- Identifies and allows for correction of deficiencies in your revenue cycle, speeding payment of claims
- Tracking and trending of claim denial to resolve payment and compliance issues
- Identification of missed charges
- Improved documentation practice result in improved quality of care
Auditing vs. Monitoring

- Auditing
  - Periodic
  - Gathering baseline information to identify risks
  - Verifying information – coding vs. documentation

- Monitoring
  - Continuous
  - Key indicators
  - Put in place as a result of previous audit findings

Auditing & Monitoring

Where do you begin???

- Conduct a baseline audit – documentation vs. codes billed
- Key indicators
- Comparative Billing Report (CBR)
- Current OIG Work Plan
Internal Auditing & Monitoring

• Reduces the risk of an audit by any insurance carrier
• Why???
  – Identifies and allows for correction of deficiencies in your revenue cycle, speeding payment of claims
  – Tracking and trending of claim denial to resolve payment and compliance issues
  – Identification of missed charges
  – Improved documentation practice result in improved quality of care

Prevention

• There are two types of audits the medical practice can perform:
  – Prospective
  – Retrospective
  – A prospective audit is performed before the claims are submitted to the insurance carrier
  • This type of audit assures the appropriateness of the coding and claim data prior to sending the information to the insurance carrier, which avoids unnecessary errors
• A retrospective audit or post payment audit is a review of the claims with supporting documentation after the claim has been paid.
  – This type of audit is helpful to identify coding errors, as well as insurance company reimbursement errors
  • It ensures the medical practice is paid appropriately
Audit Process

• Conduct claims submission audits (billing errors)
• Conduct coding compliance audits (documentation)
• Conduct focused audits (problem areas, OIG)
• Select at least 10 records per physician to establish documentation patterns
• Audit frequency will depend on audit findings
• Retrospective vs. prospective
• Corrective action

Audit Process

Audit for the following patterns that may trigger a carrier focused review:
– Using the same code over and over
– Inconsistencies among partners in a group
– Upcoding/Undercoding
– Modifiers
– Non-specific diagnosis coding
Audit Process
Using the medical record, verify accuracy of:
• CPT® coding
• ICD-9-CM coding
• Modifiers
• Medical necessity

Prevention
• If an audit reveals a repeated pattern of documentation, coding, and/or billing errors
  – Identify the errors promptly and provide a mechanism for correction
  – If documentation or coding errors are discovered
    • Education is an excellent tool to assist in the compliance process.
Performing a Coding/Billing Audit

- OIG recommends a medical practice, regardless of size, audit each practitioner at least once per year to identify risk areas, such as:
  - Coding
  - Billing
  - Medical necessity
  - Bundling
  - Documentation issues

Performing a Coding/Billing Audit

- If a practitioner has a high percentage of errors or a high error rate
  - An audit might be conducted more frequently.
- For example, if an audit of 10 medical records generate a 50 percent error rate, the physician should be educated, corrective action should be taken, and his/her medical records should be reviewed again within six months to determine if steps have been taken to correct the errors
Steps

1. Identify who is performing the audit (staff, coder, outside consultant, etc)
2. Determine if you will audit prospectively or retrospectively
3. Determine sample size (how many records you will review)
4. Identify types of services that will be audited (e.g., random, payer, E/M levels, procedures, etc.).
5. What type of audit tools will you use (Marshfield Clinic, CMS audit tool, customized)

Steps-Continued

6. What risk areas should you monitor (review OIG workplan, fraud alerts, utilization patterns)
7. Compare the E/M frequency data when reviewing evaluation and management services, based on specialty and geographic area.
8. Identify and maintain a list of claims not accurately paid by the insurance carrier.
   – Determine for each claim, either not paid or not paid appropriately, what internal follow-up action needs to be taken to ensure claims are paid appropriately in the future
Steps-Continued

9. Identify the risk areas after the audit is completed

10. Draft a written report to share with the practitioner, and/or other staff members outlining audit results and recommendation for improvement.
   – Remember keep the report simple and to the point.
   • A 10-page report will most likely be ignored

Auditing vs. Monitoring

• Auditing
  – Periodic
  – Gathering baseline information to identify risks
  – Verifying information – coding vs. documentation

• Monitoring
  – Continuous
  – Key indicators
  – Put in place as a result of previous audit findings
Comparative Billing Reports

• Provide a “snapshot” of CPT Code utilization
• Used by insurance carriers to identify aberrancies
• Insurance carriers review CBR for:
  – Standard deviations from the mean
  – Percent above the mean or median
  – Percent increase in charges, number of visits/services, from one period to another

Comparative Billing Reports

• Use for benchmarking
• Identify billing patterns above the “norm”
• Identify key areas to focus on during a chart audit
### Individual Physician & National Comparison

#### Office Visit – Established Patient

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<th>CPT</th>
<th>National</th>
<th>National - %</th>
<th>Dr. Feelgood</th>
<th>Dr. Feelgood - %</th>
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#### Utilization Comparison

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<td>99215</td>
<td>3.54%</td>
<td>3.54%</td>
<td>0%</td>
</tr>
</tbody>
</table>
True Story

• An insurance company (not Medicare) performed an analysis of solo physician practice in a major city
  – They extrapolated data for a three-year period
  – The insurance company asked for 100 level IV and level V new patient and consultation E/M records
  – Based on findings, 95 percent of the claims reviewed met the key component requirements for the level of service reported
  – BUT….did not support medical necessity
  – Physician paid insurance company back several thousands of dollars and was placed on 100 percent review for E/M levels IV and V, and advised to seek training on the guidelines

Prevention Tips

1. Develop a correction plan when problems are identified.
2. Hold regular education and information meetings for both clinical and administrative staff to keep everyone updated on new regulations, new carrier guidance, new coding rules, etc. so that everyone is fully informed
3. Continue to monitor specific areas or compliance issues on an ongoing basis
4. Keep track of audits, follow up meetings with provider and staff for compliance to support the medical practice’s efforts to report procedures and services correctly
Prevention Tips-Continued

5. Never stop improving the claims submission and audit processes in the medical practice. Review the processes each year and make improvements when necessary.

6. If you have an auditor employed by the practice, consider at least once per year hiring an outside coding reviewer to validate the medical practice’s progress.

7. Remain on the alert and the defensive, and enforce disciplinary standards within the medical practice.

CONCLUSION

• It is critical for any provider of service to be aware that any audit by an insurance carrier is fraught with pitfalls, and can have serious repercussions not only in relation to his/her status with the insurance carrier, but concerning the practitioners medical license, possible civil liability exposure, and/or breach of confidentiality.

  – Any inquiry by an insurance carrier, request for overpayment, and/or audit request should be treated very seriously.

  – Continuous education of practitioners and staff is vital to maintaining the “health” of the practice. Reinforcement of the importance of correct coding, and of consistently providing clear, accurate and detailed documentation for every patient encounter, is essential.
Thanks for Attending