7 steps to achieve compliance via internal audits

By Corina Marquardt, CPC, CPMA

With the continued decline in reimbursement and increased scrutiny of providers' documentation and coding — by government and commercial payers — establishing an internal audit process is paramount for physician practices. It's also critical to ensure charges are billed appropriately and optimal revenue is captured.

Ensure compliance in your practice

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) has a zero-tolerance policy toward fraud and abuse. Consequently, the OIG strongly encourages internal monitoring and auditing when practices establish compliance plans. The OIG recommends[1]:

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and develop corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines

It is important to understand the laws that clarify the difference between fraud and abuse. For example, the False Claims Act describes actions by persons who knowingly attempt to defraud the government.[2] Examples of fraud include:

- Billing for services, treatments, diagnostic tests, medical devices or supplies that were not provided
- Submitting claims that have been altered to obtain a higher reimbursement amount
- Deliberately billing both Medicare and the beneficiary for the same service in an effort to be paid twice
- Up-coding a claim to receive higher reimbursement

As these examples indicate, "fraud" is defined as an intentional deception or misrepresentation, a deliberate act that can result in unauthorized benefit or payment. "Abuse" is defined as unintentional, an accidental billing mistake such as entering an incorrect code due to a keystroke error. In 2016, the Justice Department recovered more than $4.7 billion in settlements from False Claims Act cases — the third-highest annual recovery in the act's history. Of the total amount recovered in 2016, $2.5 billion came from the healthcare industry, which included 702 whistleblower lawsuits with awards totaling $519 million — more than $935,000 per case. Since 2009, more than $19.3 billion has been recovered in healthcare fraud claims.[3]

Ensuring compliance has become increasingly complex. Practices have had to pay significant penalties even when they didn't intend to submit false claims. For example, a claim may have been submitted for a service that was not provided as indicated on the claim. Or perhaps a physician's service was provided by an individual who was not a licensed physician. All practice members must work together to ensure each person is aware of the rules and follows them implicitly.

Be familiar with internal and external audits

External audits are designed to recoup money, while internal audits identify risks and take corrective action, including education, to prevent penalties and payments. While many large practices are conducting internal audits, smaller practices often lack sufficient resources to do so. To ease the burden on staff, an internal audit can be performed by a qualified third party; it does not have to be conducted by someone in your practice.

Medical record auditing entails conducting internal or external reviews of documentation, coding accuracy and policies and procedures to ensure physicians and practitioners are compliant with payer coding and billing regulations when submitting a claim. Physicians and practice managers should be aware of the benefits of internal auditing:

- Improves quality of care
- Increases productivity
- Meets compliance standards
- Identifies provider education needs
- Prevents inappropriate coding
- Identifies revenue opportunities

The information received from an internal audit is essential to physicians, practice managers and coders. After all, proper education is the foundation for achieving compliance and improving the financial health of your practice.

Due to increased healthcare costs, insurance carriers can recoup money by conducting an external audit. External audit triggers include:

- Reporting the same procedure code consistently — for example, continual use of level 4 and level 5 visits will raise a red flag for most carriers

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The OIG recommends that medical practices, regardless of size, audit each practitioner at least annually to identify risk areas such as coding, billing, medical necessity, bundling and documentation issues. If a practitioner has a high percentage of errors, audits should be conducted more frequently. Reinforcement of the importance of correct coding, and consistently providing clear, accurate and detailed documentation for every patient encounter is critical. **Here are seven suggested steps to guide a successful internal audit:**

STEP 1 Determine who will perform the audit

Generally there are three options for who conducts an audit:

- A certified professional medical auditor
- A certified clinical documentation improvement specialist (CDIS)
- A third-party objective auditor

Consider the following skills if you need to select an auditor:

- Extensive knowledge of medical data auditing, interpretation and analysis
- Familiarity with regulatory guidelines and payer medical policies
- Scope comprehension
- Sampling methodologies
- Understanding of risk analysis
- Knowledge of procedure and diagnosis coding, medical terminology, anatomy and physiology, as well as 1995 and 1997 E&M guidelines
- Ability to maintain confidentiality and communicate with practitioners in a professional manner

STEP 2 Determine the audit type: prospective vs. retrospective

A prospective audit is performed on charts for which claims have not yet been submitted. With this type of audit, identified issues can be corrected before claim submission, which eliminates payment corrections on the back end. The more common retrospective audit is performed on charts for which claims have already been submitted to the payer. The benefit is that claims are not held up pending audit results.

STEP 3 Identify the scope and objectives

Within the scope, your practice must first identify which providers will be reviewed — single provider or department review of all providers. Next, identify any specific high-risk target areas for review, such as high-level E&Ms, modifier 59 and the OIG hit list. Finally, determine the sample size and time frame.

STEP 4 Determine the audit tools required

Consistently using the same audit tool increases the reliability of results. Here are four commonly used options:

Marshfield Clinic: Medicare's 1995 E&M Documentation Guidelines were beta-tested at Marshfield Clinic in Wisconsin, before the official release. As part of the process, the clinic developed an E&M audit worksheet, including a scoring system that is still widely used.

Customized tool: Depending on your practice, you may choose to customize an audit tool that meets specific needs.

MAC: Determine if your MAC recommends certain audit tools such as online specialty score sheets along with an E&M score sheet. Also, know the rules your MAC uses to score audits.

CMS: Your practice has the option to only apply CMS rules or to include additional payer policies as an extra layer. To simplify the audit process, many physician practices primarily apply CMS rules.

STEP 5 Identify risk areas to be monitored

Focus on specific risk areas that must be mitigated to protect your practice and ensure compliance:

- Determine the effect of incorrect claims on reimbursement (CPT, ICD-10-CM, E&M)
- Reduce compliance risk exposure (OIG Work Plan, high-level E&Ms)
- Improve revenue capture (low-level E&Ms)

STEP 6 Identify and track record variances

While there are many methods to identify and track error rates, the two most common options are:

- Record over record — more widely recognized, less labor intensive, considered more subjective
- Code over code — clearly defined errors, more effectively identifies trends, more labor intensive

Once you select a method, determine an appropriate accuracy and error rate. Most organizations set a 95% accuracy rate. OIG recommends an error rate of 5% or lower. Next, define the data required to perform an audit before you initiate the process. For example, you may want to trend by payer, but then realize you didn't track the payer while auditing.

STEP 7 Report results and provide education

Developing the report is often the most challenging part of an audit. A final report may include two sections — a claim detail audit spreadsheet and a summary report. Based on the audit results, provide education tailored for each physician. Most academic programs provide minimal E&M, CPT or ICD-10-CM coding education, which leaves providers at a disadvantage. Focus on addressing topics such as E&M key elements, time statements, EHR templates and procedure notes.

Figure 1. Reporting the audit results

Summary report to include:	
Scope and objectives	Audit findings
Audit criteria	Recommendations
Observations	
The summary report outlines each pattern identified and provide a practical solution	

Claim detail audit spreadsheet to include:	
Patient Information	E&M codes audited
E&M codes billed	Procedure codes audited
Procedure codes billed	Diagnosis codes audited
Diagnosis codes billed	Modifiers audited
Modifiers billed	Correct payment audited
Payment received	Explanation of errors and recommended changes
Detailed error findings	

- Reporting diagnostic procedures in the medical office on a routine basis
- Inconsistent coding among partners within a group — over-coding and under-coding
- Unbundling procedures and improper use of modifiers — for example, modifiers 25 and 59
- Patient and/or provider complaints
- Submitting unspecified diagnosis codes

Know what the OIG focuses on

Knowing what the OIG focuses on with its external audits will help your practice create an internal audit list. For example, if you know the OIG intends to audit physician practices across the country for TCM codes, then add that to your list. According to the 2018 OIG work plan, one target area is the review of Medicare payments for telehealth services.[4] Medicare Part B covers expenses for telehealth services on the telehealth list when those services are delivered via an interactive telecommunications system, provided certain conditions are met. To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary at a rural site and a practitioner at a distant site. An eligible originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office. The OIG will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements.

The OIG work plan provides a dynamic hit list of current focus areas. Updated monthly, this information serves as a tool to communicate priorities and help practices identify areas most vulnerable to fraud and abuse.

Establishing an audit schedule

As part of your compliance program, it's essential to establish a regular auditing schedule. Ideally, each provider should be audited annually, at least until a satisfactory level of documentation and coding accuracy is achieved and sustained.

- Progressive Audit Program
  - » 95-100% accuracy — yearly audit
  - » 90-94% accuracy — biannual audit
  - » Below 90% accuracy — quarterly audit

Proactive compliance yields positive outcomes

In today's regulatory environment, it is not if, but when your practice will receive a notice from a payer, either asking for medical records or proposing a planned visit. Ideally, a proactive compliance plan provides the means to avoid an external audit. With internal audits in place, physician practices can anticipate positive outcomes that preclude penalties and paybacks. By doing so, your practice will be prepared to meet the challenge. ■

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Notes:

1. "HHS OIG compliance program for individual and small group physician practices." Officer of Inspector General, U.S. Health & Human Services. Available from: bit.ly/2mZsj3a.
2. "The False Claims Acts." Centers for Medicare & Medicaid Services. Available from: bit.ly/2BjuweZ.
3. "Justice Department recovers over $4.7 billion from False Claims Act cases in fiscal year 2016." Office of Public Affairs, Department of Justice. Dec. 14, 2016. Available from: bit.ly/2gEQBuc.
4. "Active work plan items." Office of Inspector General, U.S. Health & Human Services. Available from: bit.ly/2ilopiF.