Planning and Performing a Successful Audit: Things an Auditor Must Look For

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Patti Frank, CPC
Consultants in Practice Management
Lenexa, KS

3 Sections of an Audit

• Pre-audit preparation
  – Step A1: Gathering information
  – Step A2: Contracting for the audit
  – Step A3: Selecting the sample
• Performing the audit
  – Step B1: Gather the tools for auditing
  – Step B2: What auditors should look for
  – Step B3: Recording the results
3 Sections of an Audit

• Post-audit activities
  – Step C1: Research
  – Step C2: Prepare a report
  – Step C3: Educate
  – Step C4: Develop a monitoring process

Step A1: Gathering Information
Determine Who Will Perform the Audit

• Internal auditor
  – Advantages
    • Less expensive
    • Known quantity
    • Can be done in bits and pieces
  – Disadvantages
    • May not have the expertise
    • May not have the staff time
Step A1: Gathering Information
Determine Who Will Perform the Audit

• External auditor
  – Advantages
    • Can be done under Attorney-Client Privilege
    • Objectivity
    • Physicians may listen/respond better to an outsider
  – Disadvantages
    • More expensive
    • Takes a fixed amount of time

Step A1: Gathering Information
Determine the Timing of the Audit

• Pre-billing/Pre-payment/Prospective
  – Advantages
    • No refunds necessary
    • Opportunity to capture all charges
    • Allows for chart revisions prior to billing
  – Disadvantages
    • Effect on cash flow
    • Takes longer to complete
Step A1: Gathering Information

Determine the Timing of the Audit

• Post-billing/Post-payment/Retrospective
  – Advantages
    • No time constraints
    • Can evaluate entire process in one encounter
  – Disadvantages
    • Must refile and/or refund over/undercoded services
    • Lost charges if past timely filing

Step A1: Gathering Information

Determine the Purpose of the Audit

• Education
• Benchmark
• Investigate a suspicious pattern
• Government mandate under a CIA
• Determine provider bonus
• Identify missed charges
• Unbundling
• Global periods
Step A1: Gathering information

Determine Scope of the Audit

- E/M level of code
- Surgeries/procedures
- Modifier 25 use
- Revenue cycle review
- Hospital services
- Teaching Physician rules
- Incident to services
- Nurse visits

Step A1: Gathering Information

Determine Documentation to be Supplied

- Progress note
- Op report
- Charge ticket, superbill
- Account history
- Claim form
- Remittance advice/Explanation of Benefits
- Entire chart
- Results of previous audits
Step A1: Gathering Information
Determine Documentation to be Supplied

- Medication list
- Problem list
- Immunization record
- Medical history questionnaire
- Results of tests, procedures
- Consent forms
- Information referenced in the progress note
- E&M distribution for each provider

Step A1: Gathering Information
Security

- Will the records be de-identified
- If records are removed from the site, how will they be secured
- If PHI is to be exchanged electronically, how will it be secured before and after the audit
- Disposition of records once audit is completed
  - Return to client
  - Destruction/storage by auditor
Step A1: Gathering Information

Rules to be Used for Auditing

• 1995, 1997 or both
• How to define a 1995 examine
• Use the Marshfield tool
• Request a copy of any internal policies, procedures, audit tools the practice/entity uses
• Use of an audit tool
• Definition of an error

Step A2: Contracting for the Audit

Determine Needs

• Contracting parties: practice/entity or attorney?
• Sign a business associate agreement
• Pricing
  – Per chart
  – Per hour
  – Project
  – Retainer
**Step A3: Selecting the Sample**

**Number of Records to Audit**

- For a routine audit, review of 10 records per provider is recommended
- No fewer than 5 records is recommended
- For a probe review for an identified problem, up to 20 records should be reviewed
- For a follow-up audit, 5-10 records
- Recommended time period is the most recent 3-6 months of services

**Step A3: Selecting the Sample**

**Determine the Selection Process**

- Determine who will select the sample
  - Auditor
  - Client
- Define the selection criteria
- Define the sample selection process
  - Statistically valid random sample
  - Random number generator
  - Interval selection

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Step B1: Gather the Tools for Auditing

**Resources Needed**

- CPT, ICD-9-CM and HCPCS books
- Book of standard abbreviations, acronyms and eponyms
- Audit tool
- Payer coding and billing guidelines
- Access to NCDs and LCDs
- Access to CCI edits
- Specialty society guidelines
- Medical dictionary

Step B2: What Auditors Should Look For

**Entries are Properly Documented**

- Documentation is legible
- Patient identifier on every page
- All entries in the chart authenticated as to author with full name and credentials
- Proper signature
- Are any corrections or addenda properly documented
- Are all entries dated
Step B2: What Auditors Should Look For
Entries are Properly Documented

• Times are correctly reported
  – Counseling – total time and time spent counseling or statement of >50%
  – Start/stop times – critical care, prolonged care services, anesthesia
• Doctor’s order for all tests documented
• Date and location of documents referred to in the chart are properly notated

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Step B2: What Auditors Should Look For
Entries are Properly Documented

• Allergies and reactions are noted
• Continuity records are updated regularly
  – Medication list
  – Problem list
  – Immunization record
  – Health maintenance record

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Step B2: What Auditors Should Look For Coding Accuracy

• Diagnoses on the encounter form/superbill are documented on the medical record
• CPT and diagnosis codes appropriately matched
• CPT, ICD-9 and HCPCS codes valid and correct
• Modifiers correctly used
• Units are correctly billed

Step B2: What Auditors Should Look For Coding Accuracy

• Services in global period correctly billed
• Assistant at surgery services billed correctly
• Surgeries/procedures correct per CCI
• Codes on the encounter form correct
• Laboratory panels correctly billed
• Services with a technical/professional component correctly billed as TC, 26 or global
• Interpretation of diagnostic tests on chart
Step B2: What Auditors Should Look For

**Coding Accuracy**

- Level of supervision is correct for service billed
- Was the service billed under the correct provider
  - Billing versus performing provider
  - Incident to supervision
  - Shared/split services
  - Teaching physician supervision

Step B2: What Auditors Should Look For

**Forms and Follow-up**

- Practice has a signature and initial log and non-standard abbreviation list
- Consent forms present
- ABN forms present
- Reports in the chart are signed by the physician signifying review
- Reports with abnormal results have a notation of follow-up plans
Step B2: What Auditors Should Look For

Revenue Cycle Issues

- All charges from the medical record were captured on the encounter form/superbill and claim
- Claim was correctly completed
- Codes for all services are consistent on the medical record, encounter form, claim and account history
- All services were paid appropriately

Step B2: What Auditors Should Look For

Revenue Cycle Issues

- Denied services were followed-up
- Correct place of service used
- Do special reimbursement rules apply:
  - Rural health clinic (RHC)
  - Federally Qualified Health Clinic (FQHC)
  - HPSA
  - Critical Access Hospital (CAH)
  - Ambulatory Surgery Center (ASC)
Step B2: What Auditors Should Look For

Basics of Auditing E&M Services

- Determine status of patient as new or established
- Determine the level of history, exam and medical decision making
- Determine if 2/3 or 3/3 criteria met
- Every E/M service has a chief complaint
- Are all services provided medically necessary

Step B2: What Auditors Should Look For

Basics of Auditing E&M Services

- Proper signature
  - Initials versus signature
  - Scribe used
  - Co-signing
- Services billed on counseling, have the content of the discussion documented
Step B2: What Auditors Should Look For MDM in Auditing E&M Services

- The status of each condition is noted in the documentation
- All problems listed in the impression are addressed in the plan
- Were any rule-out services billed
- Counting problems to be included in the MDM
- The nature of the presenting problem supports the level of service billed

Step B2: What Auditors Should Look For Multiple E&M Services on Same Day

- Hospital discharge and SNF admission
- Hospital admission and discharge on the same day
- Admission to inpatient from another setting
- Two office/hospital visits
- Was a problem focused visit provided on the same day as a preventive visit
Step B2: What Auditors Should Look For
Special Guidelines for E&M Services

• Academic practice guidelines followed
  – Primary care exception
  – Present during procedure
  – Appropriate documentation

• “Incident to” services
  – Direct supervision was provided
  – For a shared service, both providers
documented what part they performed

Step B2: What Auditors Should Look For
Special Guidelines for E&M Services

• Consultations
  – Is there a written request and a report
  – Was it requested by a patient
  – Was the patient Medicare

• Critical care services
  – No bundled services billed separately
  – Procedure times carved out
Step B2: What Auditors Should Look For
Special Considerations for Hospital Services

• Discharge
  – When patient expires
  – When patient leaves AMA
  – When other than admitting physician discharges
  – Date on which discharge should be billed
• Initial hospital care not meeting the lowest level of service
• Observation after surgery

Step B3: Recording the Results
Using the Note to Audit

• Recording results on a copy of the documentation
  – Use colored pens for different elements
  – Use a stamp
  – Advantage: Providers like to see the clinical note and auditor’s comments at the same time
  – Disadvantage: Providers do not learn counting requirements for HPI, ROS, etc.
Step B3: Recording the Results

Using an Audit Tool

- Audit tool
  - 1995 and 1997 exam
  - Specialty specific exam
  - Has space to write comments to use in educating the physician
  - Providers learn counting for history, exam, and MDM

Step B3: Recording the Results

Using an Electronic Audit Tool

- Electronic audit tool
  - Useful for audits:
    - Requiring a permanent record for compliance
    - Where a large number of records are audited
    - When no feedback is required
  - Can analyze data and print reports
  - Cannot determine medical necessity in codes requiring 2/3 and may give a higher level
Step C2: Prepare a Report

**Include in the Report**

- Report the findings/raw data
- Calculate an error/accuracy rate
- List each record in the report
- Show a code comparison between reported and documented services
- Use a simple spreadsheet format
- Site sources as needed

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Step C2: Prepare a Report

**Identify**

- Abnormal utilization patterns
- Coding errors
- Documentation errors
- Overpayments that need to be refunded
- Missed charges for which claims need to be filed
Step C2: Prepare a Report
Conclusions

- Recommendations to improve documentation
  - Time frame to re-audit
  - Cheat sheets
  - Templates
  - Targeted education
- Assessment of whether the documentation:
  - Supports services billed
  - Supports medical necessity based on guidelines

Audit Analysis

<table>
<thead>
<tr>
<th>Pt. ID</th>
<th>DOS</th>
<th>CPT Reported</th>
<th>CPT Documented</th>
<th>ICD-9 Reported</th>
<th>ICD-9 Documented</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1</td>
<td>10/06/xx</td>
<td>99203</td>
<td>99499</td>
<td>008.8</td>
<td>008.8</td>
<td>No exam</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>504.1</td>
<td>504.1</td>
<td>Don’t code Dx not treated</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>300.0</td>
<td>300.0</td>
<td>300.0 invalid</td>
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<tr>
<td>2</td>
<td>09/02/xx</td>
<td>99203</td>
<td>99202 99407</td>
<td>401.1</td>
<td>401.1</td>
<td>Smoking cessation counseling should be coded</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>491.9</td>
<td>491.9</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>305.1</td>
<td>305.1</td>
<td></td>
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<td></td>
<td>380.4</td>
<td>380.4</td>
<td></td>
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<td>4</td>
<td>09/31/xx</td>
<td>99212</td>
<td>99391</td>
<td>V20.2</td>
<td>V20.32</td>
<td>Child was 16 days old</td>
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<tr>
<td>5</td>
<td>10/03/xx</td>
<td>99213-25</td>
<td>99213-25 11200</td>
<td>719.47</td>
<td>719.47</td>
<td>22 skin tags removed</td>
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<td></td>
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<td>701.9</td>
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<td>11201</td>
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<tr>
<td>10</td>
<td>10/07/xx</td>
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<td>99213-25 90471</td>
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<td>250.00</td>
<td>Td given. Not documented and not charged.</td>
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<td>401.1</td>
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<td>V06.5</td>
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Recommendations:
1. New patient codes require 3/3 key components to be met.
2. A mechanism to insure all charges are captured should be implemented.
3. CPT 69210 may only be charged when the provider personally performs the service using instrumentation.
## Audit Summary

### CPT Compliance Rate

<table>
<thead>
<tr>
<th>Provider</th>
<th>Line Items</th>
<th>Records</th>
<th>E/M Over</th>
<th>Wrong CPT</th>
<th>E/M Under</th>
<th>Missed</th>
<th>CPT Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollar</td>
<td>15</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>53%</td>
</tr>
<tr>
<td>Perfect</td>
<td>12</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>67%</td>
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</tbody>
</table>

### ICD-9 Compliance Rate

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<tr>
<th>Provider</th>
<th>Line Items</th>
<th>Records</th>
<th>Errors</th>
<th>ICD-9 Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dollar</td>
<td>21</td>
<td>10</td>
<td>5</td>
<td>76%</td>
</tr>
<tr>
<td>Perfect</td>
<td>36</td>
<td>10</td>
<td>15</td>
<td>58%</td>
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</tbody>
</table>

## Review of Medical Record Findings

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Provider</th>
<th>Coder</th>
<th>Manager</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moore Dollar, MD</td>
<td>10/08/xx</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill Perfect, MD</td>
<td>10/08/xx</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susie Thompson</td>
<td>10/08/xx</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Betsy Ross</td>
<td>10/08/xx</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
Step C3: Educate

Meet with the Provider

• Provide feedback, educate, answer questions
• Have individualized examples to review and discuss
• Give the provider the opportunity to:
  – Explain the rationale behind his/her coding
  – Provide additional information
• Adjust the coding based on additional information or insight from the provider

Step C3: Educate

Design a Training Plan

• Develop a training plan based on the problem areas identified in the audits
• Training program may include one-on-one training and small group training
• Training should include: practitioners, nurses, billing and coding staff
Step C4: Develop a Monitoring Process

Base Plan on Issues Identified in the Audit

- Compliance plan
- Formal training
- Shadowing
- One-on-one coaching
- Regularly scheduled re-audits
- Updating practice policies and procedures

Frequency of Monitoring

- Internal auditing: quarterly, semi-annually, or annually
- External audit: once a year to ensure that the internal findings are objective
- Based on achievement of a set accuracy rate
  - 90% annually
  - 80% semi-annually
  - 70% quarterly
Step C4: Develop a Monitoring Process

Goals of the Process

• Ensure improvements have been made
• Measure compliance
• Measure the effectiveness of the training provided
• Maintain records to measure progress

Disclaimer

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Questions

Patti Frank, CPC
Consultants in Practice Management
Lenexa, KS
pfrank@kc.rr.com
913-541-0496

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