Why Are You Auditing?

- Proactive as part of compliance plan
- To investigate a specific issue reported
- Concurrent with a payer review
- To respond to a subpoena
Federal False Claims Act

Filing a claim that you knew or should have known was “false” – i.e., codes billed not matching documentation

No proof of specific intent to defraud is required

$10,781.40 - $21,562.80 per claim plus treble damages and paying attorneys fees for whistle blowers

HITECH makes not refunding overpayments within 60 days a false claim

Questions to Ask

Who codes the services?

Physician
Coder
EMR code generator/E&M leveler

Are there any previous audits on these services/this provider?

Known concerns or suspected concerns from a compliance perspective?

Has there been a compliance issue called in to Anonymous hotline?
Scoping out the Audit

Audit scope, defined as the amount of time and documents which are involved in an audit, is an important factor in all auditing. The audit scope, ultimately, establishes how deeply an audit is performed. It can range from simple to complete, including all company documents.

The Strategic CFO - https://strategiccfo.com/audit-scope/

The scope of an audit should be decided upon prior to the signing of an engagement letter or agreement to protect both the entity and the person doing the audit.

Failing to clearly define the audit can result in “scope creep” which can then add on not only time but also increase the monetary cost of the audit.

Working with management (or the entity requesting the audit) to clearly define the scope of the audit sets realistic expectations of what is being included in audit and what is excluded.
• Within the scope and engagement letter/agreement to be signed, the tools and/or resources that will be used to perform the audit should be identified
• If utilizing a tool from a particular vendor, identify it by name
• Will there be calculations of revenue variances/differences?

Resources such as CPT© Professional edition for a particular year, especially if performing retrospective review, ICD-10-CM book for identified year(s), CPT© Assistant, AHA Coding Clinic, Medicare or CMS Guidance and applicable Transmittals, Fee Schedules if revenue variance is to be calculated

Prospective versus Retrospective

• Prospectively performing review is “pre-bill” which is performed on claims after coding is completed but prior to being submitted to insurance payer
• Completing audits prospectively results in claims being put on hold or suspended until after review has been completed
• Retrospectively performing reviews results in review being performed after claims have been submitted for payment and subsequently paid or denied
• Time frame should be identified - more beneficial to do more real-time to provide education to providers closer to dates of service
• If issues are identified with retrospective claims, those claims should be rebilled as corrected claims
Proactive Compliance Audit

Will likely not be a statistically valid random sample

Time frame – may be Prospective or Retrospective

- Prospective:
  - Potential negative impact to Accounts Receivable (AR) if the accounts aren’t released in a short time frame
  - Access to the records may delay the review
  - If unable to meet with provider, this could also delay the claims being billed and impact AR
- Retrospective:
  - Errors identified will need to be rebilled
  - Possible effective on physician compensation

How many encounters?

What will be the scope?

Scope - Proactive Compliance Audit

- OIG Work Plan
- CERT Issues
- RAC Issues
- Top ten denials for the practice
- Top ten services billed for the practice
- Specific issues brought to your attention
The time frame to be reviewed will also depend on the reason for the audit:

- Proactive or compliance audit – may be more helpful to choose recent claims – if the purpose is education, better to work with recent visits that the provider may remember – there may have also been changes in documentation patterns.
- Audit for a specific problem will need to be for the time frame for which the problem is suspected.

If retrospective, determine when provider started if audit will cover a particular time frame: quarter of the year, month or week.

Corporate Integrity Agreement

- “Forced” compliance plan when an organization had entered into a settlement for fraud allegations.
- Require periodic audits to ensure that the coding/billing problems are resolved.
- Requires a 95% accuracy rate by providers.
Choosing the Audit Sample

This will depend on the type of audit

• If there is no specific problem being investigated – 10 encounters per provider for a proactive or compliance audit
  • “Random” sample – one days’ visits, first 10 on EOB, etc.
  • Also called a “judgmental” sample – cannot be extrapolated to a larger population since it is not truly random

OIG recommends 5 per provider per federal payer per year

• If investigating a specific problem, may consider a statistically valid random sample
• Probe sample followed by larger sample with a targeted confidence and precision
  • Probe usually 30, 40, or 50 items
• For self-disclosure, CMS requires that the sampling methodology be reviewed by a statistician or someone with equivalent experience

Choosing the Audit Sample, continued
Sampling is choosing a subset of the claims in a provider’s universe of claims for the purpose of auditing them. In a random sample, units are selected at random so that the opportunity of every unit being included in the sample is the same.

- Allows a reasonable representation of the whole without the time and expense involved in reviewing each claim.

https://accountlearning.com/simple-random-sampling-definition-advantages-disadvantages/

https://www.randomizer.org/


Will You Review for Medical Necessity?

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

- Centers for Medicare & Medicaid Services' manual system, Pub 100-4, Chapter 12, Subsection 30.6.1 A
- "Program Integrity Manual", Pub 100-08, Chapter 3, Section 3.2.3 A.
Have you read the back of the CMS-1500 claim form?

“I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were furnished by me, or were furnished incident to my professional services by my employee under my immediate supervision. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.”

Concurrent with Payer Review

- Sample will be those records requested by the payer
- Review all records or just a portion?
- Important that alterations not be made to records during concurrent review
Attorney Involvement

If review is done at the request of an attorney, he/she may determine most of the audit criteria – however, remember Attorney-Client Privilege requires:

- Attorney-client relationship and auditor/reviewing must be retained by attorney
- Attorney acting in capacity as attorney
- Communication made in confidence between the attorney and client
- For the purpose of securing legal advice.

Audit could be identified as Attorney Work Product instead

Attorney contracts with the auditor/consultant

Report is delivered to the attorney

Communication between the auditor and the client is at the direction of the attorney

Simply marking a report “Attorney-Client Privilege” does not make it protected nor does it function retrospectively to cover the findings which have already been reviewed and documented
Work-Product Doctrine:
• Documents tangible things – interview memos and notes
• Prepared in anticipation of litigation – temporal and intent
• By or for a party’s attorney are protected against discovery unless the party seeking disclosure can demonstrate:
  • Substantial need
  • That it would produce undue hardship without discovery

Routine audit reports may not be protected

What You Need To Look At
- Documentation of Encounter
- Superbills/Encounter Forms/Charge Capture Documents
- Claim Forms
- EOBs/Remittance Advice
- Payer Policies

Depending on service audited, may also need to review other documentation – Ex: For incident-to services, you will need to review entire chart for plan of care and ongoing care by supervising physician.
Questions?

What is an error?
- Just overpayments or any deviation

Prospective or retrospective?

What will be your acceptable error rate?
- CIAs allow 5%
- In other situations, CMS has stated 7%

What will you do with the results?
- Education, follow-up auditing, penalties?

Gray Areas

Coding, especially evaluation and management coding, is full of gray areas. How will your practice interpret these?

Which components are accepted or mandatory for established patients?

Is “non-contributory” acceptable documentation?

What is a detailed examination under the 1995 CMS Documentation Guidelines?
EHR Auditing Issues

Authentication – signatures, dates/times – who did what? (metadata?)

Contradictions – between HPI and ROS, exam elements

Wording or grammatical errors/anomalies

Medically implausible documentation

Audit Results

– What do you do with them?

If Audit was done Prospectively – claims should be billed according to findings of audit – may demonstrate need for further retrospective review

If performed Retrospectively and claims have been submitted, corrected claims should be resubmitted for changes to codes or payments based on audit findings

If done as part of Attorney engagement, legal counsel should determine if Self-Disclosure will need to be done and pay back will be done to payer

Is education part of the followup?
Followup Education?

How effective is this compliance and auditing program if you never educate the providers on how to “do it right”?

Education should be:
- Timely
- Targeted
- Group or Individual?

Who are you reporting the results to?

Provider
Administration
Compliance Department
Attorney
Provider

- Is the provider doing his own coding?
- How is his compensation affected by audit results?
- More interested in % accuracy or dollars involved?
- Are there issues he has no control over?

Financial pressures

- Interested in undercoding and missed opportunities as well as overcoding
- Reminder to refund any overpayments

Administration
Compliance Department

Is this an outside audit report or internal audit?

Is there a prescribed format?

Are there internal coding guidelines being followed?

Does the department or practice have policies and procedures?

Attorney

Is this audit being conducted concurrent with a payer review?

Are there legal actions or appeal proceedings pending the results of this audit?

May involve a more defensive attitude than a compliance audit

Can't change the findings themselves – but can we argue?
What’s included in this audit?

• What are the objectives of the audit?
  • “Accuracy of ICD-10-CM Coding and Reporting Guidelines, CPT/HCPCS codes; modifiers, number of units reported on claim forms and remittance advices to assess if documentation in the medical record & physician orders supports the services billed.”

• What is the scope?
  • Judgmental sample?
  • Truly randomized sample?
    • “The scope of this audit will include a review of a random sample of 10 Medicare/Medicaid encounters for each service line” OR “each provider”

What’s excluded in this audit?

• Are there certain payers excluded in data sample?
  • Only included Government Payers – Medicare and Medicaid patients
  • Government Railroad

• Are there processes not reviewed in audit?

  • “Scope Exclusions: This audit will not include testing of Advanced Beneficiary Notice (ABN) processes and controls, Pharmaceutical/drug code assignment, or claim processing by the facility.”
When?

Time frame of results?

Do you need to include “DRAFT” in watermark with the date on report until it is finalized to begin the 60 day payback obligation?

What was your time period of your sample?

- “Time period of January 1, 2017 to December 31, 2017”

Is this a retrospective pay back audit for the past 6 years? State the dates included in the review.

Where was the audit performed?

This can include details such as “audit was performed remotely” OR interviews occurred while onsite then audit performed remotely OR audit was performed remotely

Location: Was this one hospital or provider clinic or multiple sites?

If multiple sites – list them out
How was this audit performed and how is it being reported?

- Both 1995 and 1997 Documentation Guidelines for E&M services?
- Specific MAC or commercial payer criteria used?
- Was a software utilized?
- Excel spreadsheet with results?
- Narrative report?
- Charts with graphs?

Why was this audit performed?

- Was this done due to a potential compliance risk that was identified?
  - How was this identified?
- Is the audit being done due to bell curve analysis identifying providers who are outliers?
- Is the audit being done as this provider bills high risk services? (e.g. prolonged care, high levels of codes)
- Is this being done due to issue on Compliance Audit Plan?
- Is this being done due to potential issue on OIG work plan?
- Is this audit being done proactively by Compliance?
- Is this audit being done post-education?
- Is this in response to payer audit – are you dealing with best practices vs. defensive audit?
How do the risks of the audits rank?

- High
- Moderate
- Low

How does this compare?

Bell Curve Analysis may be helpful – but...

- Data available represents what was BILLED
- Medicare data available not current
- Some specialties not represented in Medicare data
- Data may be available from other sources for a fee
Are there any incidental findings?

Did the scope not include diagnosis coding in the review, yet errors were found?

Was there any concerning information revealed in interviews with staff that you think needs to be addressed?

Sample Audit Reports and Presentations
Sample Report - Spreadsheet

Sample Report - Summary

Client Name: Issues & Recommendations Report
September 9, 2016

Audit Date Range: December 2015 – May 2016
Auditor: Kim Rury, MC, CIC, CPC, CCS-P, PCS, CPCO, CDC
All Providers:

Number of Reports Audited: 81 (80 encounters – one with 2 EM)
The following audit parameters were followed:

- The auditor reviewed the medical record documentation, encounter forms, superbill, and the final-billed CMS 1500 claim form.
- Under the guidelines of Medicare, Medicaid, and all other federal and state health care programs, the auditor verified that all charges billed are for covered and allowable services.
- The auditor verified documentation of the client complaint.
- The auditor determined appropriate assignment of EM visit level CPT codes.
- The auditor verified that all billed procedures are documented in the medical record either in the progress notes or via a copy of the appropriate report.
- The auditor verified the accuracy of CPT/HCPCS coding, modifier assignment and number of units of service for documented procedures and verified that upcoding of codes has not occurred.
- The auditor determined appropriate ICD-10-CM diagnosis coding and verified that the primary focus of the visit was sequenced as the first ICD-10-CM code.
- The auditor verified the correct place of service code reported on the CMS 1500 claim form.

Records Accurately Coded: 40
49.38%
Sample Report – Summary - continued

- The auditor verified the correct piece of service code reported on the CMS 1500 claim form.

<table>
<thead>
<tr>
<th>Records Accurately Coded</th>
<th>40</th>
<th>49.38%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records Over Coded</td>
<td>41</td>
<td>50.62%</td>
</tr>
<tr>
<td>Records Wrong Category (w)</td>
<td>3</td>
<td>3.37%</td>
</tr>
<tr>
<td>Procedure Coding Accuracy</td>
<td>71.11%</td>
<td></td>
</tr>
<tr>
<td>Gross Financial Error Rate</td>
<td>27.79%</td>
<td>[Based on Alabama Medicare Fee Schedule]</td>
</tr>
<tr>
<td>Diagnosis Coding Accuracy</td>
<td>45.3%</td>
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</tbody>
</table>

Please see Audit Summaries and Encounter Detail Reports for detailed information -

Documentation and Coding Issues

- Complete Review of Systems is documented by either listing at least ten systems individually or by listing the pertinent positives/negatives followed by the statement "All other systems negative." Other statements such as "14-point review of systems is negative" or "ROS: negative except for HP" are not allowable.

- "Family History: Noncontributory" is unacceptable documentation. This statement is unclear whether the physician obtained the family history information or chose not to because it would not affect his decision-making.

Sample Report – Summary - continued

- For Hospitalists, documentation requirements were met for shared visits with CRNPs and PAs; however, I was unable to determine if the employment requirement is met. The advanced practice provider must be employed in the same group practice as the physician. If this is not the case, then these encounters are not documented sufficiently by Dr. B—— and Dr. W—— to support any level of service.

- Teaching/Physician errors – One encounter only included a co-signature by the Teaching Physician and not the appropriate attestation.

- CMS Documentation Guidelines allow the status of three chronic conditions as an extended History of Present Illness; however, the documentation for some visits merely stated the chronic conditions without describing the status.

- Dr. III—— did not appropriately document interpretation of diagnostic studies such as X-rays and EKGs. Documentation for interpretation of an X-ray should be "as complete as that prepared by an expert in the field." Ideally, per the AMA, it should be on a separate piece of paper. In all cases, it should state the structure viewed, the number of views, any comparison to previous films, and the interpretation. Likewise, documentation for EKG interpretation should include an interpretation of the tracing along with clinical correlation. Without such documentation, only the technical component may be billed.

- Dr. III—— did not document performance of procedures such as nebulizer treatment, only an order for the treatment.

- Two encounters included contradictory information entered in different sections of the electronic medical record. This may occur when the physician enters information about the patient's complaint in the History of Present Illness but then relies on a templated "Normal" review of systems without correcting/personalizing those entries.

- Counseling time not always appropriately documented. A visit may be coded based on total time spent face-to-face with the patient when the visit is dominated by counseling and coordination of care, but the documentation must indicate the total time, the counseling time, and the subjects discussed.

- Diagnosis coding was often incomplete – that is, diagnoses were documented that were not billed.

- Questionable diagnosis or those documented as rule out, probable, or suspected should not be billed if definitive.

- Diagnoses were sometimes listed but not addressed in the Assessment and Plan.
# Sample Report – Audit Summary

## Audit Summary Report

### By Provider

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Visit Dr.</th>
<th>History</th>
<th>Exam</th>
<th>Decision</th>
<th>Prox Code</th>
<th>Rev Code</th>
<th>Var</th>
<th>Diff</th>
<th>DC</th>
<th>Total</th>
<th>Dk Accuracy</th>
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### Summary Comment:

- Total Visits: 106
- Assessed Code: 79
- Under Coded: 24
- Over Coded: 74
- With Net Financial Error: 2.33%
- Net Financial Error [%]: 5.15%

*Combined number of assessed, under, over, and net financial error number of visits, will vary due to partial pages or extra pages.
Sample Report – Bell Curve Analysis

Conclusion of Audit Results

- High level overview of what the issues were/are and how they are being addressed
- Expectations
- Action plans – Education needed, who needs it, who will provide it
- Does the client need to provide documentation of education, sign in sheet of attendees, date, copy of education provided? Was education performed during the rebuttal review of the cases?
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