

Anatomy of a Coding Compliance Audit

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Anatomy of an Audit

- Detection
- Assessment
- Audit Strategy
- Determination of action
- Provider Response Strategy
- Audit Prevention

DETECTION

Why Do They Audit?

- Success of the past Medicare Recovery Audit Contractor's (RAC) demonstration project
- Enhanced call for accountability and cost-saving measures within recent federal legislation, including the Affordable Care Act (ACA)
- General perception that billions of dollars in health care expenditures are not only unnecessary, but may be fraudulent
- Success of government audits leads Commercial payers to recover "overpayments"
- Medicare Advantage plans are required per government to conduct similar audits
- Medicaid uses the Medicaid Integrity Program audits based on requirements of the (DRA) Deficit Reduction Act
- And oh so much more...



Why Me?

- Reports or data mining suggesting that a physician, facility, DMEPOS, pharmacy, code is an outlier (e.g., high frequency of certain procedure codes/modifiers, or high acuity evaluation and management codes (i.e.; level 5) more frequently than their peers)
- Repeated perceived claims submission errors, or atypical billing and coding patterns
- Plan contract negotiations or renegotiations
- Internal changes in payer bundling or claims management policies
- Reports from individuals (e.g., patient complaints, employer requests, or whistle blowers)
- Random
- Services billed are found on the OIG Work Plan
- Media/Law Enforcement/ CMS leads



Other Sources

- License and Disciplinary Issues
- Corporate records
- Online public records
- Social media
- Health plan financial exposure
- Specific benefit plans
- Geographic distances traveled

ASSESSMENT

Is it Worthy?

- Review of available information
- Answer question:
 - Does it appear valid?
 - Does it appear to violate regulation or contract?
 - Do we have resources to audit issues?
 - Can we impact the situation?
 - Does it fall within thresholds?

AUDIT STRATEGY

Type of Audit

- Contracted Provider – Audit process regulated by contract with payer
- Non- Contracted Provider Audit – Audit process regulated by state/federal rules and member contract
 - Pre-Payment Audit
 - Post Payment Audit



Audit Components

1. Correct claim demographics
2. Coverage/Benefits appropriately applied
3. Paid/write offs/denials appropriately adjudicated
4. Documentation supports/describes codes reported
5. Documentation requirements satisfied
6. State/Federal/Plan Contract Stipulations followed



Gathering Evidence

- Auditor may choose:
- Interview with subject of audit
- Interview with source of allegation
- Request medical records or other documentation related to claim
- Original claim
- EOP/ EOB payment processing information
- Etc.



Actual Auditing

- Current Centers for Medicare & Medicaid Services (CMS) guidelines
- National Correct Coding Initiative (NCCI) (MUE)
- Current Procedural Terminology (CPT)
- Current Healthcare Common Procedure Coding System Level II (HCPCS)
- Current International Classification of Diseases (ICD-9-CM & ICD-10-CM)
- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSMIV)
- Current Uniform Billing Editor (UB 04)
- All Patient Refined Diagnosis Related Groups (APR-DRG)
- Claims editing logic
- Specialty Society Guidelines
- FDA guidelines and Drug manufacturers' package label inserts as appropriate



- Payer Specific Payment and Medical Necessity Policies

DETERMINATION

Audit Report

- Audit report generated:
- Name of subjects
- Summary of audit steps taken
- Violations determined or not
- Who, What, When, Where, Why and How
- Recommended course of action

Factors Considered

- Overall strength of audit
- Credibility of witnesses
- Amount and nature of evidence
- Nature of the alleged activity
- State or Federal laws
- Sentencing guidelines
- Contractual obligations (line of business)
- Dollars involved

Action Options

- Criminal/Civil Referral
- Referral to license board
- Termination from health plan
- Referral to CMS/OHA/OIG/DOJ
- Education letter
- Education and Recovery
- No action

PROVIDER RESPONSE STRATEGY



Audit Letter Recieved

- DO:
 - Review letter to understand the “ask”
 - Identity of sender
 - Due dates
 - Assemble audit response team
 - Identify steps to be completed and person responsible
 - Leave time to review submission well in advance of due date



Audit Letter Received

- Don't:
 - Panic
 - Call Auditors to complain, yell, curse, or threaten
 - Hesitate to contact legal counsel, if desired
 - Fall prey to negativity or cynicism
 - Delay/procrastinate action or response
 - Ignore
 - Immediately pay off, unless legitimately due



Obligation to Respond

- Identify either the statutory or contractual obligation that compels you to produce records.
 - Medicare: Statutory obligation to respond or face automatic denial and recoupment
 - HHS OIG CERT: Statutory obligation to respond or face potential FCA action.
 - Commercial Carrier: Participating provider contract, UM provisions, contractual or statutory limitations period.



Obligation to Respond

- Where there is no duty to provide records and you do not cooperate with audit the carrier may:
 - Conduct pre-payment review of 100% of your claims
 - Refer your practice to State Attorney General or Federal Government for prosecution can occur in some cases.
 - Refer your practice to appropriate license board



Respond to Record Requests

- Responses must be timely and complete –track all deadlines
- Provider must be prepared for large volume of requests
- Keep a complete record of who has sent what to whom
- Keep copy of all records and correspondence
- Designate a point of contact, perhaps the compliance officer, to communicate with requesting entity
- Notify legal counsel, as necessary



Respond to Records Request

- DO NOT ALTER THE ORIGINAL RECORD!!
 - Criminal Sanctions
 - Mail Fraud
 - Obstruction of justice
- Correcting Errors/Omissions
 - Alterations
 - Draw a single line through the inaccurate information and write in the correct information, Sign and Date!
- Explain your reason for adding/changing



Duty to Refund Overpayments

- Do you have to repay money?
 - Under 6402 of PPACA, provider must report (notify contractor in writing of reason) and return Medicare and Medicaid overpayments within 60 days from the date identified or a date the corresponding cost report was due
 - Non Contracted payers can fall under state specific False Claims Act - Retention after deadline results in potential liability under the False Claims Act
 - Contracted providers – Duty specified in payer contract stipulations
- If disagree – Follow outlined Appeal Process



AUDIT PREVENTION



How to Prevent Audits

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No, Really

- Start with a journey of self discovery
 - Look inward (at your practice/facility/vendor management system)
- Develop utilization reports
- Compare your results to appropriate benchmarks
 - Medicare utilization files - <https://data.cms.gov/Public-Use-Files/Medicare-Provider-Utilization-and-Payment-Data-Phy/ee7f-sh97/data>
 - MGMA <http://data.mgma.com/EMProfile/rdPage.aspx>
 - AAPC - https://www.aapc.com/resources/em_utilization.asp
 - Specialty Society



E/M Utilization Example

- E/M Coding Profiles
 - Group by Category
 - Gather from Practice Management number of times each provider billed each E/M code
 - List physician's name and the number of times he/ she has billed each code during the period you're analyzing. Total and divide the number of times the physician used an individual code by the total number of times he or she used a code in that category to determine the frequency percentage (for instance, by dividing the number of times 99214 was used by the total number of times established patient office visits (99211-99215) were used).

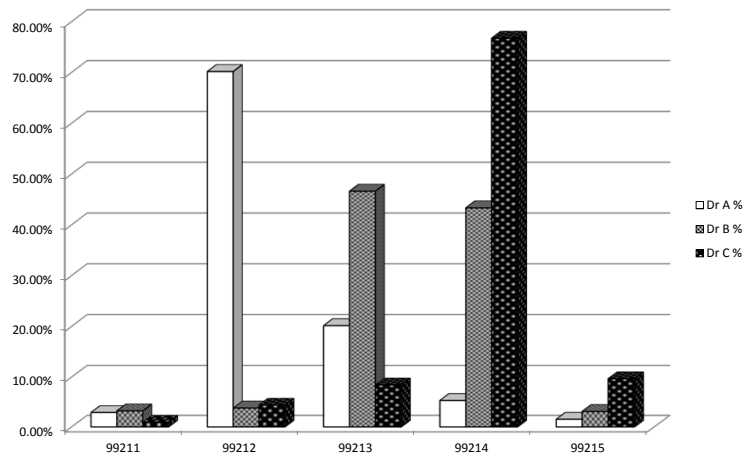


Excel Analysis Example

CPT Code	Dr A # of Times	Dr A %	Dr B # of Times	Dr B %	Dr C # of Times	Dr C %
99211	68	2.88%	317	3.20%	24	.90%
99212	1655	70.16%	2138	3.79%	116	4.35%
99213	475	20.14%	4063	46.60%	224	8.40%
99214	125	5.30%	477	43.32%	2046	76.72%
99215	36	1.53%	88	3.09%	257	9.64%
Totals	2359	100.00%	7083	100.00%	2667	100.00%



Graphs Help



Action Plan

- Adopt a compliance program or update existing program
 - Provide for regular assessments
 - Self-audit of potential risk areas/ fix them!
- Keep track of denied claims and look for patterns
- Monitor problem areas from government reports and other sources
- Training (including testing) and outreach
- If improper claims submitted, correct problem and refund overpayments
- Establish a point of contact to be notified if audit arrives and instruct all employees to notify that person immediately



Thank You

- Questions?

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