Target Practice

HOW TO AVOID AN INSURANCE AUDIT

By Madelon I. Berger, MPH, MA, CCS-P, CPC, CHBME

The Office of Inspector General (OIG) has recouped millions of dollars in highly publicized settlements targeting teaching hospitals, suppliers, laboratories, physicians, and other healthcare providers. In August 2000, CMS instituted the Comprehensive Error Rate Testing (CERT) program. Local carriers review "outlier" patterns and CPT codes that are billed over or under national or local averages, such as over coding a particular CPT code or upcoding E/M levels.

Insurance and managed-care companies have jumped on the auditing bandwagon, finding it to be a lucrative income source. Their sophisticated software systems generate historical reports and identify outliers, comparing specialties by locality and utilization. They generally request a small number of chart notes, and through extrapolation, typically over a number of years, determine that $X was over billed, upcoded, and/or not medically necessary. They then demand large repayments. Flagrant coding abuses can result in termination from the carrier or insurance plan, reporting to other insurances, and ultimately, loss of licensure.

Medicare policies are explicit and easily available to providers. The 1995 and 1997 Medicare Guidelines defined E/M requirements. The Correct Coding Initiative (CCI) edits are published and CMS and the carrier Web sites identify policies. However, insurance companies make their own rules; they don't always recognize modifiers or abide by the CCI edits. Some have their own non-published policies. They generally do refer to CPT definitions and criteria in their contracts with providers.

If your clients have long-standing established practices and have not been targeted by an insurance company, don't assume they are home free. Insurance companies are tracking down solo practices as well as groups, regardless of how long they have been treating patients.

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How can you protect your clients from getting audited? Every provider must view ***medical necessity*** as the springboard to provision of services and procedures. Here are some suggestions:

- Recommend that your clients develop a Compliance Plan as recommended by the OIG. The Draft Compliance Program Guidance for Individual and Small Group Physician Practices can be found at www.hhs.gov/oig.
- Strongly encourage clients to update their CPT and ICD-9 books annually (ICD-9 changes go into effect 10/1, not 1/1).
- Ensure that practices use modifiers appropriately. Don't think that they will remain under the radar screen by billing all low-level codes; this can also trigger an audit (outliers include codes below the average). Additionally, providers may be cheating themselves out of revenue for work that warrants higher-level codes.
- Be pro-active. Review coding patterns by running productivity reports and inform your clients of aberrant coding patterns. Show them your expertise in coding issues; they will appreciate it. Send them carrier updates.
- Review their Encounter Forms to ensure that all codes are current and complete. Ongoing education is key and part of every compliance program.
- Make clients aware of specialty coding seminars and ensure that they document their attendance.
- Provide in-service training with your clients to review criteria identified in the CPT book for commonly used codes. Don't let clients insist on using codes based on hearsay ("Dr. Smith gets paid for …").
- Before claims are submitted, conduct a Quality Assurance check. Ensure that you are billing the correct patient for the actual date of service with all pertinent codes. Make sure you are submitting claims with complete, not truncated diagnosis codes.
- Conduct an internal prospective audit, or retain a consultant to do so, as recommended by the OIG, to review five to ten charts per physician a year. If the results show incorrect coding patterns, the provider(s) should attend specialty seminars and more frequent

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What would you like to change? What is your vision for your company? It was during this phase that we at Provider Resources rewrote the company mission statement. Our vision changed and our value statement was written. It serves as our guide.

4. Designate a compliance officer and a compliance committee. Again, because we are small, designating the compliance officer was simple. I chose myself, originally. The compliance committee was another story. I selected our operations manager, accountant, and attorney, as needed. It wasn't enough. To have "buy in," I needed input from all levels of our organization. So I simply asked all employees for volunteers and advised of the meeting times and approximate time requirements. It worked! We pulled in members whom I never thought would have participated—and we found their input was invaluable. Buy-in? It was almost immediate.

5. Set the tone of the committee. In our company, all members are equal. All votes are equal. All members are required to read the *Federal Register* and become familiar with the *OIG's Guidance for Third-Party Medical Billing Companies*.

6. Develop the game plan. Be realistic—this is a process. It's not something you create, complete, and never look at again. It is a way of life, a way of conducting business. It deserves the same energy you expend in buying a computer system, the basis of how you produce your services. It gauges who you are and what you do. It takes time to develop and implement, so set a realistic time table. How much time can you expend, realistically, on a weekly basis, a biweekly basis? Initially, we met weekly for three to four hours. Meeting times grew shorter as we progressed and we had more assignments outside of the meetings. I believe it took us about 18 months to develop the plan initially, and quite honestly, our monitoring and auditing process is still evolving.

7. Get started. Feeling impending dread? Really, no need for agony at this point. You are well under way and you've done the hard part. When I got to this point, I realized that we had *already started****!*** All that was left was to determine how the seven elements outlined in the OIG's program needed to be integrated into our company. We literally took a copy of the *Federal Register*, reviewed each of the elements, and worked through them.

I believe the most important aspect of a compliance program is the development of a culture. We developed a Code of Conduct, which includes the means for reporting infractions. We didn't wait for the entire plan to be written and/or developed. We introduced this to the employees immediately. We set the expectation of compliance and began the development of the culture. In time, the culture was reinforced through job descriptions, non-compete agreements with employees, and employee evaluations.

There is hope. Create the culture. It is the beginning. ▲

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reviews should be conducted.

Keep in mind that if your client has a subspecialized practice, or patients with a higher level of acuity, the provider may be able to justify higher level CPT visit codes or procedures more frequently than his or her peers. However, all coding must be **well documented and medically necessary.**

The need for detailed documentation and understanding of the Documentation Guidelines cannot be emphasized enough. Review the Medicare Documentation Guidelines (www.cms.gov/medlearn/emdoc.asp) with your clients and determine which are more favorable for their practices, 1995 or 1997. Keep in mind every auditor's credo: ***If it isn't documented, it didn't happen***. Also, if it is illegible, it won't be considered.

If a managed care company audits a provider, it is strongly advisable that the provider retain an experienced healthcare attorney before returning any money. The attorney or firm may retain a coding expert who can review the provider's notes and analyze the insurance company's findings. Furthermore, legal firms can usually negotiate with insurance companies. Also, proof of ongoing education and development of a compliance plan by the provider will often be taken into consideration.

By taking these measures, your clients will become more compliant, resulting in cleaner claims with faster turnaround, and, in the event of an audit, the documentation to substantiate their coding. ▲

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