Outside Chart Reviews...From a Different Angle

By Shawn Keough-Hartz, CHBME

Are you sending charts or progress notes out of your shop to be reviewed? Are your clients? Do you even know if they are having them reviewed? If you are providing the coding, my question to you is: what is the quality of your coder's work? Do you really know? I'm going to give you reason to find out! In fact, I'll give you two.

- Money (We all like the green stuff…)
- Liability.

Now, I'm going to share a little history and a little information that may make you add that component to your compliance plan or at least encourage your client to do so.

Some of you may or may not be aware that, after 20+ years running a typical-sized billing company (and still providing billing services for anesthesia), I decided that I wanted to have a larger impact on the integrity of the health care system and be in a position to make a difference. We know that insurance carriers aren't going to reduce their profit margins and/or their reserves. Providers will always be fighting for their money. Those of you who attended the recent HBMA Denials Management Webcast will attest that the number of denials is astounding. Because we wanted to make a difference for the providers, billing companies, and the insurers, and because a system of integrity is best in such circumstances, Provider Resources began completing medical reviews for insurance carriers and performing educational chart reviews for the provider community. The outcome has been eye opening.

Listed below are four situations which support my reasons for billing companies and providers to consult outside companies to engage in such reviews. After you have considered the cases, I'd like each of you to ask yourselves some questions.

SITUATION #1 – SALT

We have seen a solo chiropractic practitioner who had to pay back $432,000 because his progress notes contained the word "SALT" and the date. That's it. That was all the documentation contained in the chart. Nothing more; nothing less. Scary, but true.

Now, the question is, what does "SALT" mean? I always equated it with a mineral I placed on my food for taste. How does SALT pertain to a level of history, level of exam, and any medical decision making at all, let alone create documentation for procedures performed?

Select a consultant carefully...a company is not relieved of responsibility or liability by following the advice of a paid consultant.

It turns out that SALT means: "Same As Last Time." Unfortunately, I'm sure this provider actually completed the level of service and procedures performed. Also unfortunately, the practitioner is paying money back that, rightfully, should belong to him. But only part of his job was completed. Had the documentation been correct, no money would be due the carrier.

SITUATION #2 - The template

Templates in and of themselves are, in my opinion, good. They assist the practitioner to complete an appropriate history and an appropriate exam for the reason the patient presented. They should, however, be used with care and caution. We have seen cases where, regardless of the service provided, the template was physically copied from visit to visit. Interesting. The exam was the same, as was the history taken. Needless to say, this provider carelessly billed all services as a level 4 and/or 5 and all patients, whether male or female, had a genital exam each and every time he or she presented for treatment. It didn't matter that the patient might have had an upper respiratory infection.

I don't think so…

SITUATION #3 – In-house coder—credentialed CPC

A certified coder reviewed the case in Situation #2 above. The coder performed the "audit" and counted the bullets. It was reported that all items billed and reviewed were correct. All levels four and five. The well-respected coder, with an extensive coding background, failed to see the fraudulent nature of the templates outlined above. The coder further failed to see that the extent of the history obtained, as well as the exam completed, did not meet the requirement. The AMA states that the level of the history and exam are "dependent upon clinical judgment and on the nature of the presenting problem(s)."

SITUATION #4 – Under-billing

This situation is for all of us who bill based upon a percentage of collection. We work diligently to make sure our processes are exceptional, we strive to give good results and maximize collections. We earn every dollar we collect. What do you do if you have a practice that is under-billing by approximately 24%, based upon the

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This series will discuss some of the more commonly encountered variations, although there may be many more. Every day, medical billing companies handle a wide variety of primary data elements that lend themselves to the construction and application of benchmarks, either as individual data elements or in various combinations and ratios. These building blocks are easily identified and named, but they should first be divided into two major groupings: customer data and company data.

As noted earlier, a benchmarked computer is "perfect" or "best" until it is compared to the performance of other computers. Commonly, various systems excel in a few of the parameters but seldom all of them. In some cases, the buyer may need certain optimized capabilities and not others, so objective benchmarking through standardized testing protocols affords a good source of comparison. Comparing practice and billing company data is more complex because data is often gathered and/or reported with less objectivity.

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For example, "adjustments" may mean ALL adjustments processed in a month, even if some were from a prior month; or, it might mean only adjustments from the named month; or, it might mean "net" adjustments for that month, e.g., adjustments minus credits for posting errors, successfully challenged adjustments (payor errors, posting errors, etc.). So, the adjustment reported may vary.

Furthermore, the most common use of the term adjustments refers to ***contractual adjustments***—the amounts written off for specific charges (individual CPT-4 codes) for specific amounts, based on a statutory (Medicare, Medicaid, TriCare, etc.) or contractual agreement, sometimes even if the provider is not legally bound to accept the amount proffered. Many practices and billing companies are strict about what they post as a contractual adjustments, reporting other write-offs under different classifications, such as small balance write-offs, administrative write-offs, bad debt write offs, etc.

Some practices, billing companies, and a few software systems lump all write-offs together, thereby diminishing the validity of comparisons with entities reporting ONLY contractual adjustments. The latter organizations would appear to have much better performance than their counterparts, but the objective facts might prove otherwise.

Thus, although the term "adjustment" is universally understood, our individual understanding and/or source(s) of data are not universal. Unless benchmarks use identical sources of data, comparisons of dissimilar data can be slightly-to-significantly unreliable. Debate—often impassioned debate—about the validity of one approach over another is healthy, but use of data for industry benchmarks should be based on commonly agreed-upon, or at least consistent, sources, content, and formulae.

The two articles that follow will address WHAT data are benchmarked and HOW many common benchmarks are calculated, as well as providing many established benchmarks. ▲

Robert B. Burleigh, CHBME, is president of Brandywine Healthcare Services in West Chester, PA. He can be reached at brandywinebob@aol.com.

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documentation and the nature of the presenting problem? Let's look at the case of a very small client, say 500 procedures a month, with an average charge of $90 and a Medicare reimbursement that is 40% of charge. Assume that all services are Medicare and all services are increased by two levels. This equates to more than $2,000 in revenue a month, or about 10% of the client's income. What client do you know that wouldn't leave you to earn 10% more? While the numbers are small for this practice, the actual situation outlined was for a 600+ hospital-based practice. The numbers were huge!

Put yourself in each of these situations. Now I ask that you ponder the following questions:

1. Would I even know if I had an issue?
2. Would I be held liable?
3. Who codes? Procedure? ICD-9?
4. Does my contract protect me from liability?
5. Do I have Errors and Omissions insurance?
6. Are my clients losing money because they aren't documenting well or not documenting at all?
7. How much money am I losing?

With our expenses skyrocketing as well as those of our clients, can we or they continue to ignore the chart reviews the OIG recommends in their Compliance Plan for Physicians or for that of the third party billing company? I don't think so. It is too costly. Outside chart reviews are a necessity, not an option. ▲

Shawn Keough-Hartz is president of Provider Resources, a consulting company for anesthesia billing and medical/chart review in Erie, PA. She can be reached at skeoughhartz@provider-resources.com.