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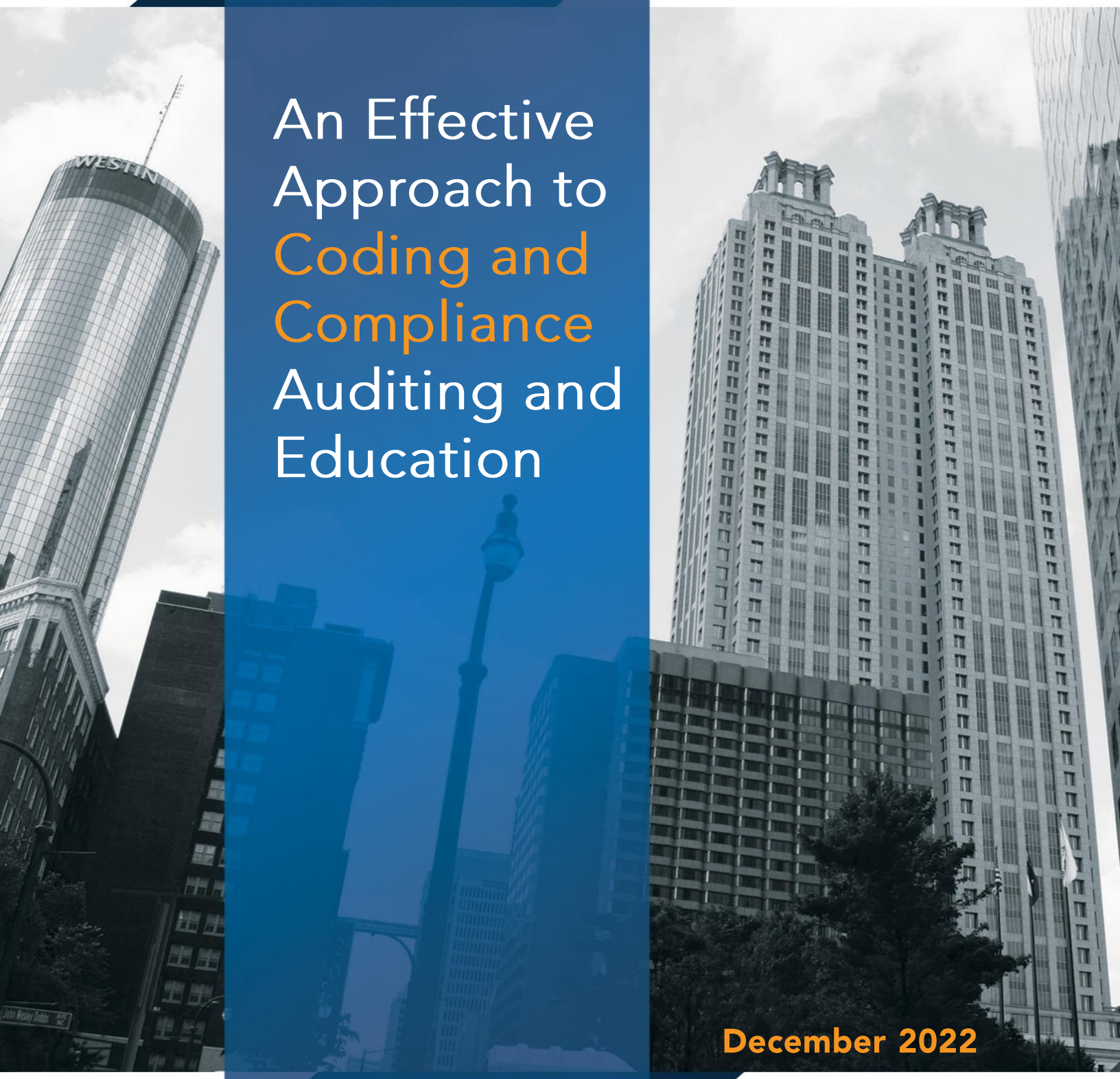
An Effective Approach to Coding and Compliance Auditing and Education



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Introduction

All physician groups, including those affiliated with healthcare organizations, feel the tension between governmental compliance and financial viability, and striking a healthy balance takes effort. Further, engaging the provider in healthy communication about coding, documentation, and billing increases the challenge, and without their cooperation and support from leadership, compliance programs may suffer and become ineffective.

Everyone in healthcare knows that following compliance regulations is mandatory if a physician group receives any payment from a governmental entity or private insurer. The Office of the Inspector General (OIG) has published guidelines with recommendations for what a compliance plan should include based on the type and size of the physician group or organization. While the OIG website refers to these compliance program guidance documents as "voluntary," Section 6401 of the Affordable Care Act made these compliance elements mandatory for all providers who participate in Medicare or Medicaid.[1] Accordingly, physician groups and healthcare organizations can use the OIG's guidelines to create an effective compliance plan to decrease the risk of fraud, waste, and abuse that may lead to the recoupment of overpayments or other costly penalties or fines. Highly functioning organizations and physician practices understand that investing in an effective compliance plan is far less expensive than being subject to recoupments, fines, and penalties.

Ask About the Compliance Plan

At the beginning of any coding project, one of the first questions is whether the practice has a written compliance plan and an audit work plan. Sadly, these items are often buried in a closet, and someone must search the office files to retrieve them, clearly indicating the lack of time and attention given to following the policies within the plan or are often absent altogether. A neglected or absent plan sends the wrong message when trying to contend for the intent to comply in the case of an audit. If a compliance plan is in place, ensure the audit approach complies with the plan directives and is based on the organization's annual risk assessment.

Interestingly, consultants most often are engaged to work with a physician group to audit their coding to look for lost revenue. The leadership assumes that if the group is losing money or struggling financially, the physicians must be missing out on revenue or under-billing. Occasionally, there are opportunities to increase revenue. Our experience has found two frequent causes of lost revenue: a code calculator with an EMR that selects the code level based on static data entered, or a physician who selects lower codes to stay under the radar and out of trouble. Typically, appropriate education can address both issues.

There are undoubtedly many reasons healthcare organizations should conduct periodic compliance risk assessments. Benefits include:

- Billing for nurse practitioner and physician assistant services using the physician NPI when incident to guidelines have not been met, resulting in an overpayment of 15%. If the nurse practitioner or physician assistant sees a new Medicare patient or a Medicare patient with a new problem, their NPI must be used for billing, not the physician's NPI.[2]

- Medicaid guidelines may be even more stringent, such as in Georgia, where any services provided by a nurse practitioner or physician assistant must be billed using their NPI.[3]

- Ancillary services should be billed alone, but an additional E/M code is assigned with a -25 modifier. Unless a separately identifiable service outside the procedure is provided, the additional E/M is not supported.[4]

- Lacking documentation to support the level of E/M code selected. Most physicians have had minimal to no coding education and are simply guessing or depending on the EMR code calculator to select the code. Even new physicians coming out of residency programs rarely receive enough coding training.

- The use of cut and paste, carry forward, or macros or templates in an electronic health record gives the appearance of cloning or results in over-documentation in the record. Medicare and its various administrative contractors have stated that such practices can lead to coding at a higher level than appropriate and, therefore, lacks medical necessity.

Begin the Discussion

The most effective approach to coding and compliance auditing and education is customization to fit the client's needs. Before beginning any audit assignment, we ask a series of questions to ascertain where to start and what resources will be needed.

Initially, we want to know the following:

- Are we being engaged by an attorney, and if so, what will be the protocol for communication?
- Is there a compliance plan? If yes, does it outline details for how audits are performed?
  (Note that the 2021 Medicare Physician Fee Schedule Final Rule has decreased the documentation burden on providers beginning January 1, 2021, with even more E&M changes finalized starting January 1, 2023.[5])
- How many providers do you have, including physicians, nurse practitioners, physician assistants, and certified nurse midwives?
- Do you currently use an electronic medical record (EMR), and if so, who is the vendor? How long have you been using the EMR?
- Have you received any payer letters about particular providers or codes in the past year?
- Do you currently have any ongoing auditing and education for the providers?
- Are there any coders on staff? What is their role?

This information is necessary for creating a customized audit plan for the analysis. Working with an attorney changes the methods of communication, and it is essential to follow the attorney's instructions, potentially to protect client confidentiality. If the group began using the EMR within the last year, there might be issues with poorly written templates or user errors. If there are in-house coders, we emphasize our intention to augment what they do to ensure we give a unified message to the providers. We cause more harm than good if we undermine the work of the practice coders who deal with the providers daily.

Common sense indicates the need to establish a baseline of competency for each provider submitting claims for billing. The initial audit will serve as a baseline for future audit comparisons and will indicate the specific educational needs of each physician.

We recommend a random sample of 13 to 15 E/M notes, including any other procedures or ancillary services billed on the same date of service. While this is not a statistically significant sample, it does give enough of a picture of the documentation habits of the provider to start the education process.

We recommend expanding the sample number if the provider sees patients in various settings, such as the office, hospital, and nursing home.

Complete the Report Cards

Report Card

Typically, the audits are performed offsite using a remote login to the EMR unless special circumstances (such as paper charts) require a different approach. We prepare a one-page report card for each provider that indicates the audit results. On this report card, claims included in the audit are listed and, using a color-coded system, indicate those that are correct in black, those under-documented that create a compliance risk in red, and those over-documented that pose a financial risk in green. We use terms that are easy to follow. For example, "exam documented supports 99213" instead of "exam documented supports detailed exam," which will not mean anything to the average physician. We include a summary of the overall audit findings at the bottom of the report card page with specific issues noted during the review (including items such as time to signature, problems with cut and paste or cloned notes, EMR template issues, diagnoses listed but not addressed, ICD-10 accuracy, etc.)

Bell Curve Analysis

In addition to the report card, we also generate a bell curve analysis comparing the E/M utilization of the provider to their Medicare specialty peers using data published annually by Medicare. This is a high-level analysis of their overall E/M coding utilization. While several factors can affect their pattern, such as patient demographics or sub-specialties within a specialty, it is enlightening to see the overall use of E/M codes compared to other providers.

Conduct One-On-One Coding Education

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The approach to coding education is critical to making a difference for the provider. We have found the following method for one-on-one provider education based on their audit results ensures success:

1. **Be prepared.**
As simple as this sounds, the provider is busy and not particularly looking forward to coding education. The goal is for them to leave the session feeling their time was well spent. Have the report card, the bell curve analysis, and the audited notes (either printed or accessible by laptop) ready, as well as tools and cheat sheets they can refer to later.

2. **Ascertain their level of coding knowledge.**
Ascertain their level of coding knowledge at the beginning of the conversation for a first-time meeting. Presumably, the physician who is the coding expert of the group or for healthcare organizations does not need to start with coding 101. This individual will likely already have coding questions and want to get right to the results. Others confess quickly to guessing or being clueless about documentation guidelines. Either way, this information is invaluable for customizing the education to suit the needs of the physician.

3. **Explain the audit process.**
People get nervous if they know they are being analyzed and critiqued, and meeting with the auditor can feel like a trip to the principal's office. We want the provider to know we are part of the compliance team, and this process is meant to be proactive and educational, not punitive. We also emphasize that we will work hard to provide them with everything they need to be successful.

4 **Start with something positive when presenting actual audit results.**

Frankly, it is treating someone like you would like to be treated. Sometimes you have to look hard, but even if their coding is awful, perhaps you can tell they care about their patients or do an excellent job with a particular portion of the note, such as HPI or assessment/plan. Of course, you should not lie; they can tell if it is empty flattery, but you will set the tone for the conversation with something positive.

5 **Prioritize the message.**

Some issues discovered during an audit create more risk than others. Begin with the discussion about the most significant compliance risk, then address the others if time allows. We've had a good meeting if a provider agrees to work on one or two items. Not only does this approach focus on the more critical issues first, but it also helps manage the time for the meeting. We do our best to honor the time constraints of the provider, particularly if they begin the session by stating they only have a set number of minutes. We end the meeting with a summary of the most important points.

6 **Seek solutions to correct processes that sabotage compliance.**

If you want your providers to leave education sessions with only frustration, ignore staff issues (such as their omission of a chief complaint) or EMR template glitches. Or, the New Patient forms are poorly designed, preventing the provider from completing their documentation. If possible, encourage someone from their office staff to attend the meetings so changes can be communicated clearly to those who can make adjustments. If the provider falls short because of a staff error or EMR template issue, then the provider should feel confident it will be addressed promptly.

7 **Include follow-up in your audit process.**

Most providers like feedback and education and want to know when you are returning. Work with the physician group leaders to create a plan for follow-up and tell the providers what to expect next. Typically, we recommend follow-up based on their audit results. Providers who do well and have a good base of knowledge can be reviewed on an annual basis. Others with more issues need a follow-up audit using only claims occurring after the education session to determine if improvements have taken place. The most significant waste of time and money are practices that perform a baseline audit and have no plans to do further reviews.

Customize the Group Sessions

In addition to providing one-on-one education sessions for the providers, as described above, group coding education is a practical choice. We recommend group sessions presented by a seasoned auditor addressing general coding guidelines and the issues often uncovered in an audit, customized for each specialty. Some groups prefer an approach that includes a general education for all providers, with the audit performed 30 to 60 days later, including one-on-one educational sessions. This approach provides more than one opportunity for the providers to receive education. The group session offers a forum for the practice leadership to endorse the process and introduce the outside auditors.

Document the Results of the Audit and Education

As with any audit, documentation of the results in a consistent and organized format will ensure a written plan for corrective action and comparison for future audits. The compliance team will use the audit report to organize ongoing compliance efforts and develop an effective compliance program.

2021 Office/Outpatient E/M Documentation Guidelines

Since January 1, 2021, providers have had the opportunity to support the code billed for Office/Outpatient services through how they document in the medical record. History and exam no longer determine the code level with the focus instead on a medically appropriate history and exam. Providers may choose to document (i) based on medical decision-making (MDM) or (ii) based on time.

Under the 2021 guidelines, time includes activities the provider performs on the day of the encounter, such as the following:

- Preparing to see the patient (e.g., review of tests)
- Performing a medically appropriate exam or evaluation
- Counseling and educating the patient/family/caregiver
- Coordination of care
- Ordering medications, tests, or procedures
- Obtaining or reviewing separately obtained history
- Referring and communicating with other healthcare professionals
- Documenting clinical information in the electronic or other health records
- Independently interpreting and communicating results to the patient/family/caregiver

For example, suppose time is chosen for a 99215 Office/Outpatient E/M. In that case, the provider must document the medical necessity of the visit and that the billing provider personally spent 54 minutes with specifics on how they spent the 54 minutes.

Upcoming 2023 Revisions and Changes to E/M Documentation Guidelines[6]

Beginning January 1, 2023, the new guidelines that took place in 2021 will apply for the remainder of the E/M code section, which includes hospital inpatient, hospital observation, emergency department, nursing facility, and home or residence services. These revisions and changes seek to provide continuity across all the E/M sections allowing the modifications implemented in the E/M office/outpatient section in 2021 to extend to all other E/M sections.

Similar to the 2021 guidelines, providers can support the code billed based on how they document in the medical record. With these changes, history and exam have been eliminated to determine the code level, and instead, there will be a requirement for medically appropriate history and exam. Providers may choose to document (i) based on medical decision-making (MDM) or (ii) based on time. The only exception with time is for the Emergency Department E/M based solely on MDM.

Under the 2023 guidelines, time will follow the same elements as in the 2021 guidelines (see previous section).

For example, suppose time is chosen for a 99223 Initial Inpatient/Observation E/M. In that case, the provider must document the medical necessity of the visit and that the billing provider personally spent 75 minutes with specifics on how they spent the 75 minutes.

In addition to the above changes, CMS created three Medicare prolonged service codes that can be added, following the maximum code time (highest codes in a series). The prolonged codes are:

G0316 for use with initial inpatient/observation, subsequent inpatient/observation, or inpatient/observation same-day admission/discharge visits

G0317 for use with initial and subsequent nursing facility

G0318 for use with home/residence services

Additionally, CMS has stated that G0316, G0317, and G0318 will carry a time of 15 minutes that must be met or exceeded before applying to a base code. No additional documentation is required to support this code because CMS believes the appropriateness would be apparent based on the nature of the clinical issues addressed at the E&M visit. It is important to note that CMS acknowledges these add-on codes may be appropriate for specialties not explicitly designated as set out above. However, practices and organizations will want to provide an ongoing auditing program to ensure that non-designated specialties utilizing these add-on codes meet the essential documentation requirements.

Although the 2021 Office/Outpatient guidelines have been in place for almost two years, providers that the 2023 guidelines will impact should begin discussing standardized approaches to the documentation choices available to them in 2023.

The revised and new guidelines will apply for the remainder of the E/M code section, which includes hospital inpatient, hospital observation, emergency department, nursing facility, and home or residence services. Providers should begin working through any necessary changes in workflows and EHR templates, where applicable. Additionally, physician groups and organizations should consider how these changes may affect risk management or medico-legal implications of reduced documentation in the medical record as well as keep abreast of what other payers will expect in the medical record to support reimbursement according to their specific guidelines.

Summary

Provider groups feel the tension between government compliance and financial viability, and striking a healthy balance takes effort. Knowledge is power, as the adage goes—the more you know, the more you can control events. Moreover, what you don’t know can hurt you, particularly about your medical practice's compliance and financial matters. When you know your vulnerabilities, you can take appropriate action. An effective coding and documentation audit can result from a well-thought-out compliance plan, a customized approach, and an investment in the time and energy to create an atmosphere of proactive education and support.

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