

# An Effective Approach to Coding and Compliance Auditing and Education

*White Paper*



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January 2019

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**Abstract:** Balancing the tension between governmental compliance and financial viability takes effort. It is even more challenging when the physician resists cooperation or does not engage in the review and educational process afforded by ongoing coding and documentation reviews. Too often, practitioners do not know their weaknesses and vulnerabilities in coding and documentation, including with their use of EHR templates. Knowledge is power, as the adage goes—the more you know, the more you can control events. What you don't know can hurt you, particularly about the compliance and financial matters of your medical practice or for hospitals and health systems, the practice of your employed providers. When you know your vulnerabilities, you can take appropriate action. An effective coding audit can result from a well-thought-out compliance plan, a customized approach, and investment in the time and energy to create an atmosphere of proactive education and support.

**Key Words:** compliance plan, Office of the Inspector General, OIG, fraud, waste, abuse, billing claims, coding, audit, under-billing, in-house coders, documentation guidelines, coding report card, EMR code calculator, templates, copy/paste, cloning, carry forward, compliance effectiveness.

## INTRODUCTION

All physician groups, including those affiliated with health care 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 (available at <https://oig.hhs.gov/compliance/compliance-guidance>) 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 and/or Medicaid.<sup>1</sup> Accordingly, physician groups and healthcare organizations can use the OIG's guidelines to create an effective compliance plan to aid in decreasing the risk of fraud, waste, and abuse that may lead to recoupment of overpayments or other costly penalties and/or fines. Highly functioning organizations and physician practices understand that investing in an effective compliance plan is far less expensive than being subject to such recoupments, fines, and penalties.

## ASK ABOUT THE COMPLIANCE PLAN

One of the first questions to ask at the beginning of any coding project 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 it, 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, make sure 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 if the group is losing money or struggling financially, then 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: the use of a code calculator with an EMR that selects the level of code based on static data entered, or a physician who selects lower codes to stay under the radar and to prevent "getting into trouble." Typically, appropriate education can address both issues.

More often, we discover billing practices that are clearly outside the guidelines of proper billing and coding, but the practice is unaware of their non-compliance. Typical patterns in non-compliant physician practices 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.<sup>ii</sup>
- 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.<sup>iii</sup>
- Ancillary services that 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.<sup>iv</sup>
- 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 that gives the appearance of cloning or result 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 needs of the client. 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:

- 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 to be performed, including, for example, accuracy thresholds and whether to use 1995 or 1997 guidelines? (See <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf> and <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf>.)  
Note that the 2019 Medicare Physician Fee Schedule Final Rule has decreased the documentation burden on providers beginning January 1, 2019, with even more E&M changes finalized starting January 1, 2021<sup>v</sup>.
- 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 in the past one year pertaining to particular providers/codes?
- 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 some issues with poorly written templates or user error. 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 day in and day out. If a specific set of documentation guidelines (1995 or 1997) has been determined by the compliance plan for audits, then we are bound by the plan to use them.

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. If the provider sees patients in a variety of settings, such as office, hospital, and nursing home, we recommend expanding the sample number.

## COMPLETE THE REPORT CARDS

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 results of the audit. 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 won’t mean anything to the average physician. A summary of the overall audit findings is included at the bottom of the report card page with specific issues noted while reviewing the provider’s specific charts (including but not limited to time to signature, problems with cut and paste/cloned notes, EMR template issues, diagnoses listed but not addressed, ICD-10 accuracy, etc.)

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. (See <https://www.cms.gov/apps/ama/license.asp?file=/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/Downloads/EMSpecialty2015.pdf>.) 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 in comparison to other providers.

## CONDUCT ONE-ON-ONE CODING EDUCATION

The approach to coding education is critical to making a difference for the provider. We have found the following method to 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** 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’s 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 they do a good job with a particular portion of the note, such as HPI or assessment/plan. Of course, you shouldn’t lie, and

they can tell if its empty flattery; but you will set the tone for the conversation with something positive.

5. **Prioritize the message.** There are some issues discovered during an audit that create more risk than others. Begin with the discussion about the greatest compliance risk; then, address the others if time allows. If a provider agrees to work on one or two items, we've had a good meeting. 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, then ignore staff issues (such as their omission of a chief complaint) or EMR template glitches (for example, the template is unable to capture enough review of systems to support higher codes). Or, the New Patient forms are poorly designed (perhaps omitting family history), which keeps the provider from being successful with their documentation. If possible, encourage someone from their office/staff also to attend the meetings so changes can be communicated clearly to those who can make adjustments. If the provider fell 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, as well as the issues most 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, and 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 as well as a comparison for future audits. The compliance team will

use the audit report to organize ongoing compliance efforts and develop an effective compliance program.

## KEEP ABREAST OF UPCOMING CHANGES TO OFFICE/OUTPATIENT E&M DOCUMENTATION GUIDELINES

Beginning January 1, 2021, assuming no further changes in subsequent rulemaking, providers will be given the opportunity on how they document in the medical record to support the code billed. Providers may choose to document (i) as per the current 1995/1997 Documentation Guidelines, (ii) on the basis of medical decision-making (MDM), or (iii) on the basis of time. If time is chosen, for Level 5 visits, the provider must document the medical necessity of the visit and that the billing provider personally spent 40 minutes (for Established patients) or 60 minutes (for New patients) of face-to-face time with the patient. For Level 2-4 visits, the provider must document the medical necessity of the visit and that the billing provider personally spent the current typical time of the CPT code required (for example, 15 minutes for a 99213). If MDM is the chosen option, for Level 5 visits, the provider must document within the requirements of the current Level 5 MDM, but for Level 2-4 visits, the only documentation required is associated with the current Level 2 (New or Established) visit. Because a choice is available to the providers, physician groups/health care organizations are well-advised to consider the approach they will take on an organization-wide basis. For those groups who will permit choice on an individual provider basis, be prepared to keep an accurate listing by provider of the choice taken (as your coder/auditor will need this information, as well).

In addition to the above changes, CMS has finalized several new “add-on” codes for certain primary care and specialty visits in order to capture more fully the resource costs associated with such visits. HCPCS Code GCG1X will be available and anticipated to be billed as an add-on code for every Level 2-4 new and established primary care focused E&M visit performed by family medicine, internal medicine, pediatrics, and geriatrics. No additional documentation will be required to support this add-on code because CMS has stated that it expects claim records to include the billing physician’s specialty, and that the medical record would include the diagnosis for the patient and the provider’s assessment and plan for the visit, and that all of this documentation would be sufficient to document that the furnished visit met the primary care complexity description. Specialists are also afforded new HCPCS Code GCG0X that likewise is anticipated to be billed as an add-on code for every Level 2-4 new and established E&M visit performed by the following designated specialties: endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, nephrology, infectious disease, psychiatry, pulmonology, or interventional pain management-centered care. Again, 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 specifically designated as set out above; however, practices and organizations will want to ensure an ongoing program of auditing to ensure non-designated specialties utilizing these add-on codes meet the essential documentation requirements.

Finally, new HCPCS Code GPRO1 for “extended” E&M or psychotherapy services beyond the usual service will be available for use in 2021 for Level 2-4 New and Established visits. The Code can be reported after an additional 15 minutes is spent with the patient. Specifically, for New patients, this code is appropriate in any case where medically necessary face-to-face time by the billing provider was between 38--89 minutes and for Established patients, in any case where medically necessary face-to-face time by billing practitioner was between 34--69 minutes. For audit purposes, the expectation is that the medical record would reflect that the billing provider actually spent the amount of time with the patient described by the code and that the visit itself, in its entirety, was medically necessary, but CMS would not expect additional documentation to demonstrate that the difference in time between the visit code and the extended visit code was, in isolation, medically necessary. For visits exceeding the length of times for Level 2-4 visits plus the extended code visit, providers may instead report using the Level 5 visit code in addition to the existing prolonged services code (CPT 99354-55, i.e., 90+ minutes for New patients, and 70+ minutes for Established visits).

Providers should begin discussing standardized approaches to the documentation choices available to them in 2021 and, accordingly, 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 the compliance and financial matters of your medical practice. 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 investment in the time and energy to create an atmosphere of pro-active education and support.

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<sup>i</sup> The Patient Protection and Affordable Care Act, Public Law 111–148—MAR. 23, 2010.

<sup>ii</sup> MLN Matters Number: SE0441. Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>. Accessed January 15, 2019.

<sup>iii</sup> Georgia Department of Community Health. Division of Medical Assistance Plans. Policies and Procedures for Physician Services, April 2011. (II.601.9:V1-7);(II.903.3:IX 13).

<sup>iv</sup> MLN Matters Number: MM5025. Available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5025.pdf>. Accessed January 15, 2019.

<sup>v</sup> Medicare CY 2019 Physician Fee Schedule Summary, Federal Register/Vol. 83, NO. 226, November 23, 2018. Available at <https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services>. Accessed January 15, 2019.