An Effective Approach to Coding and Compliance Auditing and Education

White Paper

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September 2016

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Abstract: Balancing the tension between government compliance and financial viability takes effort, and it is even more challenging when the physician resists cooperation. Too often, practitioners do not know their weaknesses and vulnerabilities in coding and documentation. Knowledge is power, as the adage goes—the more you know, the more you can control events. And 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 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.

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.

INTRODUCTION

All physician groups feel the tension between government compliance and financial viability, and striking a healthy balance takes effort. Further, engaging the physician in healthy communication about coding and billing increases the challenge, and without their cooperation, any compliance program is doomed.

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," it is wise to use these as guidelines to create a compliance plan to aid in decreasing risk for fraud, waste, and abuse that eventually involves recoupment of overpayments. Many have found the cost of recoupment is substantially more than the cost of time and money they would have incurred to create an effective compliance plan.

ASK ABOUT THE COMPLIANCE PLAN

One of the first questions to ask at the beginning of any coding project is whether or not the Practice has a written compliance plan. Sadly, it is often buried in a closet, or someone has to search the office files to retrieve it, clearly indicating the lack of time and attention given to following the policies within the plan. A neglected plan sends the wrong message when trying to contend for the intent to comply in the case of an audit. If there is a compliance plan in place, make sure the audit approach complies with the plan directives.

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.[i]
- 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.[ii]
- 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.[iii]
- 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 sufficient coding training.

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 begin 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 so, 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.)

- How many providers do you have including physicians, nurse practitioners, physician assistants, and certified nurse midwives?
- Do you currently use an electronic medical record and, if so, who is the vendor? How long have you been using the EMR?
- 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 for communication, and it's 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 intent 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 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 physician 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 for coding education is critical to making a difference for the physician. We have found the following approach to one-on-one physician education based on their audit results ensures success:

1. Be prepared. As simple as this sounds, the physician 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 printed tools and "cheat sheets" they can refer to later.
2. For a first time meeting, ascertain their level of coding knowledge at the beginning of the conversation. Presumably, the physician who is the coding expert of the group 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 to customizing the education to suit the needs of the physician.
3. Explain the audit process. Everyone gets 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 physician 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. When presenting actual audit results, always start with something positive. 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 in the course of an audit that create more risk than others. Begin with the conversation about the greatest compliance risk; then, address the others if time allows. If a physician agrees to work on one or two items, we've had a good meeting. Not only does this approach focus on the

more important issues first, but it also helps manage the time for the meeting. We do our best to honor the time constraints of the physician, 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 physicians 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 sufficient review of systems to support higher codes.). Or, the New Patient forms are poorly designed (perhaps omitting family history), which keeps the physician from being successful with their documentation. If at all possible, encourage someone from their office/staff also to attend the meetings so changes can be communicated clearly to those who can actually make the change. If the physician fell short because of a staff error or EMR template issue, then the physician should feel confident it will be addressed promptly.
7. Be sure your audit process includes follow-up. A majority of physicians like the feedback and education and want to know when you are returning. Work with the practice to create a plan for follow-up and tell the physicians what to expect next. Typically we recommend follow up based on their audit results. Physicians 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 changes have taken place. The greatest waste of time and money are practices that perform a baseline audit and then have no plans to do further audits.

Customize the Group Sessions

In addition to providing one-on-one education sessions for the physicians, as described above, group coding education is an effective 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 physicians to receive education, and the group session provides 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.

SUMMARY

Knowledge is power, as the adage goes—the more you know, the more you can control events. And 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 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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[i] MLN Matters Number: SE0441. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf. Accessed August 29, 2016.

[ii] 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).

[iii] MLN Matters Number: MM5025. Available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5025.pdf. Accessed August 29, 2016.