Steps to Internal Audits for Physician Office Records

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by Ann Zeisset, RHIT (formerly ART), and Rita Scichilone, MHSA, RHIA (formerly RRA), CCS, CCS-P

Physician offices face the challenge of submitting correct coding information through the billing process. Ensuring timely reimbursement at the highest level for which services were provided, correct coding also proves there are no fraudulent activities occurring at the facility. Performing a coding audit in conjunction with ongoing education and monitoring will assist the facility in meeting these goals. Careful planning and implementation of the audit process is worth the time invested. The following article will give you the tools you need to get started, including a number of additional resources to guide you during the process.

Why Should We Do an Internal Audit?

Besides identifying potential risk areas in your organization, an audit helps ensure compliance and adherence—to organization policies and procedures, coding guidelines, and payer regulations. Due to the impact of coding reviews upon financial and organizational procedure, HIM professionals should not undertake this type of project without full knowledge and support from the highest levels of the organization—such as physician owners, a medical director, hospital administration if the clinic is hospital affiliated, or a board of directors. Also, many organizations choose to conduct coding audits under the protection of attorney-client privilege, so check with a compliance officer or other administrative official to assure an effective review.

It is much less stressful to perform an audit on your own data—and on your own schedule—than to be surprised by the audit request from an outside agency (e.g., the OIG or other third-party payers). When you review your own work, you may uncover potential problems. However, you have the option of taking action to correct them before further damage occurs.

You also gain considerable peace of mind by performing an internal audit since you are aware of what is happening within your facility and can effect change if needed. For instance, performing an audit with the current HCFA/AMA documentation guidelines for assigning E/M codes may involve multiple physicians, coders, and billing staff who report on health plan claims. When the documentation is compared to the encounter form or charge ticket and then to the actual claim, a great deal of information can be obtained about the accurate assignment of these codes.

Auditing vs. Monitoring

Auditing is the process of examining and verifying information. It is the actual process of gathering your baseline information to identify risk areas. Monitoring is the ongoing review of your coding practices and the adequacy of documentation for code selection. It is conducted on a regular basis and includes audits and other activities such as reviewing computerized reports.

A monitor is usually put into place based upon findings of previous audits. An example would be finding a high number of certain codes used that are at variance with a peer group of the same specialty or seem unusual for the specialty. Based upon your audit, you may put a monitor into place to review these specific codes—making sure the variance is not caused by inappropriate interpretation of coding or billing rules or an attempt to gain reimbursement from health plans under false pretenses.

Objectives of Auditing/Monitoring

An audit helps facilitate the maintenance of an accurate and complete database. This should be our prime objective, since our data is used for purposes other than just reimbursement. The audit helps ensure compliance with external regulations and internal policies and patient satisfaction by accurate reporting to health plans. We can identify potential risk areas and areas for improvement that have an impact on both financial and clinical aspects of the practice.

We also audit to ensure that documentation in the medical records supports the assigned codes. Physicians must have an opportunity to get involved and support the coding and billing team. In many physician practices, physicians prefer to assign codes for services, so E/M coding is best assigned by physicians and verified by coding staff according to known guidelines. The role of coders in a physician practice is similar to a coach on the team. We keep track of the rules for our players (physicians) and make sure they have the tools they need to function at the highest level possible. Documentation is the cornerstone of code selection, and physicians need our help to correct deficiencies and cope with demands for paperwork that they may believe adds little value to patient care. Accurate coding and billing require teamwork. Physicians appreciate feedback in coding because they are interested in doing the right thing and understand that they are responsible for the codes that directly affect payment for their services—and may affect the patients they serve.

After we identify the problem areas, we can then focus our education dollars where they are most needed. Staff training needs vary, and auditing allows us to tailor education to individual needs. Auditing will also provide information on patterns and trends that will affect your entire organization.

Initial Audits for Baseline Information

Baseline audits answer the questions "Where are we now? What errors are we making?" Most baseline audits are random and should include all coding practice: medical and surgical coding, with both ICD-9-CM and HCPCS/CPT coding. Make sure to audit a representative sample of records and services, and be sure to include all physicians, coders, and payers in the review, as well as any code mapping conducted by the billing system.

Begin by auditing a random sample of records. A random sample is one in which each record has an equal probability of being chosen for review. If you select the records you will review, your audit is not random. An example of choosing records would be selecting only small charts or only a particular physician's charts. This is not a random sample. A good way to select a true random sample is to select dates of service and then select every fifth patient in the appointment system for review. The records are flagged for review upon completion of the documentation and the billing process.

Ensuring Adequate Sample Size

For high-volume cases, a certain percentage of patient encounters can be used to ensure a representative sample. Auditing too few records may distort your results, while auditing too many records becomes too time- and labor-intensive to be effective. The compliance officer or office manager can help determine the appropriate number of records to review. A good rule of thumb: 50 records is an adequate sample as long as they are chosen randomly.

All low-volume or high-risk areas should be 100 percent audited. For instance, a new procedure introduced in the practice or one of the focus areas on the OIG "hit list" are good areas to perform a total audit.

Whatever your methodology, document it when you determine your sample size. Furthermore, be as consistent as possible when choosing the sampling methodology—this will eliminate confusion.

Guidelines for Auditing and Monitoring

After your baseline audit, monitor any internal risk areas identified in the random audit. The definition of a risk area is any area that falls below the acceptable threshold for accuracy. Determine an acceptable threshold before your audit. While we should all strive for 100 percent accuracy, we must set meaningful, measurable, and obtainable goals. It is helpful to classify variances by source such as:

- documentation inadequate to support code choices (physician problem)
- codes omitted when documentation is available (coder or biller problem)
- violation of official coding guidelines (coder problem)
- noncompliance with third-party payer directives (coder or biller problem)

- codes assigned, but not found on claim form (biller or computer problem)

Other risk areas you might choose to review include:

- unbundling of CPT codes
- ordering services where medical necessity (by payer definition) is not established and no advance beneficiary notice is provided by the physician
- billing service companies processing of coding selections without additions, revisions, or deletions to maximize their financial return
- CPT codes with high impact on reimbursement
- OIG hit list—some target areas for 1998 and 1999 relating to physician services include physician visit coding (E/M), use of modifier -25, physicians at teaching hospitals (PATH), use of diagnosis codes, excessive nursing home visits, medical necessity for podiatry visits, and psychiatric services. The full list is available in the OIG's 1999 Work Plan.[1]

If the practice is not heavily dependent on Medicare revenue (or even if it is), you may also develop your own internal list of areas you want to review. This is called a focused review. You can list areas of special interest to you, or services known to be prone to problems in reimbursement or complex to code. There may be a specific physician's documentation in the practice that you are instructed to review, or perhaps a new coder was hired. Individual physician reviews should be conducted with full knowledge of the practice administration and the physician involved. Most physicians want to improve and are not threatened by the process. However, there are instances when a surprise audit (without the physician's knowledge) creates conflict and distrust. Make sure everyone agrees and consents to the review and is willing to learn from it. This is different from a coding review in a hospital, where the records belong to the hospital and the coding does not have a direct financial impact on the physician. Other possible reasons for focused review might include the introduction of new procedures or codes, new HCPCS codes, or unlisted procedures for all physicians.

Office service reports from your computerized billing system can provide a great deal of information. For example, you can compare patterns of code use and how different physicians are assigning E/M codes. Comparison with national or state specific data is helpful to identify variances that warrant further investigation and confirmation for appropriateness. You may be able to spot incorrect modifier usage, over- or under-reported CPT procedures, or areas in ICD-9-CM diagnosis coding that needs improvement.

Implementing the Process

Determine whether you want to do a retrospective (after billing) or a concurrent audit (pre-billing). Each has its own benefits and disadvantages. A concurrent audit may help if office procedures and time constraints allow for it. Reviewing codes before health plan claims are submitted prevents the extra work of resubmitting claims where errors are found. It also prevents public relations problems with patients who may not understand why the information has to be changed when it affects their coverage for services. If retrospective audits are conducted, a commitment must be made to fix any problems that are found. External agencies would not look favorably on a practice that knew significant errors were made—even if they resulted in unearned financial rewards—if the overpayments were not refunded.

Review records to validate complete and accurate coding, in accordance with Official Coding Guidelines and the National Correct Coding Initiative. The official resource for ICD-9-CM coding is Coding Clinic, available from the American Hospital Association at (800) 261-6246. The resource for CPT coding is CPT Assistant, available from the American Medical Association at (800) 261-8335. The Health Care Financing Administration's (HCFA) National Correct Coding Initiative (NCCI) edits are available for purchase at (800) 553-NTIS or online at www.ntis.gov.

There are several tools available to assist you in completing your audit, including:

- reference materials—current ICD-9-CM and CPT books, and those that were in effect for the date of service of the records; Medicare bulletins; local medical review policies (LMRP); and NCCI edits

- audit worksheet—develop your own form using the following suggestions as a guide:

    - patient name and identifiers
    - date of service
    - provider name and/or number
    - insurance/payer
    - CPT codes submitted
    - correct CPT codes
    - ICD-9-CM codes submitted
    - correct ICD-9-CM codes
    - comments section
    - room for additional observations
    - coders identification (if applicable)

  If you are monitoring E/M coding, you will also need a worksheet to select the correct level of E/M codes. The form should contain the HCFA/AMA documentation guideline requirements (for 1995 or 1997 as appropriate). Until new guidelines are tested and adopted, Medicare allows use of either set and will use the set that is most beneficial to the provide

- encounter history detail, charge ticket, fee ticket, or encounter form—this should include any modifiers used

- HCFA 1500 form showing codes submitted/explanation of benefits (EOB)—if performing a retrospective review, these are helpful in looking at the payment. If electronic filing or remittance is used, the data sets from these forms should be available for review

Now That You Are Finished...

The next step is to complete a report of your findings. A second tool is needed to aggregate your data. Items you may want to include on your report are:

- summary/introduction—briefly state the objective of the audit and your findings

- statistical analysis—include the total number of charts reviewed and the total number of CPT and ICD-9-CM changes. Identify the specific error, since documentation may support a higher or lower level of E/M service. Detail the information per coder or physician as needed. It is usually helpful to present this information as a percentage and in a graph

- observations and recommendations—list each observation of your findings, followed by a description of recommendations to correct the problem. In addition, identify which individual has the responsibility to resolve the issue

Gather accuracy rates and trends on the total coding group if coding is performed after analysis of documentation. Give positive feedback, along with suggestions for improving coding skills and accuracy. Encourage staff and generate open discussion about difficult coding issues. Many times an audit only concentrates on the few errors, rather than highlighting the correct information reviewed. Good results reinforce best coding practices and show where your office excels.

Target the errors as areas for improvement. Look for trends and patterns that point to coding or reimbursement variances or changes in procedures. This helps educate the medical staff and determines follow-up procedures to meet future demands.

Review and analyze your findings in a timely fashion. Set priorities to address findings. Make sure that you do not let review findings sit—take immediate action. Letting them sit could be detrimental to the facility. It is difficult to defend yourself against accusations of fraud if you are aware of a problem and do nothing to correct it.

In addition, determine whether you need to submit a corrected claim and refund any overpayments. For plans that do not attach reimbursement to codes, this may not be necessary. It is common to have a fee structure based on codes, so the patient

and the health plan may have been overcharged or undercharged for services. Develop a policy to direct the course of action after a review uncovers coding errors.

Good communication is a key factor in translating an audit into a positive force. Present your recommendations to all parties involved (e.g., coding staff, physicians, compliance officer). This is a good time to reinforce compliance and stress the need to proactively prevent coding and billing errors, rather than correcting those already made.

Subsequent Audits

After the initial audit and corrective action plan occurs, it is important to follow through and ensure that you have made improvements. Develop a monitoring process to measure compliance and response to training. To do this, develop a schedule —either monthly, quarterly, semi-annually, or annually. Perform an external audit at least once a year. Auditors need valid references and consultants must have knowledge of correct coding and billing practices and be able to offer recommendations taken from authoritative sources. It is also important to maintain documentation of these follow-up monitoring activities in order to report on progress and findings.

Education/Training

Identify the specific type of training required and who must be involved. Develop the training tools and document the entire process. Some successful training techniques include small groups or one-on-one training and case studies from the practice for physician education. Maintain records of attendance and keep copies of the materials used.

Develop an education schedule. Some suggestions are:

- immediately follow the initial audit results to address high priority areas
- hold monthly staff meetings (e.g., review Medicare bulletins, keep abreast of fraud alerts)
- annually review coding changes and receive reports from external review

If the problem is an area identified by the OIG, schedule training immediately after the audit and consult legal counsel to ensure compliance with the appropriate steps for resolution.

Due to the greater legal exposure associated with coding medical services, it is recommended that positions associated with the coding function receive specialized training, in addition to certification as a coding professional. Periodic in-service training will help reinforce understanding of policies and procedures and regulatory requirements. Some specific training ideas include:

- payer seminars to review coding constraints or regulatory guidelines that have an impact on code assignments and reimbursement
- computer training to improve data analysis and use of software tools for coding skill enhancement
- formal classes in coding, medical terminology, medical billing, or anatomy and physiology specific to the practice conducted at academic institutions
- meetings of professional healthcare organizations
- trade associations/trade journals
- audio conferences and Internet-based education
- in-house training programs

Office staff must receive coding guidance from reliable, authoritative sources. False claims have been generated from healthcare professionals who followed advice that was not verified. All coding protocols should be based on official coding

guidelines and/or written regulatory mandates. It helps if one person in the organization reviews and establishes coding protocols for areas not well defined within the official coding guidelines.

What About the Results?

The development and implementation of a corrective action plan and compliance plan can raise many sensitive and complicated legal issues. Before undertaking any coding review, it is recommended that investigative work be conducted at the direction of legal counsel for the organization. Seek legal assistance throughout the process and refer any concerns to the attorney before disseminating the results or taking any action. A provider has a legal obligation to refund any overpayments. Policies and procedures for reconciliation of audit findings should be established with all of the stakeholders before the baseline audit occurs. You should fix the problem, quantify the amounts, and repay it with an explanation. Ongoing monitoring and evaluation may be conducted according to the established policy and procedure included in the organizational compliance plan.

The OIG Provider Self-Disclosure Protocol was published in the Federal Register and was designed "to address the concerns of the provider community by removing disincentives to participation, while at the same time emphasizing that providers have a legal and ethical duty to identify and correct incidents of noncompliance with program requirements."[2] The publication—created to encourage providers to report suspected fraud—will provide the information you need to determine actions after your audit.

Notes

1. Department of Health and Human Services. *1999 Office of Inspector General Work Plan.* Download the complete plan at www.dhhs.gov/progorg/oig/wrkpln.

2. Department of Health and Human Services. "Publication of the OIG's Provider Self-Disclosure Protocol." *Federal Register* 63, no. 210 (Friday, October 30, 1998).

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Ann Zeisset *and* ***Rita Scichilone*** *are coding practice managers at AHIMA.*

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