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6 Steps to Healthcare Audit Success

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If you treat billing, coding, and compliance audits like routine annual physicals or yearly flu shots, you're shortchanging your practice or facility. While regular checkups are important to your health and that of your business, audits go beyond general maintenance. They could uncover coding and billing improvement areas, compliance pitfalls, or even deserved revenue that you're not capturing.

Audits can make your billing more accurate and thorough, as well as ensure that all rendered services are appropriately documented, charged, and paid. Review these best practices to ensure you're getting the most out of your auditing efforts.

1. Stick to the Compliance Plan

The auditing process begins with your compliance plan. Within your overall compliance plan, include a provision for auditing and monitoring coding and billing. Then, ensure your audit routine matches what your compliance plan requires. For example, if you have a very aggressive audit plan that reviews 30 dates of service per physician, but you consistently audit only 10, either amend your routine or your plan.

Following what is in the plan is critical. You don't want your payers or the government to think you're not taking your compliance plan seriously. Not following your own rules can lead payers to question your general compliance and billing practices, and possibly even raise fraud concerns.

2. Decide Prospective vs. Retrospective

To determine when and how you'll review charges, codes, and documentation, you need to make two choices: first, between prospective and retrospective audits and second, between internal and external auditors.

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Should you run an audit before or after claims have gone out? The answer depends on several factors specific to your healthcare organization.

Prospective audits: Prospective audits are best for your office if you want your claims reviewed prior to submission to ensure coding accuracy. This type of audit will help you avoid disclosure issues that retrospective audits raise. With prospective audits, you can talk to the doctor and fix the claim without the payer ever knowing about the error.

Other important details prospective audits have in common are:

⇒ The communication is usually between the provider and the auditor.
⇒ The claims are time-sensitive, so you must finish the audit quickly to meet timely filing requirements.
⇒ The audited claims may cover a limited range of codes.
⇒ Services are coded correctly, so you're more likely to see payment.

Retrospective audits: Choose retrospective audits if you want your claims reviewed after they've gone out to insurance companies and have been paid or denied. With this type of audit, be prepared to deal with disclosure issues and to decide how you will handle instances in which a payer paid for an over-coded claim, and you now know the claim's error. If you uncover over-coding and you don't notify the payer and repay the overage, you'll face legal penalties for knowingly misappropriating a payer's funds.

Other important retrospective audit considerations are:

⇒ They're not time-sensitive because you've already billed for the claims.
⇒ They can cover more codes used by the provider. You can select claims more randomly or choose based on frequency of code use.

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⇒ They don't affect current payments, but could affect past payments found to be improper.

3. **Weigh Internal vs. External Options**

Next, decide whether you want to have an internal member of your staff perform your audits or if you want to hire an outside entity.

The dilemma: If you appoint someone in-house who does not have the proper training or time to devote to the task, the audit process will not achieve maximum effectiveness. Conversely, if you hire a third-party auditor when you have someone on staff who could perform the task, the office will spend money unnecessarily.

Internal: In-house auditors are more intimately aware of the practice's billing and coding patterns than a third party is and can usually audit the records with more frequency. The downside is that internal staff may be less objective than an external auditor.

External: If you're under-resourced, an external auditor may be the best alternative. Plus, an external auditor whose specialty is chart auditing may have expertise your staff does not. External auditors are also a great help when a practitioner has questionable results in an in-house audit or payer-initiated audit. Another plus is that billing and coding staff's time is not taken up performing audits.

4. **Outline Review Requirements**

Your next step is to define the focus of the audit. Ask: "What do we want to accomplish?" Then determine:

⇒ The audit's scope. Which providers, services, date range, and payers will it address?

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⇒ How to select charts. Will you fix this process for each provider, or will you randomize the chart selection? Pull charts and organize supporting documentation such as a printout of physician notes, account billing history, CMS-1500 forms, and explanations of benefits.

Whoever oversees or manages the audit must gather all the necessary information. Follow these steps to collect data before beginning the review process:

⇒ Print out the patient list forms on the appointment schedule for the review period.
⇒ Pull out the encounter forms.
⇒ Print out the patient accounts.
⇒ Gather patient documentation.

5. **Focus on Common Procedures, E/M Codes**

When you conduct the audit, consider focusing on the billing issues that are most likely to disrupt cash flow or cause compliance issues. Audits should be based on the utilization patterns of the physician and the billing areas with which your payers are most concerned.

When in doubt, focus on:

⇒ Areas the Office of Inspector General (OIG) plans to target in its Work Plan
⇒ Evaluation and management (E/M) visits, especially high-level codes
⇒ High-cost surgeries and procedures
⇒ Modifier use, particularly hot-bed ones such as modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service and modifier 59 Distinct procedural service

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⇒ Consultation codes

When checking codes and bills against documentation, determine whether your office missed billing some services that were performed and documented, check the documentation of services rendered, and substantiate the codes that were charged. Be sure ancillary services, such as in-office lab tests, that were performed were billed.

Depending on the scope of your audit, you may review:

⇒ Level of E/M services
⇒ Duplicate billing
⇒ Billing for services that providers didn't do (and records with insufficient documentation)
⇒ Modifier use
⇒ Date of service conflicts
⇒ Consultation service supporting documentation
⇒ Diagnosis codes matching encounter notes
⇒ Provider signature verification

6. Communicate with Practitioners and Staff

Before beginning your audits, get your staff, including the physicians and non-physician practitioners, on board. Explain to everyone why an audit will benefit your practice. If your staff members seem reluctant to participate, let them know that the point of the audit isn't to ferret out errors and get people into trouble; it's to improve coding, compliance, and, ultimately, reimbursement down the line.

Audits — internal or those conducted using an outside resource — protect providers and coders from noncompliance and lost revenue. In fact, audits primarily focus on documentation and data, not how coders and billers are doing their jobs.

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Your practice or facility needs to decide how often to perform audits. Experts suggest starting with a baseline audit and then setting a regular schedule. Some billers, coders, and physicians may need more frequent auditing than others. Perform the initial audit and study that data to decide whether to audit each provider monthly, quarterly, semi-annually, or annually. Say, for example, you conduct a baseline chart audit for Provider X, and the results show his chart compliance is less than 60 percent for the last six months. For Provider X and other practitioners lagging in chart compliance, it would be beneficial to conduct quarterly audits until they reach 90 percent accuracy. Your goal is to get your practitioners, billers, and coders as close to 100 percent compliance as possible.

Consider conducting coding education sessions, followed by more frequent audits, for anyone with compliance problems. It may also help the physicians to see how they compare to others. For example, the auditor can present to each provider a printout of the normal distribution of E/M codes and E/M codes in the specialty. You can also show distributions of procedures to see where your surgeon falls within the range of coding, according to national standards.