

Under the Microscope

What puts a practice at risk for an audit?

BY PATRICIA M. SALMON, CHBC

Fraud is an intentionally deceptive act committed to obtain payment for a service to which a person or entity is not entitled. It includes reporting an incorrect diagnosis to obtain payment for a service that might not be covered otherwise. Abuse is an incident or practice that is inconsistent with accepted and sound medical, business, and financial practices. It includes overutilizing medical services and submitting claims for services that are not reasonable and necessary. Audits are designed to catch fraud and abuse, but the fraudulent and abusive are not the only ones who are audited. This article describes practices that gain the attention of auditors and explains what to expect if you are audited.

RISK FACTORS FOR AN AUDIT

Unusual Billing Patterns

Third-party payers routinely monitor physicians' billing patterns. Carriers sometimes flag physicians whose patterns differ greatly from those of others in the same specialty and geographic area. Although these "flags" do not necessarily result in an audit, they may put a practice on its carrier's radar screen. If a physician treats many of the glaucoma patients in a given location, he or she may bill for optical coherence tomography, for example, more than other physicians in the area. The physician may receive a letter from the carrier asking why the billing pattern for this service is high. In such cases, a letter of explanation to the carrier usually settles the inquiry.

Consistently using just one or two levels of Evaluation and Management (E/M) services signals to the carrier that the practice is using codes that are too high or too low, and an audit may ensue. The same applies to eye codes. If a practice consistently uses the comprehensive eye code or consistently uses an intermediate eye code, the pattern may attract attention. Carriers do not track the use of E/M services alone; they track the utilization of *all* services.

Certain Codes

The nature of some procedural codes makes them more susceptible to fraud and abuse, due to either the frequency of their use or their reimbursement rate. For example, consultation codes are more highly compensated than new or

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A record of services that is outside the norm for a specialty and geographical area could result in a letter from the carrier."

established patient visits. Consultation codes also require that specific criteria are met. Because they require a request from the referring physician and a letter from the consulting physician, not all visits qualify.

Complaints

Occasionally, complaints from patients and/or employees may initiate an audit. Most often, patients who complain to the carrier do so because they do not recall having a certain service performed. Unfortunately, disgruntled employees may complain to the carrier as well. While neither instance can be fully prevented, communication is vital in lessening the likelihood that either will occur. By thoroughly explaining the service or procedure to the patient, physicians may avoid confusion when patients receive their bills. Physicians who increase communication with their employees may be alerted to potential problems before they become complaints.

Work Plan Services

Every year, the Office of Inspector General publishes the *Work Plan*, which identifies the services to be evaluated during that year. A service's presence in the *Work Plan* does not guarantee that a practice performing it will be audited. It does indicate, however, that the service is frequently used and that concerns exist about how accurately physicians bill for it. Practice patterns that indicate high usage of any services included in the *Work Plan* may be at greater risk for an audit. The 2005 *Work Plan* includes physician services per-

AUDITING DO'S AND DO NOTS

In the event of an audit, remember these tips.

DO:***Designate one person to respond to all requests for documentation by carriers.***

This will ensure that someone knows the number of requests and the type of information under review.

Alert the physician to the request.

Make sure your staff knows to alert you upon receiving an audit request. Ultimately, you are responsible, and you may know better than your staff what information is relevant to the provided service.

Respond promptly to the request for review.

Allocate appropriate time if your documentation is located off site. Most carriers will agree to an extension for the submission of information, but be sure to ask early. If your request for an extension is granted over the phone, confirm it in writing.

Send the documentation by certified mail.

Get a receipt and request confirmation of delivery.

Consider a third-party review.

Outside consultants who specialize in coding and reimbursement may identify potential problems so you can begin to correct your practices immediately.

Consider obtaining legal counsel.

Although not always necessary, legal counsel may ensure peace of mind during an audit.

DO NOT:***Intermingle a patient's financial and medical information.***

Provide only the requested information.

Send originals to the auditor.

Make two copies. Send one to the auditor and keep the other in the office. Keep your copies in a designated area so they can be easily located if needed.

Alter or destroy documents.

Any additions to or updating of medical records must be clearly identified as such and include the date of the change.

Make changes to handwritten notes when transcribing.

Hard-to-read handwritten notes may be transcribed into a typed version, but these should be identical to the original. Send copies of both.

formed at a skilled nursing facility (particularly services with a Part A and Part B component); E/M services; the use of the modifier -25, which indicates a significant, separately identifiable E/M service by the same physician on the same day as a procedure; and the use of modifiers with Correct Coding Initiative edits.

WHO PERFORMS AUDITS?

Depending upon the third-party payer, audits may be performed by carriers, Program Safety Contractors, or the Office of Inspector General. Most audits in which a Medicare carrier contacts a practice for information on a spe-

cific patient/service or a list of patients/services take place in the carrier's office, rather than at the practice's office. The carrier reports the results of the audit in writing. Carriers rarely perform on-site audits; most are conducted through the mail. The Centers for Medicare and Medicaid Services uses Program Safety Contractors to perform safeguarding activities such as audits, data analysis, education, and fraud detection. These are often conducted off site. The Office of Inspector General audits government programs to detect and prevent fraud and abuse. Audits conducted by the Office of Inspector General are almost always performed on site.

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Questions? Contact Gillian McDermott, Editor-in-Chief, at (484) 581-1812; gmcdermott@bmctoday.com

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PRACTICE POINTERS

In New York, California, and Florida, audits are also conducted by Recovery Audit Contractors. The Medicare Prescription Drug Improvement and Modernization Act set forth an initiative to determine whether Recovery Audit Contractors could cost-effectively spot and correct payment errors that slip past automated carrier audits. After 3 years, the initiative will be evaluated for further implementation.

THE MEDICARE REVIEW PROGRAM

The goal of the Medicare Review Program is (1) to identify providers' potential errors in coverage and coding by proactively analyzing data, including the profiling of providers, services, and beneficiary utilization; (2) to correct the identified errors; and (3) to educate providers. Medicare audits include prepayment reviews, selected claim/service reviews, postpayment reviews, and probe reviews.

Program Safety Contractors often perform probe reviews to identify or confirm potential billing problems. Typically, the reviewer asks a practice to send 20 to 40 medical records for a specific provider within 30 days of receiving the letter. Once the probe review is complete, the practice will receive a written notification that includes educational information for the provider, the detailed claim review results/rationale (which includes the patient's health insurance claim number, the date of the service, the code provided and amount paid to the practice, the amount the practice should have received, and, if necessary, the amount the practice must pay back), peer comparison reports, educational reference materials, a list of expected improvements to the documentation of future claims, and the corrective action plan.

AFTER THE AUDIT

In some instances, a physician may believe the auditor's findings are incorrect. Most corrective action reports outline your options to dispute the auditor's findings.

Practices should not wait for an audit to identify and address potential billing and coding problems. They should be proactive by performing periodic internal audits and ensuring that their internal compliance plan is up to date and actually followed. □

Patricia M. Salmon, CHBC, is President of Patricia M. Salmon and Associates, Ltd., a practice management consulting firm located in Wayne, Pennsylvania. She is a member of the AAOE and an active member of the Society of Medical-Dental Management Consultants. Ms. Salmon may be reached at (610) 225-1990 or (888) 322-3599; psalmon@psalmonassociates.com.