

# Surviving.....and Embracing a Payer Audit

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# Disclaimer

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# Goal today

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To provide an overview of the audit process from a payer-auditor's perspective based on actual audit experiences and to gain a better understanding of the process so that it can be embraced rather than feared!

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# Overview of the Payer Audit Process

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- Audit?
  - Who is coming?
  - Why?
  - Preparing for the visit –payer and provider
  - Which patients will be audited
  - Scheduling
  - Audit findings and resolution
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# Fear Factor....

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- When we hear the word audit?



# Audit is.....

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' a methodical examination and review'



# Embrace.....

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- ❑ ' to avail oneself of.....to welcome'



# Survive.....

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- 'to continue to exist or live after....'



# Typically, audits are.....

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- ❑ A routine function within payer organizations
- ❑ An expectation of the groups (Customers of the payer)
- ❑ Outlined in the provider agreement
- ❑ Ensure the Payer has been billed appropriately for medically necessary, covered services per the contracts
- ❑ Done to ensure a provider is conforming to standard coding/billing practices

Note: This is in accordance with members' and provider contract between the provider and payer.



# Something to remember.....

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- The groups decides the benefits to offer employees
  - The payer is obligated to enforce the benefits under the contract
  - Payers are not the bad guys
  - Payers do not have deep pockets
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# Payer auditors

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- Which department (s) audits?
  - Healthcare Services?
  - Special Investigations Unit? (aka Fraud and Abuse)
  - Provider area?
  - Medicare?
  - Compliance?
  - Coding?
  - Third Party Contractor?

Note: auditors may come from different departments within the payer organization.

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# Who will the auditors be?

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- Certified Professional Coders?
  - Certified Public Accountants?
  - Nurses?
  - Certified Fraud Examiners?
  - 'Other staff as assigned'
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# More about the auditors

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- Should identify themselves on audit day
    - No personal id
    - Company id ok
  
  - Names and titles
  
  - Business cards
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# The Audit...what type will it be?

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- Onsite – in your office / facility
  - Desk – records are requested for review
  - Self audit – problem identified, you conduct a self review of the identified issue
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# Scheduled vs.. unplanned visit

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- The auditor will check the provider contract for audit notification policy
    - Reasonable advanced notice?
      - 10 business days?
    - Written notice required?
    - Telephonic notice?
    - All of the above?
    - None of the above?
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## Scheduling the audit...

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- A phone call is made to the office to schedule the audit
  - Ask for the office manager
  - Schedule the provider audit for a mutually convenient date/time
  - Follow-up with written confirmation of the scheduled audit and process
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# What to ask when you get the call to schedule an audit

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- What day and time?
  - How many auditors and who?
  - What kind of space is needed?
  - Equipment needs?
  - How many charts / files will be reviewed?
  - What date span?
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## Continued.....

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- Advise Auditors – EMR vs. Paper
    - If converting - inform the auditors !
  
  - How long are charts are onsite?
  
  - Multiple offices.....?
  
  - Will the auditors want an office tour?
  
  - When will audit report be published?
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# Onsite auditing vs. sending records to payer

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## Payer Advantage

- Payer copies charts in office
- Limited records can be selected
- View / inspect office equipment
- X-ray
  - Lab

## Provider Advantage

- No staff time to copy records
  - No resources to send to payer
  - Opportunity to ensure licensure is updated
    - Staff
    - Equipment
-

# Sample language allowing records review

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- Our member, your patient - agreements:

“You must submit health information”

We can require you....to submit health information concerning benefits to which you are entitled when necessary to process claims. We can also require you ....to authorize your healthcare provider to give us information about a condition for which you....claim benefits.

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# Don't forget the CMS 1500

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- CMS 1500 is the standard claim form for professional services.
    - See box 12 'Patient's or authorized person's signature'
      - "I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below."
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# The Auditor prepares for the audit

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- HIPAA compliant
    - Only services during the 'insured' time
      - OED – termination of policy
    - Contractual obligation to audit?
    - Member (patient) contract?
    - Provider contract?
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# What triggers and audit?

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- ❑ Hotline calls to insurance company
- ❑ Member/Worker – Complaints (see next slides)
- ❑ Former / Current Employee of providers
- ❑ In-house referrals
- ❑ Proactive data mining

Note: overall, only a small percentage of providers audited are considered to be intentionally document or code incorrectly

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# True stories – tales from the auditor

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Names have been changed to protect the not so innocent



**Complaint: “My doctor has be come in all the time, I don’t know why.”**

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- Review of codes billed and paid showed:
    - Year 1 – 99213 majority of billings
    - Year 2 – 99214 billed majority
    - Year 3 - 99215 billed majority
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# Audit indicated SOAP charting

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- S – patient came in
- O – patient has high blood pressure
- A – treat high blood pressure
- P – treat high blood pressure

Question: is this a 99215?

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# Audit interview with doctor indicated

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- New billing manager went to a seminar
- Billing manager started teaching seminars
- Seminar focused on how to increase your revenue (by up coding)
- In 2 years revenue was enhanced, but patients were not sicker..hmmm....

Question: Was the level of E&M driven by the chief complaint? (no)

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# Moral of the story.....

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- Follow the coding guidelines
  - Be wary of seminars to enhance billing
  - Document what you do.....the devil is in the details
  - Consider self audits
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Complaint: “ I never see my doctor”

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□ Review of billing patterns indicated:

- 99213 billed at rate of 33 visits per day
- Could this be face to face time with one doctor?



# Audit of records indicated

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- Medical Assistants and Nurses provided care to many patients
  - Phone calls billed as E&M
  - Medication refills billed as E&M
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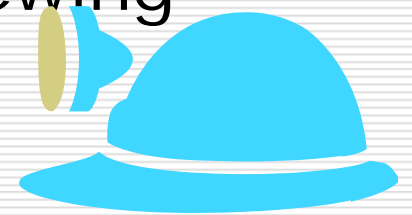
*And now the audit.....*

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# The auditor has used the tools to identify more unusual billing patterns that warrant further research

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- Data mining tools
  - Ad hocs
  - Software programs
  - Utilization review programs
  - Prepayment software
  - Training – red flags for staff reviewing claims



# They auditor selects the proper equipment

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- Audit software / programming
- Portable copiers, scanners or digital cameras
  - Copiers are cost effective, not as efficient
  - Scanners also cost effective, – multiple feed
  - Additional supplies – we take our own

Extra toner / cartridges

Copier paper, misc office supplies

Suitcase on wheels for equipment

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# We are prepared....we bring our own supplies

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- Equipment - camera, scanner, or copier
  - Ink?
  - Cartridge?
  - Paper
  - Power Cords / extension
  - Manual (directions, if all else fails)
  - Lights
  - Document stands



# The audit staff is prepared...

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- Two staff members (minimum) per audit
  - Know the size of the office and the size of the audit
    - One lead investigator
    - One – two other staff members
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## **The staff has selected the member (patient) charts to audit prior to audit day**

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- May be highest paid claims 15-30 files
- Focused audit: selected codes / claims only

Rationale: claims issues based on preliminary findings (i.e. evaluation and management codes only, surgical codes only, etc.)

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# How far back will the auditors go? (this varies with the payer)

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- Suggested: DOS no older than 18 months

Rationale: Older claims harder to reconcile

Claims history purged/archived

Files may be in storage

- Tip: Do your contracts have limitations re ability to audit and how far back? (claims payment error vs. billing irregularity, or misrepresentation)
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# The auditor may prepare a confidential patient list

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- Alphabetical names - easier for office to pull charts – include middle initial
  - Include date of birth
  - Include Id # (not ss #)
  - Keep one copy of list for office, one for auditors
  - Names given the day of audit
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More audit stories.....

Case of the patient saying “I was not in the office this day” after receiving the EOB

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Onsite audit indicated

- Nervous staff during the audit
  - Long delay delivering the files to be audited
  - Documentation similar for all visits
  - Eventually no documentation for visit
  - Eventually no chart - I mean NO CHART available to audit
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# Audit findings – the case of the tortoise and the hare

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- ❑ Chart notes created in back room on day of audit
- ❑ Some files never documented – created in back room during audit
- ❑ The auditor was faster than the office staff – they could not create records fast enough....they gave up



# Moral of the story.....

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Smart auditors know!

Disgruntled former employees tell!

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# The audit team may.....reassure office of audit procedure

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- Walk clinic manager through audit protocol
    - Patient names given the morning of the audit only
    - Advise team will be unobtrusive, out of the way
    - Describe practice of copying records/scanning on audit day
    - Advise when the detailed written report will be given with findings
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# The day of the audit, the audit team may

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- Be prepared – know what time the office opens and closes, goes to lunch, audit during open hours
  - Be prompt – auditors should plan ahead on where and when to meet
  - Be Professional – appropriate business attire (suits, ties)
  - Take business cards
  - Offer letter of introduction
  - Ask for clinic tour (arrange during the scheduling)
  - Have cell phones off
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# Jonnie's onsite audit rules

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- ❑ Be on time
  - ❑ Act professional, dress professional
  - ❑ Keep talking to a minimum – professional at all times, respectful of environment
  - ❑ Return charts to exact condition as when received – this includes paper clips, staples, etc.
  - ❑ Take audit materials with them if they leave for lunch
  - ❑ “Pack it in pack it out” auditing – do not leave anything behind! (not even garbage in garbage cans)
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# What auditors look for in the files

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- Compare charting to codes billed
  - Watch for post it notes, sticky notes – can be good reading!
  - Review everything you are legally allowed
  - Phone call records and internal logs
  - Prescriptions including dates
  - Insurance information
  - Watch dates, look for white outs, erasures
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# What auditors look for in clinic

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- General observations during clinic tour
  - Size of clinic – appropriate to volume billed?
  - Supplies available?
  - Is there equipment available to support billings?
  - Lab – in house? CLIA certified?
  - Staff – who sees the patient
  - Physician – onsite?
  - Equipment – does it require license?
    - X-ray – is the equipment licensed? Current?
    - Is there a licensed x-ray technician onsite?
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# At the end of the day, the auditors are instructed to.....

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- Clean up the audit site
- Return to original condition – everything!
- Return all files in same exact condition
- Leave ‘Onsite Survey / feedback form’ – with office manager ?
  - Opportunity for provider to give feedback
- Advise final audit document takes \_\_\_# of business days
- Offer to answer any questions / exit interview



# Compiling the audit report – the ‘good auditor’

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- Thoroughly researches the specialty – what are the coding rules, supervision rules, licensing issues
  - Examine the documents copied
  - Matches billed/received claims
  - Is there money owed to the Payer?
  - Have audit findings reviewed by all appropriate internal staff –Certified Coder? Medical Director?
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# The audit report back to the provider.....

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- Basics should include:
    - The rationale for determinations
      - Current Procedural Terminology (CPT) review
      - Applicable state law
      - Medical Policy
      - Licensure requirements
      - CMS guidelines
      - Other rules and regulations as applicable
-

# More on report writing.....

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Provide a detailed explanation of each code with detail of discrepancy



Examples:

- Not documented (no notes in file for dos)
  - Unlicensed/ineligible provider
  - Investigational (most likely billed with an eligible code)
  - Upcoded (charting does not support level of service billed)
  - Unbundled
-

# **With the report of the audit, you may also received a spreadsheet.....**

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## **□ Includes:**

- Patient**
  - Claim number**
  - Date of Service**
  - Diagnosis Code**
  - CPT Code**
  - Reason (for asking for money back)**
  - Amount owed**
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# No audit findings?

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Good job! Get it in writing!

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# Ask what options you have when you do receive the audit findings (you owe money)

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- Pay the findings?
  - Appeal the findings?
  - Consider educational?
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# Is there audit appeal language?

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- If appropriate, the payer will offer appeal policy to provider
- Include details on appeal requirements, time lines
  - What is acceptable documentation to submit?
  - Can missing documentation be resubmitted? (payer guideline?)

**Tip: Follow the appeal language closely!**

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## If you disagree with the audit findings, and decide to appeal...

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- Watch for the deadline to appeal
  - Know how many levels of appeal you have
  - Where to send appeal exactly – name and address – send certified?
  - Special form to submit appeal?
  - Special format to submit appeal?
  - How long does the payer have to respond once you appeal?
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## More appeal tips.....

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- Do not let deadlines pass
  - One person in office should coordinate the appeal
  - Correspond directly with payer contact
  - 2<sup>nd</sup> level of appeal – next steps?
  - 3<sup>rd</sup> level? Peer review? Independent review?
-

If you agree with the audit findings, and owe money.....

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- Lump sum payoff negotiation?
  - Or, ask for payment arrangements
    - How long can you make payments?
    - 12 months?
    - 24 months?
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## **Post onsite audit - worse case scenario, most egregious only....**

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- Terminated from contract? (rare)
  
  - Reported to licensing Board?
  
  - Placed on 100% prepayment review?
    - Addressed in audit findings letter?
    - If so, for how long?
    - All claims?
    - Certain codes only?
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# Audit resolution

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- Money recovered should be credited back to the patient (member) account
  - Is this an education only audit? (no or minimal findings)
  - The payer should shred records when closed/resolved
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# In summary.....

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- We discussed what triggers an audit
  - What happens during an audit
  - Options to ask for if audited
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# Congratulations!

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You survived the onsite audit process today!





Questions???

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Thank you!

