

Audit Process

SCRUTINY implies inspection, study, examination, analysis, and research. Medical records auditing involves conducting internal or external reviews of coding accuracy, policies, and procedures to ensure the documentation withstands scrutiny. Auditing helps determine outliers and reveals any variations from national averages due to inappropriate coding, insufficient documentation, and lost revenue. It also helps identify and correct problem areas before insurance or government payers challenge inappropriate coding. Would you make a good medical coding auditor?



Audit

Objective:



Explain the medical coding audit process and the consequences of inaccurate coding.

Key Terms:



appeal
auditor
claim
claims adjudication

compliance program
denied claim
medical coding
medical records audit

prospective audit
protocol
rejected claim
retrospective audit

Medical Coding Auditing

Medical coding is “the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes.” (Source: AAPC at <https://www.aapc.com/medical-coding/medical-coding.aspx>) It is a process that accurately assigns codes to the description of a patient’s condition and communicates the correct information to insurance companies. Diagnosis codes are retrieved from medical records (e.g., physician’s notes, lab and X-ray results, etc.).

Medical coding is an integral part of the healthcare system and requires the use of thousands of codes to ensure providers have the full picture of a patient diagnosis. It is a specialized occupation that requires the coder to be extremely accurate and detailed-oriented.

Medical coding is crucial to ensure that health systems, hospitals, and physicians are properly reimbursed for the services they provide. Medical coders accurately assign codes to a patient's condition and communicate the appropriate information to insurance companies.

MEDICAL AUDITING PROCESS

Coding Errors

Given the complexities of the coding system, it's not surprising that mistakes are made. It takes a seamless, highly efficient system to conduct medical claims processing without critical errors.

A March 2016 NBC News report noted medical claim error rates between 7 to 75 percent, depending on the source of the statistics. Regardless of the true error percentage, billing mistakes can have a big impact on the reimbursement rate for the services provided by physicians and hospitals. Unfortunately, even small errors can lead to claim denials and payment delays.

The causes of coding errors include:

- ◆ Poor documentation
- ◆ Failure to review entire record
- ◆ Insufficient coder education
- ◆ Lack of coding knowledge/skills
- ◆ Lack of understanding of disease process
- ◆ Misinterpretation of coding rules/guidelines
- ◆ Lack of familiarity with NCCI edits
- ◆ Poorly supported encoding software
- ◆ Inaccurate superbills (e.g., Superbills are the main data source for healthcare claims.)
- ◆ Selection of first listed diagnosis based upon reimbursement rather than documentation
- ◆ Inappropriate use of modifiers
- ◆ Lack of or outdated reference materials, including code books



FIGURE 1. It takes a seamless, highly efficient system to conduct medical claims processing without critical errors.

Approximately half of the coding errors result from insufficient or lack of documentation from providers, and one-third of errors are associated with providers who fail to respond to repeated requests to submit documentation from an auditor.

Billing Fraud and Abuse

Eliminating healthcare billing fraud and abuse has become a top priority for the federal government because fraud and abuse cost the healthcare industry billions of dollars annually. While providers may or may not intend to commit healthcare fraud and abuse crimes, government investigations are on the rise and healthcare providers could face a review that would cost them their reputation and significant revenue.

Medical Records Audit

A **medical records audit** is a management tool that evaluates the medical coding process for completeness and accuracy by methodically examining medical records and the codes assigned for services. In the simplest terms, a medical records audit is a chart review used to identify what is being done correctly and what needs improvement. The goal of an audit is to ensure the facility has an efficient and liability-free operation.

An **auditor** is an individual appointed and authorized to examine accounts. The auditor ensures that medical coding is accurate and that institutions have initiated the appropriate protocols. A **protocol** is formal standards and/or policies comprised of rules and procedures: in this instance the protocol evaluates the medical coding process. One of the best ways to prevent billing mistakes and payer audits is with regular monitoring and self-audits.

The steps in the auditing process are:

- ◆ Step 1: Choose the Focus of Your Audit
- ◆ Step 2: Define Measurement Criteria
- ◆ Step 3: Determine Which Records to Review
- ◆ Step 4: Decide Sample Size
- ◆ Step 5: Develop Recordkeeping Tools
- ◆ Step 6: Gather Data



FIGURE 2. The goal of an audit is to ensure the facility has an efficient and liability-free operation.

- ◆ Step 7: Summarize Your Findings
- ◆ Step 8: Analyze the Data and Implement Appropriate Changes

An audit can take two forms. Both forms should be conducted regularly either by internal staff or by paid, outside consultants. Specifically:

- ◆ A **prospective audit** is an evaluation performed before claims are submitted for payment.
- ◆ A **retrospective audit** is an evaluation performed after claims have been paid.

Auditing medical records can be a time-consuming process, but the benefits far outweigh the inconvenience. Keep in mind that no one expects a zero percent error rate. Mistakes are tolerable if they truly are mistakes and actions are taken to prevent their recurrence. Depending on the clinical setting, internal or external auditors will periodically perform audits of coding and documentation for accuracy and completeness.

- ◆ **External:** Audits conducted by an external party are generally to review compliance. A good external audit can help evaluate risks objectively and produce recommendations for implementing a proactive approach to correct any problems. Furthermore, external audits help promote physician education and awareness, a focus on documentation issues, and coder training. There are companies that specialize in providing education, consultation, exhaustive reports, and recommendations for improvement. External auditors are normally immune to conflicts of interest that may otherwise compromise an internal audit staff.
- ◆ **Internal:** Internal audits are usually performed to evaluate current treatment processes and measure quality of care. These internal audits may indicate problem areas requiring more intensive review and corrective action. While it may seem as that an internal audit would be less costly, a medical billing audit requires objective, dedicated resources. In large facilities more resources are available to manage the audit process. With a dedicated internal audit group, audits may be performed on a periodic or even ongoing basis, allowing the facility to continuously adapt its processes for improved accuracy. However, even a dedicated audit staff must be checked, so every practice should have an independent, external audit performed on an annual basis.

Audits should be conducted under the direction of legal counsel to ensure the findings are protected under the attorney-client privilege.

CONSEQUENCES OF INACCURATELY CODING CLAIMS

Claims

A **claim** is a request for payment that the patient or their healthcare provider submits to a health insurer to request reimbursement for items or services that appear to be covered by the

insurance policy. ICD-10 is a drastically more specific set of codes than were used in the past, and incorrect coding can be more likely to occur. But it's important to understand the consequences.

The consequences of inaccurate coding affects:

- ◆ **PATIENT TREATMENT:** Failure to code correctly could affect a patient's treatment. A great example of this would be an incorrect diagnostic code. Codes have slight variances between the specificity of a diagnosis. Inaccurate coding of these specificities during diagnosis could result in improper patient care at another practice.
- ◆ **REIMBURSEMENT:** Hospitals rely on the reimbursement (repayment) from insurance companies to operate. Failure to provide correct coding would cause insurance payments to be delayed, denied, or limited. Delayed reimbursements are also costly, as they are unexpected. A build-up of delayed reimbursements can cause a backup of paperwork, missed errors, and even more incorrect coding to be filed.
- ◆ **REJECTED CLAIMS:** A **rejected claim** is the refusal of a request for reimbursement due to one or many errors found before the claim is processed. These errors prevent the insurance company from paying the bill as it is composed, and the rejected claim is returned to the biller to be corrected. A rejected claim may be the result of a clerical error, or it may come down to a mismatched procedure and ICD codes. A rejected claim will be returned to the biller with an explanation of the error. These claims are then corrected and must be resubmitted.
- ◆ **DENIED CLAIMS:** A **denied claim** is a request that the payer has processed and deemed unpayable. These claims may violate the terms of the payer-patient contract, or they may contain a vital error that was only caught after processing. Payers will include an explanation for the denial of a claim when the denied claim is returned. Often, a denied claim can be appealed and sent back to the payer for processing, but this process can be time-consuming and, therefore, costly. For that reason, it's important to submit as many "clean" claims as possible, and avoid wasting any time billing for procedures that are incompatible with a patient's coverage.

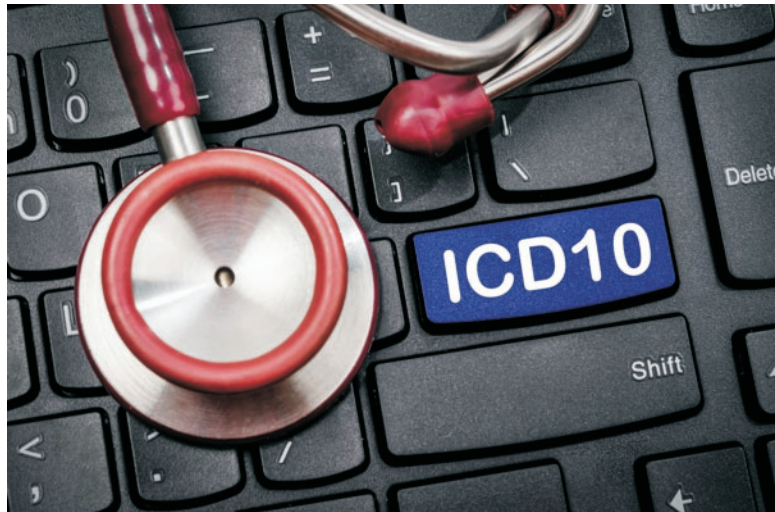


FIGURE 3. ICD-10 is the latest version of the Classification of Diseases released in October 2016.

Appeals

An **appeal** is a process used to disagree with any decision about healthcare services. Appeals are a consequence of inaccurate coding. Following submission of a claim to the payer, a response is normally received within 60 days. Often, large payers respond within 15 days. If

the claim process is ideal, the payer processes the claim as anticipated, and the payment is correct. If not, an appeal needs to be sent for the claim. When filing an appeal:

- ◆ Be prepared. Anyone speaking with the carrier regarding an appeal—whether coder, biller, office manager, or physician—should have the knowledge and specific information necessary to discuss that appeal in full. The caller should be able to review the operative report with the payer, to explain the rationale for the coding/billing and to demonstrate why the claim should have been treated differently.
- ◆ Correct the claim before an appeal is necessary. If the original claim was incorrect, appealing with the same claim will not change the results. Double-checking the claim's documentation to be sure it is correct is recommended including applying modifiers appropriately. Once the claim has been reviewed, make the necessary changes before resubmitting.
- ◆ Write a concise and precise appeal letter. The payer shouldn't have to guess the problem. Instead, spell out for the payer exactly what should be reviewed (e.g., fees, coding denials, etc.). Sending the appeal to the proper address and sending it via certified mail, return receipt requested is recommended.

Claims Adjudication

Claims adjudication is the determination of the insurer's payment or financial responsibility after the member's insurance benefits are applied to a medical claim. Claims adjudication has three possible outcomes:

- ◆ Paid: A claim is paid once it has been determined that it is reimbursable.
- ◆ Denied: A claim is denied once it has been determined that it is not reimbursable.



FURTHER EXPLORATION...

ONLINE CONNECTION: Becoming a Medical Coding Auditor

To learn more about becoming a medical coding auditor, access the Study.com website article, "How to Become a Certified Medical Auditor," at https://study.com/articles/How_to_Become_a_Certified_Medical_Auditor_Career_Guide.html and the Indeed website references, "Medical Coding Auditor Jobs," at <https://www.indeed.com/q-Medical-Coding-Auditor-jobs.html>. Follow the links to review schools and curriculum, and at Indeed.com investigate the current positions available.

Certified medical auditors, like other types of auditors, usually work full-time, during business hours. They often work independently, though some collaboration with other auditors, medical office managers, or accountants might be necessary. They operate in an office setting and might travel to the locations of the medical offices they are auditing.

- ♦ **Reduced:** A claim can be reduced, if it is determined that the billed service level isn't appropriate for the diagnosis and procedure codes. It is then paid at a lower level decided by the claims examiner.

Compliance Programs

A **compliance program** is a comprehensive plan that helps the healthcare facility and its employees conduct operations and activities ethically; with the highest level of integrity, and in agreement with legal and regulatory requirements. Compliance programs and corrective actions are based on the Patient Protection and Affordable Care Act of 2010 that requires doctors treating Medicare and Medicaid beneficiaries to establish such a program. Internal compliance programs ensure that the facility's claims are both true and accurate. Simply submitting claims to third-party insurance companies is not enough. For example:



FIGURE 4. A compliance officer is an official whose job is to ensure that a company is complying with regulations, and that its employees are following internal policies and procedures. Providers treating Medicare and Medicaid beneficiaries must establish a compliance program.

- ♦ Should an audit identify an inappropriate coding or billing practice that could be construed as fraud (e.g., overcoding), the matter is referred to the facility's compliance officer. A compliance program to correct the problem and ensure it doesn't recur should be implemented at once before a fraud investigation occurs. Corrective action must be put in place with management fully committed to the compliance plan.
 - If a government investigation does occur and it is discovered that management was aware of the problem and did nothing, the government may find the organization has acted in reckless disregard, which will increase the penalties.
 - However, if management has taken appropriate steps to correct the problem and prevent its recurrence, the government is less likely to issue sanctions.
- ♦ Corrective action may include:
 - New policies and procedures
 - Employee discipline and education
 - Computer system modifications
 - Refunds may need to be paid to affected third-party payers

- ◆ Sometimes, voluntary disclosure of the misconduct to the appropriate authorities may be warranted. For example:
 - In cases involving small overpayments, it may be sufficient to simply send a refund check with a brief explanation that funds are being returned for claims billed in error.
 - When the refund is large, further explanation or a face-to-face meeting may be necessary, especially if it is not possible to make full restitution to all third parties that are affected.
 - Taking no action and/or retaining the financial benefits of a detected violation is not an appropriate response. That action could lead to increased criminal or civil liability if later discovered.

Summary:



Overall, when conducted correctly and with findings used appropriately, well-performed coding audits can greatly benefit a healthcare organization. Regular audits provide feedback, identify issues, and monitor compliance to improve the overall quality of medical coding. Proper coding on current claims reduces the potential for edits and denials. And, perhaps most importantly, while accuracy and compliance are good business practice, they also help to ensure timely adjudication of claims.

Checking Your Knowledge:



1. What is a medical records audit?
2. Differentiate between a prospective and a retrospective audit.
3. Describe the advantages and disadvantages of internal and external audits.
4. What is a claim? What is an adjudicated claim?
5. What are the consequences of inaccurate medical coding?

Expanding Your Knowledge:



The following federal fraud and abuse laws apply to physicians: False Claims Act (FCA), Anti-Kickback Statute (AKS), Physician Self-Referral Law (Stark Law), the Social Security Act (which includes the Exclusion Statute and the Civil Monetary Penalties Law (CMPL)), and the United States Criminal Code. Violating these laws may result in non-payment of claims, civil monetary penalties, exclusion from all federal healthcare programs (including Medicare), and criminal and civil liability.

A booklet from the Medicare & Medicaid Services, titled, “Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians,” briefly summarizes each law and includes hyperlinks to the text of the laws. You can access the book from the CMS

website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf. Read through the information and understand how to comply with these federal laws by identifying “red flags” that could lead to potential liability in criminal, civil, and administrative enforcement actions.

Web Links:



16 Great Reasons to Start a Medical Billing and Coding Career

<https://www.aimseducation.edu/blog/why-start-medical-billing-and-coding-career/>

Compliance

http://www.fortherecordmag.com/compliance_index.shtml

Measuring Compliance Program Effectiveness: A Resource Guide

<https://oig.hhs.gov/compliance/compliance-resource-portal/files/HCCA-OIG-Resource-Guide.pdf>