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Chart Auditing 101

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Montgomery County Medical Society

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Overview:

The US Government, as well as State Governments, are looking for ways to generate revenue.

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Overview:

Medicare and Medicaid cover 25% of all Americans and represents 19% of the federal budget.

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With additional:

- Enforcement
- $ Allocated
- Audit Activity

The environment is increasingly risky for providers who do not code and document properly.

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Overview:

EVERY practice needs to be diligently focused on this risk area.

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Compliance Plans – Why??

- Will help your case if you are audited
- Govt looks very kindly at a practice's efforts to do the right thing

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Compliance Plans – Why??

- Mandatory under the ACA in order for practices to continue to par with Medicare and Medicaid (final rules not yet completed)

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Compliance Plans:

Independent, external baseline and follow-up internal chart audits are an important part of a good compliance plan.

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While ALL practices should consider a chart audit, realistically…

- Practices with more than 20% Medicare or Medicaid populations

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- Specialty practices that tend to have a high volume of Medicare patients (i.e., Rheum, Cardiology, Geriatrics)
- Large practices are targets (larger penalties and recoupments)

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- Practices with high rates of E&M coding in dollars paid (higher chance of subjective coding errors)
- Practices who have been audited in the past through CERT, pre-payment review, RAC, or ZPIC

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Elements of a Chart Audit:

- Random sample of charts to be selected from the patient schedule
- Providers should not be aware in advance that an audit is occurring

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Elements of a Chart Audit:

- Include all types of visits, high frequency and high risk codes (including new, established, office and hospital codes)

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Elements of a Chart Audit:

- Important to include at least 40-60% Medicare patients and some Medicaid, if applicable

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Elements of a Chart Audit:

- Pre-billing (to enable provider to correct errors found before submission)

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Elements of a Chart Audit:

- Gather signature samples and abbreviations used for each practitioner

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Elements of a Chart Audit:

- Utilize supporting documents
  - Fee / charge slips
  - HCFA forms
  - Progress or consult notes
  - Patient history form / intake form
  - Flow sheets, medication lists

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Elements of a Chart Audit:

- Utilize supporting documents
  - Lab reports
  - Test results
  - Radiology reports
  - Rx scripts written
  - Any other outside reports available

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Elements of a Chart Audit:

- Utilize the fee slip or HCFA form to see what the provider was intending to bill

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Elements of a Chart Audit:

- Consider the following during an audit:
  - Accurate billing and coding
  - Adequate documentation for what is billed (new risk areas with EMR systems)

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Elements of a Chart Audit:

- Documentation that service rendered was reasonable and medically necessary (big area of risk!)

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Elements of a Chart Audit:

- If counseling occurred during the visit and was more than 50% of the visit, the practitioner should be denoting the time spent and reason for counseling to enable them to code based on the time component

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Elements of a Chart Audit:

- Chart was signed by the practitioner
- Chart is legible

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Elements of a Chart Audit:

- Medicare E&M scorecards are helpful when performing your internal audits

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Follow-up Work and Presentation:

- Results should be reviewed with each practitioner
- Coding differences should be reviewed and discussed (codes should be changed if there is additional information to add to the auditor's review)

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Follow-up Work and Presentation:

- Chart/graph the results to compare frequencies to other providers in the practice and to national norms for the particular specialty

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Audit Results:

- If provider scores less than 80% on a full chart audit, a follow-up audit should be scheduled (i.e., smaller sample within a 3 month time period)

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Audit Results:

- If provider scores 60% or less, a full follow-up audit and training should occur within 3 months and should continue until a successful score is achieved

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Audit Results:

- If provider scores less than 50%, a Corrective Action Plan should be put in place and followed until a successful pattern is achieved

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Other Follow-up Items:

- Encourage coding training for all practitioners and coding staff at least once per year

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Other Follow-up Items:

- Look for trends and quick fixes (i.e., fee slip adjustments to help with proper coding, signature stamps with printed name and a line above for provider to sign, adjustments to EMR templates, etc.)

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Other Follow-up Items:

- Bring clinical staff into the training process
- Audit new providers early on

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Other Follow-up Items:

- Develop a CULTURE OF COMPLIANCE in your practice
  - Front Desk
  - Clinical Area
  - Billing Department

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Other Follow-up Items:

- Make your entire staff part of your Risk Management initiative

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In Summary:

- A baseline independent chart audit should be performed at least every two years, especially in high risk practices

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In Summary:

- Quarterly internal audits should be performed in-house for all practitioners

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In Summary:

- Annual coding seminars should be attended by all physicians, mid-levels, and billing staff

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In Summary:

- Communication between the billing department and physicians should be encouraged

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In Summary:

- Errors, when found, should be discussed and approved by the provider before corrected

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In Summary:

- Last, ICD-10 should be considered when performing late 2014 and 2015 audits

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BE CAREFUL OUT THERE.....

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Any Questions?