Internal Medicine Coding Alert

Protect Compliance, Educate Physicians, Increase Efficiency, and Detect Lost Revenue: Perform Internal Coding Audits

Are your internal medicine physicians using the correct CPT evaluation and management (E/M) codes to report each visit? Are you experiencing a high percentage of claim denials due to errors in ICD-9 coding for medical necessity? Are your physicians confident that they can quickly and correctly choose codes to report their visit levels, procedures, medication and application charges? Or does your office spend too much time on paperwork, when it could be seeing more patients?

These are just a few of the questions that can be answered with an internal coding auditan objective look at a sample of each physicians charts to examine how well the codes reported match the documentation available.

With concerns about prepayment audits by Medicare and other third-party payers, as well as the possibility of a fraud-and-abuse investigation, many internal medicine practices are deciding that they must have an in-house protocol for evaluating how well their practice is coding and billing.

Why It is Important for All Practices

The doctors here were very interested in some sort of ongoing educational program, explains **Teresa Burnett, CPC,** reimbursement specialist with the Clark-Holder Clinic, a 42-physician multispecialty clinic in LaGrange, GA. Clark-Holder has an outside consultant come in each month to audit a sample of charts from each of their physicians.

Most groups are working with smaller and smaller staffs these days. If you have a lot of denials or errors coming through and have to file appeals, then you are just doubling everybodys workload, she says. Mostly the audits are for educational purposes, but that is another focus, trying to streamline things so that you are not overworking your staff.

Many physicians are missing the boat when it comes to assigning the correct E/M level and are leaving additional revenue on the table, says **Barbara J. Cobuzzi, MBA, CPC,** president of Cash Flow Solutions, Inc., a physician practice billing company in Lakewood, NJ. Cobuzzi, who works with billing clients to establish internal audit protocols, recently attended an educational seminar on the topic.

One of the things I saw there was many doctors are falling short on the review of systems and how they document it, she explains. We went through about 50 sets of chart notes and it was almost impossible for anyone to get a high level of service. They would have a good history of present illness [HPI], they would have the past family and social history [PFSH], but wouldnt have enough information in the ROS, and that was always knocking them down [into a lower code].

And, she notes, at some point practices are likely to get audited. They need to be prepared and be confident that they are coding correctly for the services provided.

Somewhere, sometime, a payer is going to detect a pattern of billing and you are going to get audited and you need to know your ducks are in a row, she says. I have had doctors deliberately undercode because they were petrified of being audited, which is not a good alternative.

Instituting Internal Audits

The first step any physician practice should take when setting up a system of in-house auditing is to decide whether to do it all internally or hire an outside firm.

We dont really have the staff to do it ourselves. I am the only certified professional coder in the area and I cant do it all myself, notes Burnett, explaining why her group chose to hire a consultant.

Cobuzzi says the ideal situation would be to have each chart audited before the claim goes out the door to the payer, but says that is impossible for most internists. An internal medicine practice that is successful cannot afford the personnel and the time because usually they have very high patient volume, she notes. My primary care doctors see 60 to 70 people a day. That is the only way you make enough money in primary care.

Cobuzzi also recommends bringing in a consultant, because, she says, physicians tend to listen to criticism from someone outside and may ignore advice from a person working on their billing staff.

I have found that practices listen to outside consultants more than they do to inside people, she says. So, if you give the job to your nurse supervisor, they might not listen to her or might get angry and that would not be a good relationship.

Cobuzzi does, however, recommend that someone in the practice be trained in chart auditing by attending workshops or seminars. My belief is that small practices should at least know how to sample their charts, how to interpret them, and how to do this internally, she says. Someone in the office should be trained, preferably a clinical person. I look at the nurse supervisor in my [client] primary care practices. She is the one who should be trained to do audits.

In searching for a consultant, Burnett recommends attending seminars on coding and chart auditing and paying attention to the presenters. If you attend one you like, find out whether they or their company offers auditing as a service, she recommends.

After you have a few companies to choose from, compare them based on price. Once you have narrowed the field in terms of what you can afford, it is important to choose a consultant with whom you are comfortable, she states.

You might even want to negotiate for the person that will be coming to your office, Cobuzzi adds. If you go to one seminar and see someone from that company that you really like and who explains things well, but you go to another session with someone else from the same company and they dont seem to know a lot, you might want to negotiate for that first person.

Remember, the consultant will be coming to your practice, auditing patient charts, and speaking with your physicians, and there needs to be a good match just in terms of personality, she feels.

Many consultants charge a fee per chart audited, Cobuzzi advises. However, if you put a consultant on retainer to do periodic audits over a set length of time, you may be able to negotiate a flat fee or discount, she notes.

Prospective or Retrospective Auditing

Ideally, practices would want to audit every claim before it goes to the third-party payer, notes Cobuzzi. But, for most practices, even those who hire an outside consultant, this is simply not possible.

Many practices choose to audit a sample of charts prospectively.

We have [our consultant] come in and do the charts for 10 physicians each month, notes Burnett. He will do sets from another 10 the next month. So it is not always the same doctors who are audited.

The practice is assured that, at least for those charts, the claims wont be denied and they are not overcoded or undercoded, she says.

Another option, notes Cobuzzi, is to audit charts retrospectively, after they come back from the payer. This way, the chart audit does not delay the claim from being processed, holding up the revenue stream. This might permit the practice to audit more than just a sample of claims. However, if you find that something is overcoded you must take corrective action and send that money back to the payer, she says.

Focus Area of Audits

Many practices audit a specific set of charts
or look at specific parts of the chart at each audit.

We have different focuses, explains Burnett. Right now his focus is E/M levels. Next time, it will be something else. For internal medicine practices, a big focus will be on E/M coding and diagnosis coding for diagnostic test and procedures, Cobuzzi adds.

Clark-Holder looks at medical necessity and diagnosis coding, and at the percentage of denials per each physician. We go in and extract denial codes that we are getting from carriers and we make the physicians aware of their denial rate, why the claims were denied and what they need to do to improve, she says.

Another focus is lost charges for lab work or medications, she adds. A lot of times the physicians forget to charge for certain items or forget to charge for lab work, she says. There are a lot of issues to cover. It can almost be an endless process.

Follow-up is Important

The most important part of the audit process is educating individual physicians about what they can do to improve their coding and documentation, says Burnett. Their consultant sets up an appointment with each physician individually to go over the results of the audit and detail areas of needed improvement. In this process it is important not just to tell the physicians what they did wrong but to show them how to change their process to get it right.

You cant just say to the doctors, You didnt have a detailed history here. she says. You tell them why it was not a detailed history, and what he or she missed.