Optometry Coding & Billing Alert

Chart a Course for Ultimate Audit Success in 4 Easy Steps

Tip: Experience trumps titles when choosing an internal auditor

Even small optometry practices should take the time to check their claims for errors in an internal audit. If you don-t, the Office of Inspector General will--and they won't be nearly as friendly.

Experts recommend internal audits--examining a collection of your practice's claims, checking closely for coding and billing errors--as a proven way of keeping your office in compliance and keeping the OIG from your door.

The key to a successful internal audit is preparation, which means you can't just decide to perform an audit when a few spare hours pop up in your schedule. Instead, ensure a fruitful internal audit by taking these preparatory measures.

Before you begin, -drawing out the plan of the audit is very important,- says **Curtis Udell, CPAR, CPC, CMPA**, senior advisor with Health Care Advisors Inc. in Annandale, Va. Your practice's compliance plan should outline specific audit procedures, and you should take time to document each step of the process, he says.

For a smooth audit process, use these four preaudit steps as a guide:

1. Choose an audit approach. Basic audit types are retrospective (examining paid claims) and prospective (examining new claims before you file them). Performing a retrospective audit is usually more informative because you have a wealth of historical data (such as documentation, charged codes, and received payments) to draw on, as opposed to a prospective audit, in which you can only analyze the documentation and codes before you charge them, Udell says.

Try this: A prospective audit is -hit or miss- in identifying patterns of errors that you can work to correct, Udell says. Your compliance plan should, however, try to incorporate a -two-tier audit process that is both retrospective (probably 70 percent) and prospective (30 percent),- he says. Performing a mixture of both types of audits will allow you to analyze the most current data and catch mistakes before claims drop, but also allow long-term analysis of larger trends.

Set limits: Retrospective audits -allow you to analyze more data so you can see patterns of coding [and billing] errors and have stronger, more convincing results to point toward an action plan,- Udell says.

But don't try to cast your auditing net over too much at once, he says. You should define specific objectives, code sets and time frames so you don't over-commit time and resources.

Important: If your retrospective audit finds that you coded a service at too high a level, you will need to disclose that fact to your payers and will probably need to refund payments within 30 days after you find the error, says **Rita Knapp, CPC,** billing specialist with Whitson Abrams Vision Center in Indianapolis. Her office has an overpayment form that she submits along with the payment, she says.

Check with your carrier for specific forms and instructions for submitting overpayments.

2. Collect benchmarking data--and use it. Identify the codes you should focus on by charting the frequency data you have for each code against your specialty's average (called benchmarking data).

Charting out the bell-shaped curve for code use is a good way to visually inform your staff where your billing stands (whether you-re over- or under-using certain codes) and why you-re going to focus on auditing and correcting certain areas, Udell says.

Success story: One practice Udell works with analyzed benchmark curves for E/M coding and found it was over-reporting level-three visits by 40 percent. When Udell focused on this area during the audit, he found that almost every doctor in the practice was downcoding some level-four visits, thereby causing a higher percentage of reported level-three services. Now the practice is educating its doctors and taking in more deserved reimbursement as a result.

Remember: Potential problems you identify with benchmarking don't always hold water after you audit, Udell says. Various acceptable circumstances, such as treating high-risk patients, can make your data stand out from the rest.

Where to get it: Most specialty societies and associations have gone to Medicare and collected benchmarking data, so try your specialty association first. The Medicare Web site also has a list of the most-submitted E/M codes for each specialty. Download it from www.cms.hhs.gov/statistics/feeforservice/default.asp; look for the -Evaluation and Management (E&M) Codes By Specialty- header.

Note: For more information on which E/M codes optometrists nationwide reported most frequently, see -Are You Raising a Red Flag? Check Your Billing Frequency Against National Statistics- at left.

3. Decide which codes to focus on. After benchmarking your claims data, you-ll have a better idea of what areas you should focus on first during an audit. Also remember that your top-20 high-volume codes will usually account for 80 percent of your practice's reimbursement. So focusing on these 20 codes is a good place to start.

You should also consider the HHS Office of Inspector General Work Plan when deciding where to focus your energy, Udell says. For instance, this year the OIG is looking closely at consults, care plan oversight, physician assistance billing, modifier 25, etc.

Compliance opportunity: Include a section in your audit plan to cross-reference your services with the OIG focus areas, he says. -This is a good way to demonstrate that [your] compliance plan is dynamic, versus something that just sits on the shelf,- says **Mary Falbo, MBA, CPC,** president of Millennium Healthcare Consulting Inc. in Lansdale, Pa.

4. Choose an internal auditor. Don't be too impressed by titles and credentials, Udell says--experience is more important.

Your internal auditor should have coding and billing experience and be familiar with chart auditing, says Falbo, who has seen a certified coder successfully perform an audit in conjunction with a physician. This arrangement can bring both clinical and billing expertise to the auditing table.