Part B Insider (Multispecialty) Coding Alert

Clip & Save: Review 5 Provider-Audit Hot Spots

Hint: E/M coding is a perennial Medicare claims audit favorite.

Medicare Part B coders should get to know five main areas involved in provider audits:

1. E/M Codes: Everyone is interested in audits of E/M codes, noted **Frank D. Cohen,** director of analytics and business intelligence with Doctors Management, LLC, during the webinar "Building a Risk-Based Audit Plan." Although E/M codes make up 1 percent of all procedure codes, they comprise about 18 to 20 percent of all volume and about 26 percent of the total paid claim amount.

"I've done 400 to 500 post audit extrapolation cases throughout my career, and I can tell you that E/M codes make up a very small percentage of what the actual overpayment damage estimates are," Cohen said. "It's my opinion that we spend way too much time focused just on E/M codes and not enough time on other codes looking at things like frequency."

2. Frequency: Many auditors such as ZPICs like to focus on frequency of improperly paid claims because they can generate, under the False Claims Act, penalties of up to $11,000 per claim - so for them to meet high-dollar recoupments, they need to have a high number of those claims, Cohen said.

3. Procedure Code Utilization by RVU: The relative value units (RVUs) are looked at more by recovery audit contractors (RACs) and private payers, Cohen said. "They're looking at the magnitude of RVUs being reported. RVUs can easily be converted to cost, such as the Comparative Billing Reports that come out." If reviewers discover that your costs for providing services are higher than your peers', they may investigate further, he added.

4. Modifier Utilization: "We've always seen modifier utilization, particularly with modifiers 25 and 59, but in 2018 we saw a lot more modifier audits that were impacting the 24 and 78 modifiers as well, and I expect that will expand into the near future," Cohen said.

5. Time: The Harvard RUC time study assigned a certain number of minutes to every procedure code that has a work RVU, Cohen said. "The analysis is used to determine whether the number of assessed hours a provider reports is reasonable and believable. The government has something called the 'medically impossible day,' which is when the physician's assessed hours exceed 5,000 hours per year - the government says, 'we don't think that is possible,' and the OIG considers this a big issue that they look at."

Risk accumulates, Cohen said. "If you have RVU issues and E/M issues and frequency issues and time issues, it significantly increases your profile across the board."