Part B Insider (Multispecialty) Coding Alert

Compliance: Calculate Your Audit Odds with Expert Advice

Tip: Gauge your stats with Medicare utilization data.

With audits on the rise, CMS remains laser focused on fraud and abuse. And what's more, recovery audit contractors (RACs) have said a significant focus this year is going to be on physician practices. But there are ways you can find out exactly what your risk of an audit (or repayment) could be.

That was the word from **Frank D. Cohen,** director of analytics and business intelligence with Doctors Management, LLC, during the webinar "Building a Risk-Based Audit Plan," last month.

Read on to prepare your Part B practice.

Know the Approaches CMS Uses

CMS itself says it has developed "a variety of approaches over the past several years to audit Medicare and Medicaid claims." One of those is the Fraud Prevention System (FPS), which CMS introduced in July 2011 as a series of predictive analytical algorithms designed to identify high-risk providers, Cohen said.

Since "that time, 100 percent of all Medicare fee-for-service claims - including your claims - have passed through these algorithms prior to payment," he said. CMS reported that during the FPS' first three years, it was able to prevent nearly $1 billion in inappropriate payments from being sent out, and recovered another $2.4 billion in payments that its contractors had already sent to providers, which were later determined to require recoupment.

When reviewers go over your claims, they're looking for a wide variety of issues. "On the lowest level are just basic mistakes," Cohen said. "We have a really complex coding system with complex coding guidelines, and there are some 2.6 million edits out there among all payers, so these are simple mistakes like transposed diagnosis or procedure codes. For instance, I've seen people bill out $99,213 when they meant to just put in the code 99213 - the issue just involved adding the number in the wrong box."

Inefficiencies create a lot more financial waste, and include issues like lack of medical necessity, medically unnecessary services, improper diagnosis code linking, and sometimes just bad coding practices by the provider.

The bending of resources often results in accusations of abuse, and that can include improper billing practices such as upcoding, improper referrals, or use of unlicensed or unregistered staff, Cohen said.

There's also fraud, which involves deception such as billing for services that weren't provided, or intentionally unbundling services when it's clear it wasn't permitted, or even altering medical records. "But remember that fraud only accounts for about 3 percent of what the total spending dollars are, so it's a small percentage compared to what we find in the other areas," Cohen said.

Auditors Seek Patterns

"Auditors have access to all the data of the claims that have been reviewed ... [and] they're looking for patterns," Cohen said. "If they find patterns, they do an expected value calculation trying to determine their return on investment for these particular audits. They want to know for every dollar spent, how much they get back."

Oftentimes, reviewers won't come to your practice and perform an audit - they'll instead ask you to do a self-audit and report the results to them. In other cases, you'll be audited based on red flags that reflect what the government is seeking as part of the OIG Work Plan. "Billing for critical care and E/M services, hyperbaric oxygen services, and other

items are on it [OIG Work Plan] currently, and all of them [auditors] have the ability to drill down to a more specific area," Cohen said.

A way to see whether your practice might throw up any red flags is to compare the national frequency of particular services to the frequency that those services are performed at your own practice, Cohen indicated. "To do this, you'd look at your top 25 most frequent services and compare that back to the data from the government," Cohen said.

Check Out 5 Specialties' Most Frequently-Used Codes

Consider this list of the most frequently-performed services in five distinct specialties based on Medicare utilization data, and compare your practice's utilization to theirs:

1. General surgery: Under this specialty, 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...) is the most used code and represents 8 percent of general surgeons' claims.

2. Gastroenterology: For gastroenterologists, 43239 (Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple) is the most utilized code at 7 percent.

3. Emergency medicine: According to the Medicare utilization data, 99284 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity...) comprises 16 percent of these specialty claims.

3. Oncology: 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity...) is the top individual code used by oncologists at 7 percent of the time.

5. Family practice: CPT® codes 99213 and 99214 are tied for most used codes and put into play by family practitioners 7 percent each.

Tip: So, if the national average of a code is 5.5 percent of all services and you use it twice as often, it's a high priority for you to perform a self-audit and review that service to ensure you are coding, documenting, and billing it correctly.

Resource: To see the most recent Medicare Part B utilization data, visit https://data.cms.gov/Medicare-Physician-Supplier/Medicare-Provider-Utilization-and-Payment-Data-Phy/utc4-f9xp.