Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Miss This Chance to Improve Your Practice's Coding Accuracy

Self-audits are well worth the time, experts say

Although some coders believe that self-audits are only necessary if your practice has been scheduled for an **Office of Inspector General** (OIG) audit, there are many other reasons why chart reviews can help your practice. For one thing, you could be throwing money away if you-re not auditing your charts regularly.

-Chart audits are a good way to pick up things that aren't billed, and then things that are billed but aren't documented,- says **Maxine Lewis,** a consultant with **Medical Coding Reimbursement Management** in Cincinnati. You may actually rescue some money with audits, and you may avoid compliance nightmares.

What it means: When you perform a self-audit, you-re comparing your physician's billing records, claims, and medical records to verify expected treatment outcomes and medical necessity of services, says **Susan Vogelberger, CPC, CPC-H, CMBS**, owner and president of **Healthcare Consulting and Coding Education** in Boardman, Ohio. In addition, you-ll look for appropriate documentation to support fees and reasonable charges for services your physicians rendered.

Why you audit: When you audit your physician's services, you can uncover incorrect coding patterns or compliance issues. The plus here is that you-ll discover any problems before an outside auditor (such as one from the OIG or a private insurer) does.

Before you perform your first audit, you should make sure you have current CPT, ICD-9 and HCPCS code books available. And get your most recent National Correct Coding Initiative (NCCI) edits close at hand, along with local medical review policies, E/M guidelines, and a medical dictionary for reference during the audit.

Who should participate: You should involve every member of your practice in your audit, Vogelberger says. In particular, you-ll want to hold a staff meeting before the audit to explain what you-re doing and why, and to remind staff members that you-re not trying to get anyone in trouble. Instead, you-re hoping to help them figure out what they-re doing right, and determine what they should work to improve that will help the practice ethically bring in more reimbursement and decrease denials.

If your practice has never performed an audit, you should consider the following factors so you can determine how many records to audit:

- your annual case volume
- the number of physicians in your practice
- the number of coders and billers in your practice.

You should audit at least 10 to 15 records per physician if you-re in an outpatient practice, or 5 to 10 percent of the records if you-re at a facility, Vogelberger says.

If the outcome of your audit shows a compliancy rate of 90 percent or above, you should self-audit once a year thereafter. If the outcome shows a compliance rate of 70 to 89 percent, you should perform a repeat audit at six months. If the outcome reveals a compliancy rate lower than 70 percent, you should perform repeat audits quarterly until the percentage improves to 90 percent or above.

Examine Documentation for Problems

When you perform the self-audit, you should read the documentation and select which ICD-9 and CPT codes you think apply to the chart. Then check which codes the physician or coder actually assigned to find out whether they selected the right codes for the services that the physician documented.

Tip: Someone other than the original service provider should review the chart for accuracy, because the audit must be objective.

Combat Problem Areas

Following the audit, you should develop some tools within your practice to make documentation easier. For instance, if your audit reveals that one surgeon in particular bills all 99213s, make him a card that explains the details of each E/M code, or write up a template that shows him exactly how many elements in each section must be examined before he can bill 99214. Then he-ll be more inclined to select the right code.

Some coding experts recommend that each physician memorize the requirements of the E/M code that he bills most frequently. Then, if he performs more or less than what that code requires, he-ll know to bill a different code and he can look up the requirements of the others.

Or you might want to make up a list of the top-50 diagnosis codes that your practice reports so the physician can easily reach for the right ICD-9 code every time, rather than writing nonspecific diagnosis statements such as -incontinence,- which often leaves questions about the type of incontinence or cause.

Hang on to Documentation

You should retain all of the documentation from your self-audits in your office to demonstrate what you reviewed and what you changed. Your records should indicate whether your audit was part of a regular compliance program or whether you performed it because you had a problem and you wanted to use prospective measures to avoid future inaccuracies.