Psychiatry Coding & Reimbursement Alert

Compliance: Perform Self-audits to Protect Your Practice from Payer Audits

Focus on these hotspots to reduce audit risk.

Though your practice takes every possible safety measure to avoid compliance missteps by incorporating very strong policies, there is still the risk of a payer audit to put your practice and your profit lines in a soup. If your practice performs regular self-audits, however, it could reduce anxiety about auditors at your door.

"Self-audits are one of the most important tasks for practices," says **Steven M. Verno, CMBSI, CHCSI, CMSCS, CEMCS, CPM-MCS, CHM, SSDD**, a coding, billing and practice management consultant in central Florida.

Performing self-audits can also help you uncover the reasons behind revenue losses, claim denials, and refund demands, Verno continues**.**

Slow down: Before heading full-steam for a self-audit, however, you need to know the areas where your practice is most vulnerable, and focus your self-audit on those areas.

Check out this FAQ on what areas you should focus on when preparing for self-audits, and look for information about how best to conduct self-audits.

Q: Why do payers decide to audit medical practices?

A: According to **Frank Cohen, MPA, MBB**, principal and senior analyst for The Frank Cohen Group in Clearwater, Fla., a payer might opt to audit your practice for several reasons: a random event that created an anomaly in your coding/billing, a benchmarking event, etc.

However, "it may be impossible to determine what triggered an audit," Cohen said during his January 7 webinar, "Is Your Practice a Government Target? Pre-Audit Risk Analysis." "But you must always be prepared for one," he adds.

Q: Which coding/billing areas do payers audit most often?

A: Cohen says that payers decide to audit most frequently due to concerns in the following areas, which he defined as "The Big 5":

1. Evaluation and management (E/M) codes (99201-99215, 99281-99284, etc.)
2. CPT® procedure code utilization by frequency
3. CPT® procedure code utilization by relative value units (RVUs)
4. Modifier utilization (modifiers 25, 57, 59 [or the new 'X' modifiers], etc.)
5. Time (total provider work hours for which your practice bills)

Best bet: Be sure to keep compliant with all payer rules on all issues but take extra care to ensure that you have no compliance holes in Cohen's aforementioned "Big 5" areas.

Q: What are some specific reasons payers conduct audits?

A: Within Cohen's "Big 5" of audit hotspots, there are several specific missteps that could drive auditors to your front door. According to Cohen, practices are frequently audited for these reasons:

- **No documentation:** The provider doesn't submit any medical records to support the claim.

"As a patient, I see this so many times when I am sent a bill," Verno says. His response to a bill without documentation, as a patient, is to request a copy of the medical record.

Claims without any documentation at all are low-hanging fruit for auditors, as they are often the easiest to prove. "With no documentation, there is no support for the bill," Verno reports.

- **Insufficient documentation:** The provider's documentation lacks certain patient facts that the payer deems vital (e.g., the patient's overall condition, diagnosis, services the provider performed, etc.).

"I see this a lot as well," Verno says of insufficient documentation for a practice's claim. And quantity of documentation does not necessarily equal quality, Verno warns.

"Too many times, I see volumes of words [on claims], but they don't say anything nor do they comply with the documentation guidelines," he says.

- **Medically unnecessary service:** The payer's claim review staff identifies information in the medical record that leads them to decide that services the provider reported "were not medically necessary based on Medicare coverage policies," Cohen reports.
- **Incorrect coding:** The provider submits documentation that does not line up with the choice of code. This often occurs when coding for E/M services.

According to Verno, some of the more frequently incorrect E/M claims are: coding for a consultation (99241-99245) rather than an outpatient office visit (99201-99215); misreporting new (99201-99205) and established (99211-99215) patient E/M codes; and coding for a high-level office visit (99204-99205; 99214-99215) when reporting a lower-level code would have been more accurate.

Best bet: Make sure your practice is as compliant as possible in the above areas; also, make sure you conduct your self-audits in the areas of most concern to your particular practice.