Investing through Assessment: A unique perspective to the audit purpose and process

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When asking the average administrator why they are requesting an audit the average response is-- *it's our annual review*. It's great that practices are taking the compliance initiative, but it's time that the audit is more than just a completed item on a checklist.

How do you do that?

This session will provide you 5 tips on how to take an audit performed internally or by a third-party organization from a to-do list to an investment resource that your providers will look forward to each year.

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If I told you all 5 now- you wouldn't need to listen to the rest of the hour….

So instead, I will tell you one nugget at a time…. Haha!

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Tip 1
Adjust the Focus

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Adjust the focus

1

Too often the primary and ONLY focus of an audit is the documentation, coding, and deficiency of the provider

2

We fail to remember old school audits the full focus of what we USED to evaluate in audit and what ALL an audit should evaluate

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An audit should not only evaluate documentation and coding, but also it should evaluate the billing and RCM of the claim as well

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Audit the RCM of Each Encounter

- The claim holds vital information
  - Diagnosis linkage
  - Modifier usage
  - I-2 information (to be discussed later)
- Wait, what about EOB review?
  - Denials
  - Reimbursement rate
  - Charge amounts
- So, should you perform a prospective or retrospective audit in the future?

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namas
Considerations needed within the Audit Approach
Learn more at:
www.namas.co
Prospective is preferred as no billing will need to be corrected for identified errors.
When performing a Compliance Audit- Risk Based audits are preferred as they are specific to risk and budget conducive.
E&M is NOT the only area of risk- so why do organizations ONLY audit in that area?
Consider ALL factors for in your organization for your audit!
Considering the Audit Approach
Retrospective Approach
Prospective Approach
Probe or Target Approach
Baseline Audit
HCC/MRA Focused Audits
Appeal Response Audits
Risk Based Audits
E&M vs. Procedures

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Tip 2
Note the Proficiencies

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Audit Findings & Reporting

- The standard audit is created to report deficiencies
- Rarely does the report or the findings report proficiencies
- It's not punishment, it's just the nature of compliance
- Consider the reports…

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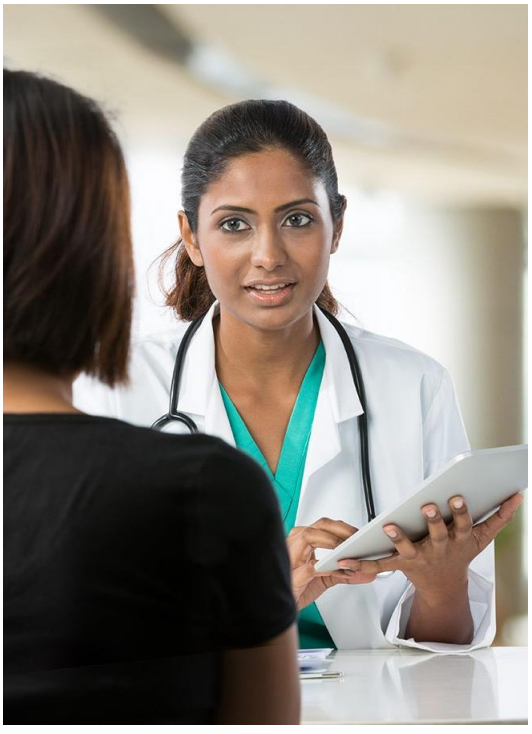
Feedback Sessions with Providers

Elaboration of complexity of care

Systemic symptoms vs. General symptoms

Late entry



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Spreadsheet Analysis- Claim Line Entry

We SHOULD see more positive feedback here, but more frequently you see "Agree" only

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Considerations for the Spreadsheet

This should give an overview of EACH claim line → There should be a row on the spreadsheet for EACH row on your claim → There should be a finding for EACH claim entry

Even if the finding is documented and billed appropriately- how about tell why!!! Not JUST documented and billed appropriately! → WHY DO YOU COPY & PASTE WHEN YOU TELL THEM NOT TO? → Consider what should be included or omitted

- Modifiers
- Units
- ICD-10
- Proficiency scores
- Names

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DoctorsManagement - Coding Compliance Audit Review
Client: I'm a Big Kid Now Pediatric Care Comprehensive Care
DM Auditor: Shannon O. DeConda
2022 PROGRESSIVE REVIEW
Provider: Diane J. Bank, DO

CONFIDENTIAL INFORMATION: DRAFT COPY

	Patient First Name	Patient Last Name	Patient ID	Date of Service	E&M Code Reported	Medical Decision Making OR Time	E&M Code Supported for Claim Submission	Auditor Comments Findings/Suggestions
JANUARY 2022 Q1 REVIEW								
1	MERI	JACKSON	104557	11/15/2021	99214	LOW MDM	99213	
2	ANTONIO	TOLBERT	188575	11/15/2021	99214	LOW MDM	99213	

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Precision Ratings

Encounter Type	Total Codes Audited	Reported Accurately	Not Reported Accurately			Accuracy Rate
			Lower Level Supported	Higher Level Supported	No EM Supported	
E/M Codes	2	0	0	2	0	0%
			Not Supported	Alternate Code	Supported but Not	
CPT/HCPCS Codes	0	0	0	0	0	N/A

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Written Reports

- The purpose of the written report is to provide published guidance resources. Therefore, if a provider scores a 90-95% proficiency- a report may not be needed
- If a provider doesn't meet accuracy- many still will not use the report a resource, but that the point is for the sake of compliance- the resources have been provided
- Many, however, are relying- for cost efficiency on the spreadsheet alone to feel this gap

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Tip #3

MONEY TALKS

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Show the Cross Comparison

- Sometimes showing the difference is dollar
- Sometimes showing the difference is an RVU
- Either way the value of the difference can better communicate the need for change

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Consider the Under-Coding

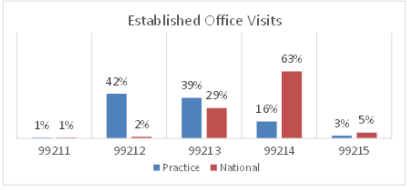
Rheumatology

New Office Visits

E&M Code	Count	Current Fee	Total RVUs	Current Gross Charges	Current Practice Dist. %	National Dist. %	Variance Practice vs. National	Redistributed Count	Redistributed Gross Charges	Charge Delta
99202	75	150	2.15	$11,250	30.00%	0.72%	4082.35%	2	$269	$10,981
99203	125	229	3.05	$28,625	50.00%	12.59%	297.08%	31	$7,209	$21,416
99204	45	345	4.63	$15,525	18.00%	62.98%	-71.42%	157	$54,321	($38,796)
99205	5	452	5.82	$2,260	2.00%	23.58%	-91.52%	59	$26,648	($24,388)
Totals	**250**			**$57,660**	**100.00%**	**100.00%**		**250**	**$88,447**	**($30,787)**

Established Office Visits

E&M Code	Count	Current Fee	Total RVUs	Current Gross Charges	Current Practice Dist. %	National Dist. %	Variance Practice vs. National	Redistributed Count	Redistributed Gross Charges	Charge Delta
99211	5	48	0.64	$240	0.64%	0.66%	-3.71%	5	$249	($9)
99212	332	116	1.27	$38,512	42.35%	1.70%	2386.90%	13	$1,549	$36,963
99213	302	184	2.09	$55,568	38.52%	28.66%	34.43%	225	$41,337	$14,231
99214	125	264	3.06	$33,000	15.94%	63.49%	-74.89%	498	$131,415	($98,415)
99215	20	368	4.1	$7,360	2.55%	5.49%	-53.50%	43	$15,829	($8,469)
Totals	**784**			**$134,680**	**100.00%**	**100.00%**		**784**	**$190,379**	**($55,699)**



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General Surgery

New Office Visits

E&M Code	Total RVUs	National Dist. %
99202	2.15	11.61%
99203	3.05	41.87%
99204	4.63	35.26%
99205	5.82	9.54%
Totals		**100.00%**

Established Office Visits

E&M Code	Total RVUs	National Dist. %
99211	0.64	1.34%
99212	1.27	17.86%
99213	2.09	49.58%
99214	3.06	26.31%
99215	4.1	4.91%
Totals		**100.00%**

Rheumatology

New Office Visits

E&M Code	Total RVUs	Current Practice Dist. %	National Dist. %
99202	2.15	30.00%	0.72%
99203	3.05	50.00%	12.59%
99204	4.63	18.00%	62.98%
99205	5.82	2.00%	23.58%
Totals		**100.00%**	**100.00%**

Established Office Visits

E&M Code	Total RVUs	Current Practice Dist. %	National Dist. %
99211	0.64	0.64%	0.66%
99212	1.27	42.35%	1.70%
99213	2.09	38.52%	28.66%
99214	3.06	15.94%	63.49%
99215	4.1	2.55%	5.49%
Totals		**100.00%**	**100.00%**

Family Practice

New Office Visits

E&M Code	Total RVUs	National Dist. %
99202	2.15	10.92%
99203	3.05	49.60%
99204	4.63	34.65%
99205	5.82	4.26%
Totals		**100.00%**

Established Office Visits

E&M Code	Total RVUs	National Dist. %
99211	0.64	1.94%
99212	1.27	2.19%
99213	2.09	39.40%
99214	3.06	53.37%
99215	4.1	3.10%
Totals		**100.00%**

Compare the Benchmarks

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Tip #4
Explaining the Risk

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Consider the 25 Modifier Violation

- The cost to the practice for intentional unbundling of services
- 25 modifier is an “unbundling” modifier which means it ensures you get paid for something that normally you should NOT get paid for
- Make sure your providers understand this and the financial risk and cost to the practice vs. running an “injection” day in the practice

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Mitigating Risk: Office Based Services

- The rigidity of the rules of the 25 modifier never cease to amaze me
- The willful neglect to this rule also never ceases to amaze me- that is until individuals get audited and need appeal support
- Personally (I shouldn't put personal opinion in a PPT) I DO NOT AGREE WITH THIS RULE, but this session is on Mitigating Risk- not on rules I don't agree with!
- Let's break this down literally one step at a time so you have the rationale you need to make determinations necessary in your organization

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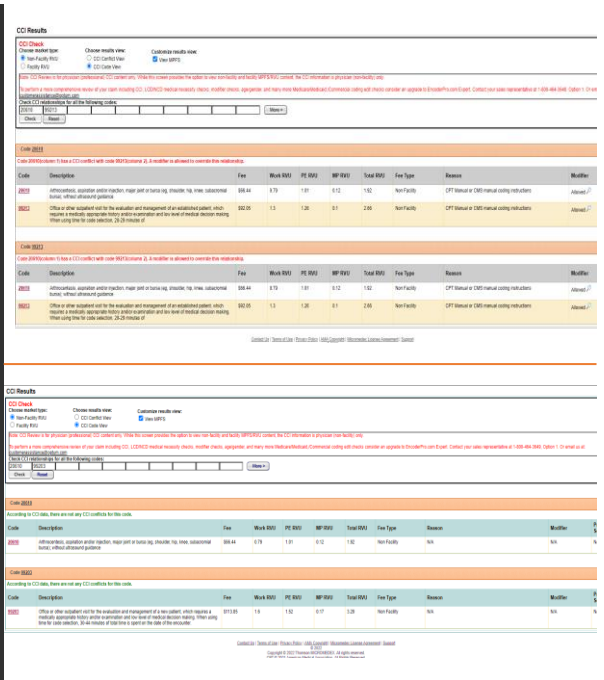
Bundling Edits Make the Difference!

- Validate your team is using the 25 modifier appropriately
  - It's ONLY needed if a bundling edit exists
  - Although, some commercial policies do have their own rule- even though they claim to follow CMS NCCI edits
- Let me show you what I mean:



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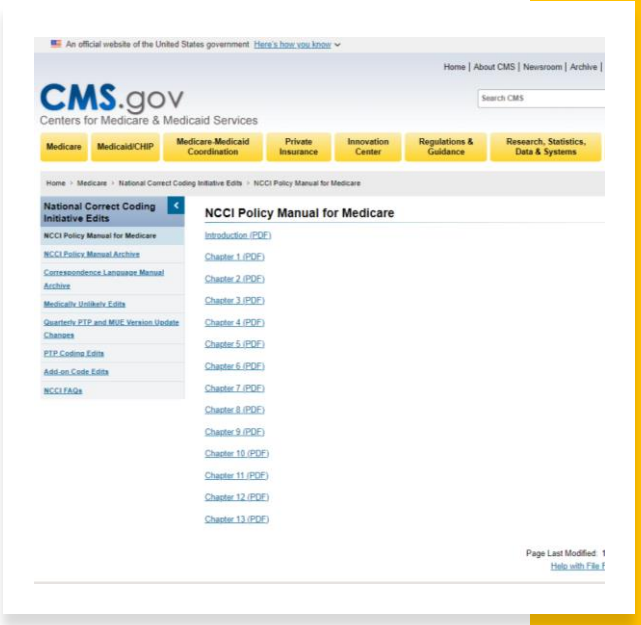
Steps in Applying the 25 Modifier

- Now that I have verified the 25 modifier IS required in order to obtain reimbursement for the office visit AND the procedure, we must verify if the documentation meets the necessary requirements to support the use of the 25 modifier
- If you want the black and white rules- Google “NCCI Policy Manual”
- Your first hit should be the CMS.gov page and when you click it you should see this image



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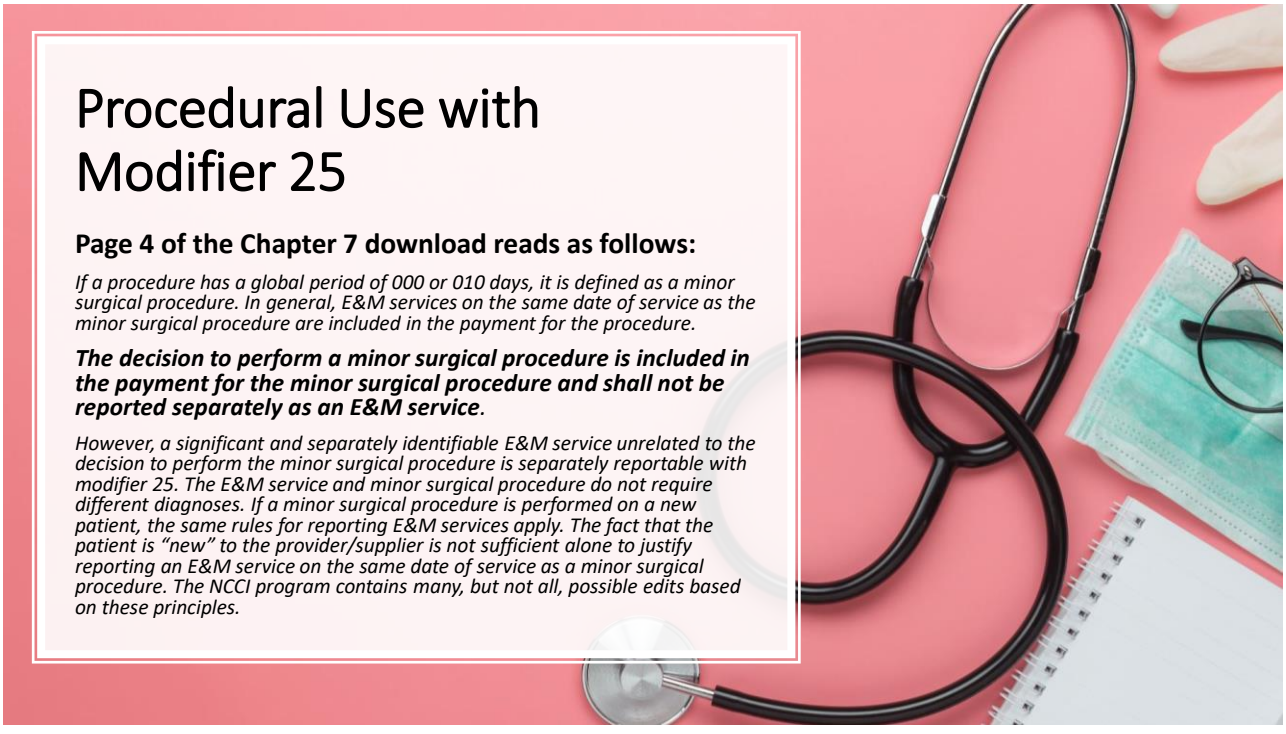
Procedural Use with Modifier 25

Page 4 of the Chapter 7 download reads as follows:

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.

The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service.

However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.



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Also in Chapter 1, the use of 25 Modifier

Modifier 25: The "CPT Manual" defines modifier 25 as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service."

Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is **significant and separately identifiable** from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s). Modifier 25 may be appended to E&M services reported with minor surgical procedures (with global periods of 000 or 010 days) or procedures not covered by Global Surgery Rules (with a global indicator of XXX).

Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider/supplier shall not report an E&M service for this work.

Furthermore, Medicare Global Surgery Rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient.

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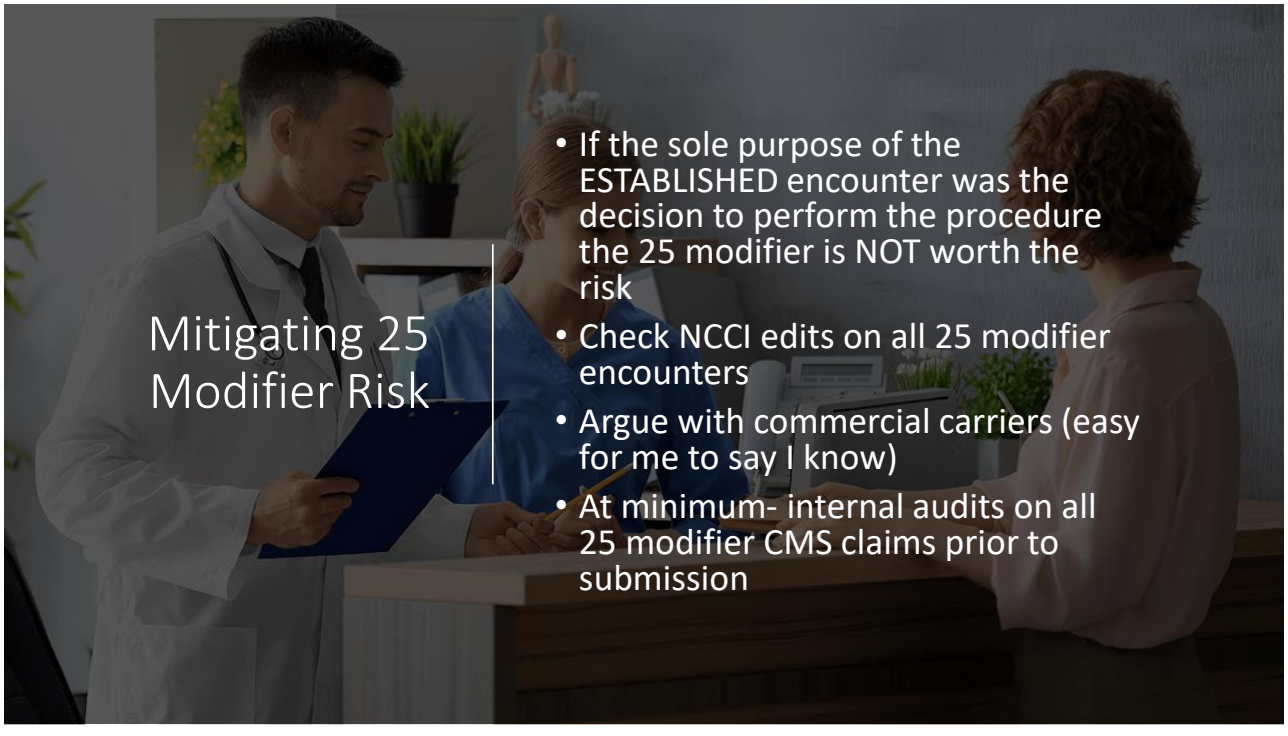

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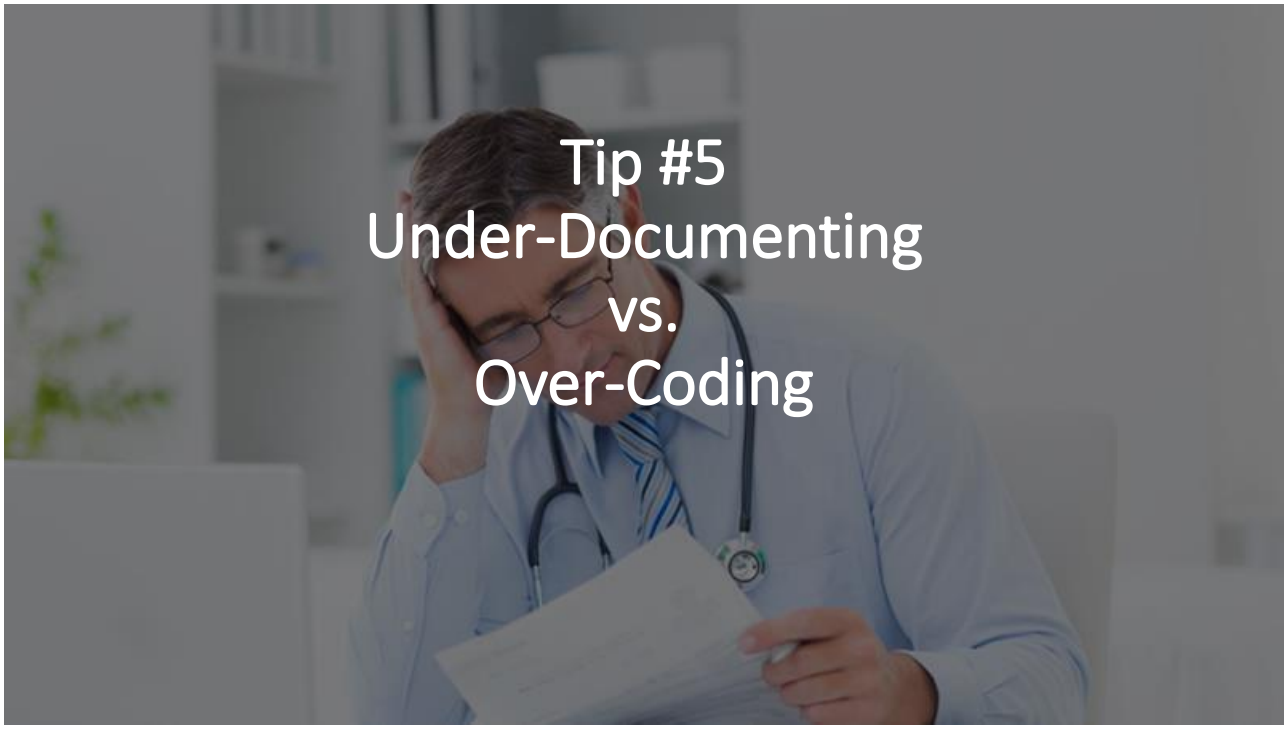
Tip #5
Under-Documenting
vs.
Over-Coding

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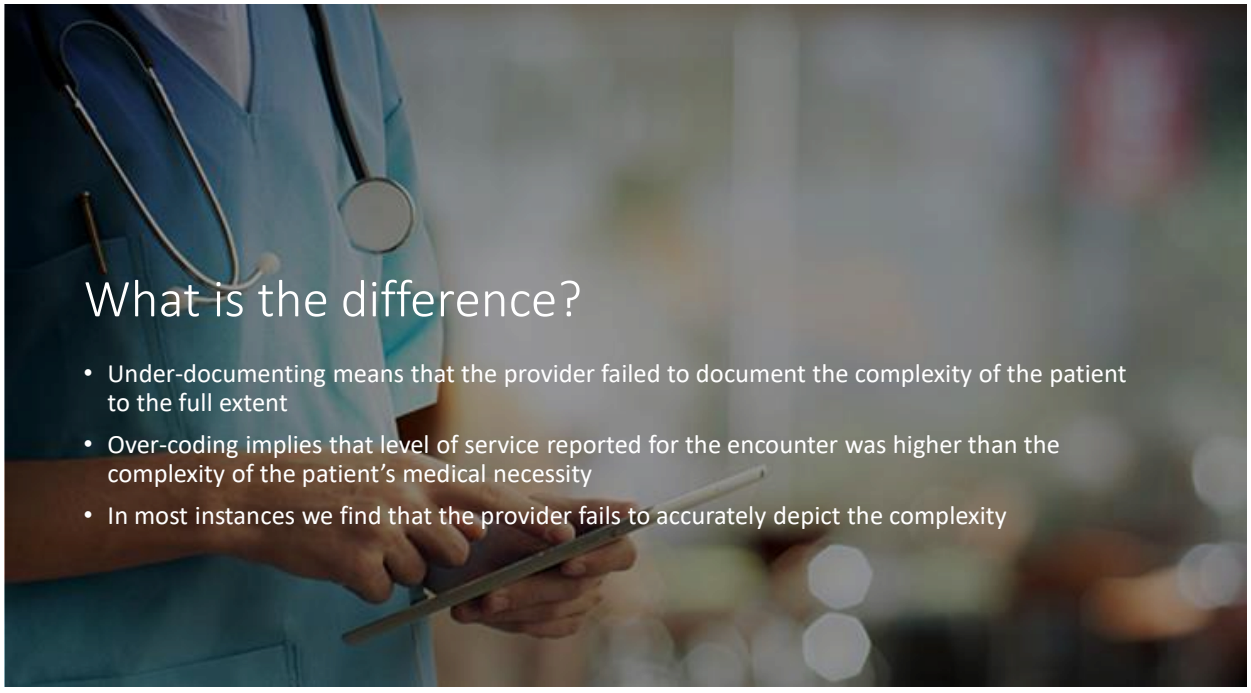
What is the difference?
• Under-documenting means that the provider failed to document the complexity of the patient to the full extent
• Over-coding implies that level of service reported for the encounter was higher than the complexity of the patient's medical necessity
• In most instances we find that the provider fails to accurately depict the complexity

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Case Sample #1

Chief Complaint

Inflammatory Polyarthritis: polymyalgia rheumatica;

History of Present Illness

Ms. Joseph is a pleasant 73-year old female presenting for followup of PMR.
In the interval since the patient's last visit, the following issues have been noted:
-Pt had severe muscle spasms in her lower back last weekend limiting her ability to sit and/or stand. She reports the pain was a 9/10 and was excruciating. Today, she has R-sided LBP that can be elicited by palpating in a small region to the R of her spine. It does not radiate. No TTP spine or SI jt.
-She reports overall feeling well on her 15mg Prednisone dose. She feels so well today she "forgot her cane and is doing great."
-No c/o headache, blurry vision, double vision, scalp tenderness, or jaw pain. She denies any muscle weakness, stiffness or shoulder/neck/hip pain.

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Case Sample #1

Would I shock you to tell you this was billed as a level 5 encounter?

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER
1	02 09 2021	02 09 2021	11	N	99215		A B C D
2							
3							
4							
5							

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Assessment

Discussed long term plan for pt's PMR at length today. Explained 15mg of prednisone is not a sustainable dose, which patient understands as this was discussed at her last visit. Reiterated that if the prednisone taper does not work, we will be progressing to MTX. We discussed MTX today, but she would like to trial another taper. She has been taking 15mg/day for the last month, so tomorrow she will start at 14mg. She will decrease her dose by 1mg every 2 weeks until she sees us again in 2 months.

Pt's pain was limited to a small spot on her back today. As her proximal muscle strength was 5/5, she experienced no pain with testing her shoulders and hips against resistance, she does not c/o stiffness she did not experience TTP neck, shoulder or hip we discussed her back spasms could be a different mechanism. She feels that they are more "spastic" in nature, and agrees they seem slightly different than her PMR pain. We will trial tizanidine as she previously tried Flexeril and says it decreased in efficacy.

Pt stated she has been trying an antiinflammatory diet but is having issues and would love to be referred to our dietician.

Will continue to monitor for any blood dyscrasias, hepatotoxicity or renal injury by obtaining bloodwork today. Bloodwork from 12/31 discussed with patient. As her ankle edema is increasing and she is on Tribenzor recommended she move her May appt with her PCP up if she begins to experience orthopnea, markedly increased ankle edema or DOE.

The patient was assessed by Danielle Tran, PA-C, with Dr. Withers present in the room assisting with the patient examination and treatment plan. Greater than 50% of today's 40 min visit was spent providing education and coordinating care.

Plan

I recommend that this patient work with our Registered Dietitian (RD) for nutritional counseling. The RD is to evaluate patient to establish a nutritional wellness plan which may include education on nutrition, weight loss, exercise, and stress management. The referral was created and assigned to Dietitian's work flow to contact patient to review details of this service and encourage scheduling visit.

Now let's consider the rest of the story…

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Complexity is the story

- While our provider should use staff efficiencies, we must be sure to create notes that show complexity
- Complexity is defining the problem that is addressed and the risk of managing that problem- through the documentation of the encounter
- That alone is what is valued by the carrier

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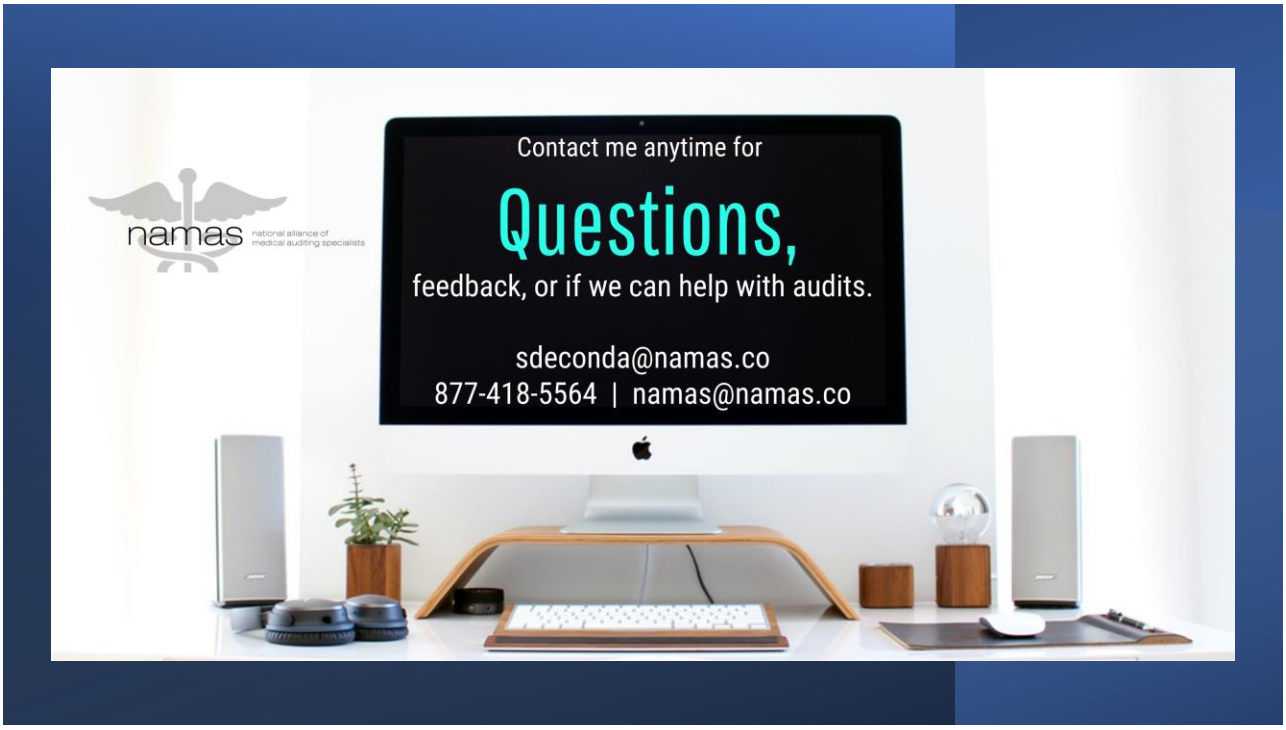
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