Health Information Compliance Alert

Compliance: 6 Steps Help You Perform a Successful Self-Audit

Use all the resources at your fingertips, including any applicable worksheets that your MAC offers.

With all the attention lately on fraud and abuse issues in Medicare, auditing the way you handle health information is becoming increasingly important -- but many practices aren't sure where they should begin. We've got six important tips that can help you get on your way.

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. In addition, you'll look for appropriate documentation to support fees and reasonable charges for services your physicians rendered. The plus here is that you'll discover any problems before an outside auditor does.

1. Involve the whole staff. Let every member of your practice know what you're doing and why, and remind them that you aren't trying to get anyone in trouble. Instead, you want to determine whether they're bringing in the right amount of reimbursement and cutting out denials.

2. Select the charts. Most auditing specialists recommend that you review 10 to 15 records per physician during your audit.

3. Examine documentation. Read the documentation and determine which ICD-9 and CPT codes you think apply to the chart, then check which codes were actually assigned to the services.

4. Pay special attention to difficult services. When examining physicians' records, review not only the procedures, but also the E/M services. Some records are trickier to code, such as consults or time-based E/M records.

Time-based pitfall: "You have to have a believable reason that you had to provide the majority of the service on counseling/coordination of care" to justify basing your E/M level on time, advised **Bruce Rappoport, MD, CPC, CHCC,** medical director of Broward Health's Best Choice Plus and Total Claims Administration in Fort Lauderdale, Fla. during his presentation at The Coding Institute's recent Coding & Reimbursement Conference in Orlando, FL.

"'Bronchitis takes a lot of time to explain to a 20-yearold' is not a believable reason."

The official recommendation is that the documentation should include the start and end time of the counseling/coordination of care. "It's better to have this written from the physician, rather than just from an EMR time stamp," Rappoport says. "Without seeing how a system's time stamp works, it's hard to say if the 'start' time indicates the time the exam started or the time that the patient came into the room."

Auditors will look at having time in documentation when reviewing your records, he adds.

5. Use a score sheet. Many MACs offer audit tool score sheet templates that can help you when auditing documentation. For instance, High-mark Medicare offers several templates on its Web site, such as the E/M worksheet at www.highmarkmedicareservices.com/partb/reference/pdf/scoresheets/8985.pdf.

"I would always recommend one of these audit tools," says **Socorro Ramon, CPC,** coding and audit manager with the Medicare Advantage division at Universal American. "The audit tool helps the auditor document the findings so that by the end of the record review, the documented information can be totaled to finalize the E/M key elements and come up with the appropriate level of E/M."

Tip: Be sure that the tool is compliant with the documentation guidelines, Ramon says. "A record of the review should be

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kept as proof of the internal audit."

6. Educate your staff about your findings. After the audit, show your practitioners, coders, and billers what the outcome was so you can combat any problem areas. Forinstance, if one of your physicians bills all 99213s, you might make him a card that explains the details of each E/M code.

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