Pain Management Coding Alert

Compliance: Avoid Auditors With These Coding Tips

An ounce of prevention can make audits less likely.

To paraphrase Paul Revere, it looks as if the RACs are coming for physician practices this year.

So believes **Frank D. Cohen**, director of analytics and business intelligence with Doctors Management, LLC, during the recent webinar "Building a Risk-Based Audit Plan." The latest focus for recovery audit contractors (RACs) is going to be on physician practices, he says.

That means your practice needs to be aware of what the RACs are looking for and use the same investigative methodology they use when you perform your own internal audits.

Prepare yourself for potential RAC auditors with this plan.

Know CMS Approaches CMS

CMS itself says that 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," said Cohen.

"Beginning at that time, 100 percent of all Medicare fee-for-service claims - including your claims - are 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 recouped 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 three percent of what that total spending dollars are, so it's a small percentage compared to what we find in the other areas," Cohen said.

Auditors Look for Patterns

"Auditors have access to all the data of the claims that have been reviewed ... 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."

In some cases, 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 currently, and all of them 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 PM services to the frequency those services are performed at your own practice, Cohen said. "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. So, if the national average of a code is 3.57 percent of all services and one specific pulmonologist does it twice as often, the higher the priority for performing a self-audit and reviewing that service to ensure you are coding, documenting, and billing it correctly.