Do you know how your practice is currently performing? If an auditor knocked on your door tomorrow would you be comfortable in knowing that you are utilizing your code choices correctly?

The article below stresses the importance of self-audits and offers suggestions to help reduce anxiety about auditors at your door. Through the passing of the Affordable Care Act every doctor will be audited; it is now a matter of ***WHEN*** not ***IF***!

Let OMS help ease some of your anxiety with our Practice Pulse Review.

Priced at $599 the Practice Pulse includes the following:

- ✓ Medical record audit of ten records (looking into compliance and code choices/utilization).
- ✓ Medical record review includes an audit of what was billed tied to the corresponding Explanation of Payment (EOB/ERA) validating proper claim filing and reimbursement.
- ✓ Code utilization analysis using a CPT productivity report and comparing use of 92XXX vs. 99XXX codes, procedure volumes, and a breakdown of medical vs. vision volumes (if tracked).

Contact **Jerry Godwin** at jgodwin@optmedsol.com or call 210.249.0234 ext 4 for more information!

Compliance: Know Your Vulnerabilities Before Auditors Come Knocking

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Focus on these hotspots to reduce audit risk.
Even if your practice puts the strongest policies in place to prevent compliance missteps, a payer audit is always possible.

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 to best conduct self-audits in future issues of *Practice Management Alert*.

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 your practice bills for)

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,” reports Verno.

- **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 on 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 Vermo, some of the more frequently incorrect E/M claims are: coding for a consultation (99241-99245) rather that 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.