Five Steps for Auditing Physician Charts

With continuing decline in reimbursement, establishing an internal audit process is critical for physician practices to ensure charges are being billed appropriately and optimal revenue is being captured. Correct coding is essential to getting paid appropriately and avoiding audits by Medicare, Medicaid and other payers. Even the best practices can experience billing errors and the only way to minimize them is to have a system in place to monitor the work done by staff and physicians.

**Step #1 – Establish and Follow a Documented Compliance Program**

While voluntary for 12 years now, the Healthcare Reform law of 2010 mandates that all physicians participating in Medicare and Medicaid must adopt a compliance program in the near future. While most large healthcare organizations already have some type of compliance program in place, small physician practices may be unprepared for this requirement. Although details have not yet been defined, all healthcare providers will need to increase their compliance efforts. The new regulations will undoubtedly raise the stands but incorporating a model compliance plan now will reduce the risk of liability under the False Claims Act (FCA) requiring providers to prevent and identify improper payment of government funds.

The goal of a compliance plan is to ensure appropriate billing occurs and avoid fines that could result by submitting codes you know or should know are wrong. Under the civil FCA [31 U.S.C. § § 3729-3733], fines up to three times the reimbursement plus $11,000 per claim could be assessed. Criminal fines and imprisonment could also result from the criminal FCA [18 U.S.C. § 287]. A good compliance plan will not only protect against these violations, but will also minimize billing errors, optimize appropriate reimbursement and minimize refunds or take-backs if RACs, MICs or other auditing agencies come knocking on your door.

**Step #2 – Conduct internal monitoring and auditing**

Ongoing evaluation is necessary to ensure policies and procedures remain current, and also demonstrate that the compliance plan is working. Periodic chart audits should be conducted to ensure that documentation supports the levels of service billed. Consider the following when establishing a plan for your internal auditing program:

1) **Number of Providers and Charts to be Audited** – The Office of Inspector General (OIG) recommends auditing claims submitted during the prior three months on five to ten randomly selected claims per physician. The more providers you have, the more time it will take for the chart auditing process.

2) **Frequency of Audits** – Will you audit weekly, monthly, quarterly, semi-annually or annually?
3) **Who Will Perform the Audits** – Will you outsource this to a coding consultant or company? Train internal staff? Train physicians and have them audit each other’s records?

4) **Schedule of Audits** – A practice with four providers might audit five charts per provider, rotating providers on a weekly basis. A larger practice may audit ten charts per provider quarterly or annually, with more frequent education and monitoring for those with higher error rates.

5) **Retrospective vs. Prospective Audits** – A retrospective audit is done on charts where the claims have already been submitted to the payer. If coding errors are found, a corrected claim must be submitted and any overpayment refunded to the payer within 60 days of discovery. The benefit to this type of audit is that claims are not held up pending audit results. A prospective audit is done on charts where the claims have not yet been submitted. With this type of audit, any problems found can be corrected before claim submission eliminating payment corrections on the back end.

6) **Presenting the Findings to the Provider** – Findings should be documented in a written report and presented one-on-one or to a group. Education should be based on findings and documented.

**Step #3 – Start by Reviewing Evaluation and Management Services**

Evaluation and Management (E&M) codes are typically the best place to start because they are the most frequently used codes and have a variety of elements required.

The selection of E&M codes is based on:
- Patient status (new, established, initial or subsequent hospital visit, etc.)
- Place of service (office, hospital, emergency room, nursing facility, etc.)
- Type of service (office visit, consultation, counseling, admission, etc.)
- Extent of documentation

Documentation of **three key components** is essential in determining the appropriate level of E&M service. The three key components are: 1) **History**, 2) **Examination**, and 3) **Medical Decision Making**. There are elements within each key component that must be documented depending on the nature of the presenting problem and the level of service billed. Refer to the [Evaluation and Management Services Guide](http://www.veicorp.com/IMM) from the Medicare Learning Network® for more information on E&M documentation requirements.

**Step #4 – Look for Other Missed Revenue Opportunities or Risk Factors**

Some common errors to look for when conducting chart audits include:
- Copied or “cloned” EMR records where every visit looks the same resulting in higher level services being billed than what is medically necessary for the presenting problem(s)
- Billing for a service marked on the billing sheet but not documented in the medical record
- Services documented in the medical record, but not billed resulting in lost revenue
Billing separately for services included in another code or global fee, like 99211 billed for a nurse visit when the only service performed was a routine venipuncture billable with code 36415 or a post-op visit billed with an E&M code during a global surgical period

- Incorrect number of units billed for medications, vaccine administration codes, and certain skin procedures resulting in lost revenue
- Inappropriate or missing modifiers that could affect the payment or denial of a claim
- Records not signed legibly or electronically by the provider

**Step #5 – Document Your Audit Findings**

Reports, spreadsheet, graphs and wall charts are ways of tracking progress. Audit findings must be documented and maintained to:

- Prove that audits are being performed for compliance purposes
- Show the corrective action plan and when educational efforts occurred
- Identify date of discovery and when claims were refunded or corrected and rebilled
  
  *(NOTE: If a significant error is found, contact a healthcare attorney for advice on following the [OIG’s Self-Disclosure Protocol](http://www.veicorp.com/IMM))*
- Demonstrate the program is working and improvement is occurring

**Be Proactive and Start Auditing Now!**

With Medicare RACs, Medicaid MICs and others out looking for overpayments, an internal review of physician charts is something every practice should do to prevent refunds, take-backs and fines due to incorrect coding. Remember the familiar saying “If it wasn’t documented, it wasn’t done.” A proactive approach is your best defense!

**References:**