

# How to perform a physician practice internal billing audit

One neurology practice identified over \$30,000 that was lost annually in legitimately earned income for not accurately reporting physician visits.

An internal billing audit can help ensure appropriate payment and compliance with applicable laws.

Auditing physician charges and billing practices is burdensome, but it will typically yield improved claims management processes, cash flow and compliance with applicable laws and regulations. An annual audit allows physicians and practice staff to identify specific coding issues that may recur in similar claims submissions. Careful pre-submission monitoring and review of these similar claims may safeguard against errors that could result in a claim denial. An internal audit allows the physician and practice staff to identify incorrect billing patterns before claims are denied or outside auditors assess penalties.

## What is a billing audit?

A prospective or retrospective physician practice billing audit is commonly performed to ensure the physician is submitting appropriately coded claims according to *Current Procedural Terminology* (CPT®) codes\*, guidelines and conventions, and payer payment policies, as the physician is ultimately responsible for claims submission, even if a billing service or clearinghouse is used for claims submission to payers.

- In a **prospective** billing audit, a designated practice staff person or internal compliance officer reviews the claims before they are submitted to the payer to ensure the appropriateness of the coding, documentation and adherence to health plan medical payment policies.
- In a **retrospective** audit, a designated person reviews claims for appropriateness after they are paid. All overpayments and billing errors identified during a retrospective audit should be handled according to the payer's repayment guidelines.

If the audit reveals a pattern of repeated billing errors, the physician should obtain legal advice from a health law attorney to determine possible responsibilities. Additionally, the physician practice should determine and take the necessary steps to ensure the billing error doesn't recur. A physician practice should perform a prospective audit annually, or when new physicians or billing staff personnel are hired, to identify and address potential errors promptly.

## Who should perform the audit?

Physicians and practice staff should participate in the audit process for best results. As a physician, you are entitled to be paid for the services you provide when they are coded and documented appropriately. Physicians and practice staff with a strong knowledge of CPT codes and guidelines, the Resource-Based Relative Value Scale (RBRVS), as well as payer's medical payment policy, contracts, fee schedules and reimbursement guidelines are invaluable to a successful audit.

Designate a practice staff person to be responsible for the audit process and consider hiring a consultant specializing in billing and collections to assist in specified audit tasks. The consultant's contract should ensure confidentiality and compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

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\*CPT is a registered trademark of the American Medical Association.

## How do I prepare for a billing audit?

- 1 Adopt a compliance audit and monitoring program for the practice.** Obtain a copy of “Compliance Program Guidance for Individual and Small Group Physician Practices,” published in 2000 by the Office of the Inspector General (OIG) of the Department of Health and Human Services ([www.hhs.gov/oig](http://www.hhs.gov/oig)). This audit recommendation can be adapted to a physician practice’s internal claims review procedures.

The American Medical Association (AMA) encourages physician practices to implement a compliance plan in the document titled, “Physician Compliance Planning” ([www.ama-assn.org/ama/pub/category/print/4598.html](http://www.ama-assn.org/ama/pub/category/print/4598.html)). “The existence of an effective compliance plan provides evidence that any mistakes were inadvertent, and this evidence could be considered by the federal government in determining whether reasonable efforts have been taken to avoid and detect fraud and other misbehavior. A compliance plan also will detect undercoding and improve communications within a practice setting.”

- 2 Review a report of physician services and how frequently they have been performed over a one to six-month period.** Most computerized medical software can produce this report. A physician’s evaluation and management (E/M) frequency data usually is distributed according to a bell-shaped curve because different patients in different settings receive different services. The E/M frequency data differs among different specialists because of variability in practice populations and other factors. According to the Medicare data, (See **Figures 1 and 2**) for example, neurologists generally perform proportionally more higher-intensity E/M services than all specialties combined.

- 3 Obtain the most current Medicare E/M frequency data from your Medicare carrier or fiscal intermediary for your state and medical specialty nationally.** Comparison of your E/M frequency data with that of your peers may be helpful—both before any audit and in the event of an audit. The comparison may help you to determine whether you are over or undercoding E/M services compared with your peers. If you are audited by an external agency or payer, a comparison of your claims history with that of your peers (by state and specialty or other appropriate geographically defined area) may be appropriate. In consultation with your counsel, consider obtaining the most current Medicare E/M frequency data by CPT code from your Medicare carrier or fiscal intermediary for your state and specialty.

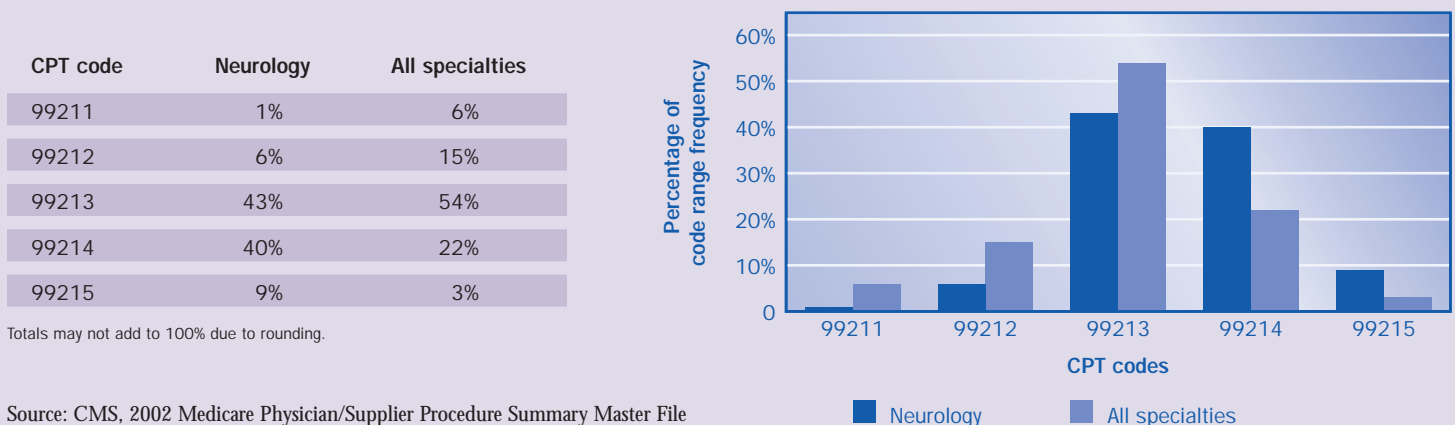
Know which set of Centers for Medicare and Medicaid Services (CMS) E/M guidelines—the 1995 or 1997 version—the payer follows under its medical review guidelines, since it will impact the payer’s E/M frequency data. The physician may report E/M services based on one of the two sets of CMS E/M guidelines.

- 4 Review the E/M supporting documentation and indicate why the distribution of your E/M frequency data is different than the Medicare E/M frequency data for your peers by specialty and state or other appropriate geographically defined area.**

## How often should you audit?

The OIG recommends that practice audits be conducted at least annually, and that they be used to identify risk areas such as coding and billing, reasonable and necessary services and documentation requirements.

**Figure 1** Established patient office visits, 2002 Medicare data for Neurology compared to all specialties



## What are the steps to perform a billing audit?

- 1 Determine who in the practice will be responsible for auditing the health plan payments. Assign staff, physicians and an outside consultant (if appropriate) to perform the audit.
- 2 Review the recommended OIG audit process previously referenced, and adapt it to your practice. Address concerns including:
  - Will the audit be performed retrospectively or prospectively?
  - What type and size of sample will be drawn: random, controlled, select payers, all payers?
  - What audit tools will be used to determine the appropriateness of claims?
  - What risk areas should be closely monitored?

The OIG recommends auditing 5 or more medical records per federal payer (ie, Medicare, Medicaid), or 5 to 10 random medical records per physician. Additionally, the OIG suggests three methods of drawing a random sample: from paid claims, claims by payer or claims containing one of the top 10 denials by payers.

- 3 Use a claim analysis checklist to identify the appropriateness of coding, documentation and completeness of a claim. Sample checklist items include:
  - Was the service performed and documented appropriately?
  - Are the correct physician and practice identification numbers listed on the claim?
  - Is there a CPT code that would more accurately reflect the service performed?

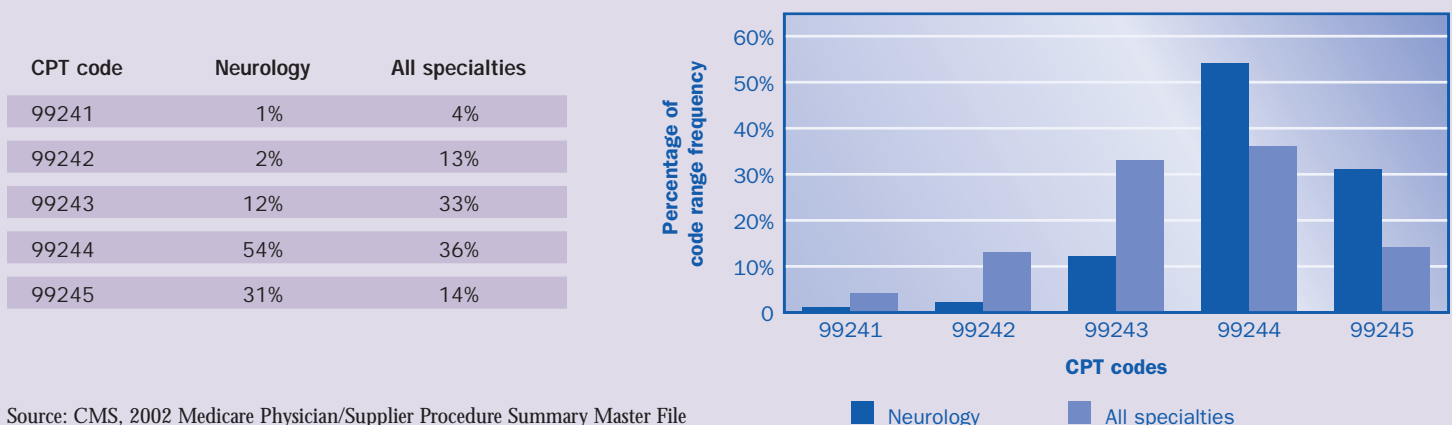
- Is the appropriate modifier appended to the CPT code to more exactly reflect the service performed?
- If this medical record was reviewed by an outside auditor who does not know the patient, does the record support the CPT codes selected?

- 4 The medical record should substantiate that each service provided by the physician was medically necessary and reasonable. Physicians and practice staff should carefully review the payer's medical service agreement for the specific definition of medical necessity. Payers, and even employer groups, may have their own definitions of medical necessity. AMA policy defines medical necessity as:

“Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.”

- 5 Ensure that the patient's chart documentation is appropriate to the billed service. The physician may report E/M services based on one of the two sets of CMS E/M coding guidelines. Know which set of CMS E/M coding guidelines—the 1995 or 1997 version—the health plan follows under its medical review guidelines. (Note: The 1995 or 1997 CMS E/M guidelines may be downloaded from the CMS Web site, <http://cms.hhs.gov/medlearn/emdoc.asp>.) All the required components of the E/M service must be met and appropriately documented in the medical record.

Figure 2 Office consultations, 2002 Medicare data for Neurology compared to all specialties



Source: CMS, 2002 Medicare Physician/Supplier Procedure Summary Master File

- 6 Compare the Medicare E/M frequency data for the practice's state and specialty on which the payer may base its E/M audit with the physician's E/M frequency data. Explain any significant variance based on patient population or other factors.
- 7 Identify and maintain a list of claims not accurately processed by the payer. Determine for each claim listed the practice staff's internal follow-up action to prevent similar non-payments from recurring. New staff should be presented with this information before billing. Additionally, current staff should remain aware and routinely review this information.
- 8 Hold a meeting with the practice's claims submission and auditing team, including physicians, to discuss any claims processing issues that can be resolved through staff and physician education or through the adjustment of the practice's claims submission process. Document the practice's efforts to improve its claims submission process.
- 9 Never stop improving the practice's claims submission and auditing processes.

For additional information, go to the American Medical Association Private Sector Advocacy Web site at [www.ama-assn.org/go/psa](http://www.ama-assn.org/go/psa).

For more information, you may also visit the American Academy of Neurology's Web site at [www.aan.com](http://www.aan.com).

