THE REALITY OF THIRD-PARTY PAYER AUDITS

With the volume of audit types, the reality is that every ophthalmologist will be audited at some time during their career. It's not a matter of if, but when. Being the subject of an audit is stressful and time- consuming for physicians and staff. However, you can protect your practice by preparing for when that request for records arrives.

The purpose of this toolkit and ongoing resources on the Academy's website aao.org/audits is to educate you to the variety and types of audits and identify target areas so that your documentation is consistently in compliance with the payer requirements.

To assist you in proactively navigating the inevitable audit, this toolkit will cover the following topics:

- Coding Compliance Goals
- CMS Mandated Training
- Best Practice Tips
- Audit Triggers
- Competency Question and Answers
- How to Build Your Own Audit Toolkit

This toolkit contains helpful checklists and guidelines for your everyday use (see pages 8-51).
Additional information and ongoing updates are available at aao.org/audits as an Academy and AAOE membership benefit. These resources contain:

- A list of each audit type:
  - CERT
  - RA
  - SMRC
  - TPE
  - UPIC/ZPIC
- Each of the audit target areas such as:
  - New or established patient exams
  - Cataract surgery
  - Extended ophthalmoscopy
  - Scanning computerized ophthalmic diagnostic imaging

All payers conduct audits. Why?

Here is one anonymous carrier medical director's response:

1. Because they can. As a physician, you are a contractor generally not independent.

2. Because they should. There is fiduciary responsibility to patients, taxpayers, stockholders and employers to control cost and limit fraud. It is driven more and more by insurance competitors rolling out proposals on how they will save the purchaser more money than current vendor.

Who gets audited?

Everyone who accepts money from a third-party payer gets audited. The list that follows highlights scenarios for those who commonly undergo audits.

- With comparative billing reports, you could be an outlier compared to your peers by state or by region. Note: Unique taxonomy identifying you as a specialist isn't factored into the data–yet.
- Creative coding might put the whole practice at risk, unlike investments where one can diversify. Is the increase in income worth the risk of an audit or worse? Avoid the "hot" idea to bill patients out of pocket for dropless cataract surgery, or laser assisted cataract surgery with a standard, not premium IOL.
- Past audit failures often lead to additional future audits.
- With random audits, it may just be bad luck.

Is there any way to avoid an audit?

The only way to avoid an audit is to opt out of all insurance plans. Of course, this may opt you out of receiving any patients too when they are unable to use their insurance at all.

Fraud/abuse—what is the difference?

Fraud is intentional and illegal and includes any of the following:

- Knowingly submitting, or causing submissions of, false claims or making misrepresentations of fact to

obtain a Federal health care payment for which no entitlement would otherwise exist

- Knowingly soliciting, receiving, offering and/or paying remuneration to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health services
- Billing Medicare for appointments the patient failed to keep
- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the file
- Knowingly billing for services not furnished, supplies not provided or both, including falsifying records to show delivery of such items
- Paying for referrals of Federal health care program beneficiaries

Learn more about Medicare fraud and abuse in the MLN booklet provided by CMS:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf

Abuse examples:

- Mistakes such as incorrect coding
- Inefficiencies such as ordering excessive tests

CODING COMPLIANCE

To ensure your practice is prepared for an audit, you must be coding compliant. To maximize the impact and minimize the time away from patient care, coding compliance should focus on the following steps.

- Educate physicians and staff in coding regularly
- Know each payer's unique rules
- Create checklists to increase compliance to the payer rules
- Document so well that no outside source can recoup monies
- Submit clean claims
- Rework and resubmit denied claims within 24 hours
- Keep a list of denial reasons and share with all who need to know to stop perpetuating the errors

The result will be that you appropriately maximize reimbursement.

Who are the key players?

The list that follows highlights the key players in your practice and helpful tips for each to maintain coding compliance.

- Physicians
  - Take ultimate responsibility for documentation, CPT and diagnosis code selection
- Technicians
  - Obtain a history to make the physician and payer proud
  - Don't copy forward
  - Understand medicine to appropriately link CPT and ICD-10 codes
  - Know testing services documentation and billing requirements
  - Identify minor surgery as a 0- or 10-day global period; major surgery as 60- or 90-day global period depending on the payer
  - Know payer preoperative requirements
  - Know modifier application
- Scribes
  - MUST know requirements for E/M and Eye visit codes
  - Don't copy forward
  - Know testing services documentation and billing requirements
  - Identify minor surgery as a 0- or 10-day global period; major surgery as 60- or 90-day global period depending on the payer
  - Know payer preoperative requirements
  - Know modifier application
- Billers/Coders
  - Never change CPT or ICD-10 code without physician approval
  - Ask questions when unsure about surgery being performed
  - Provide monthly list of claim denial reasons so that mistakes are corrected, not perpetuated
- Administrators
  - Have internal chart audits performed the way the payers do
    - Never let an outside source review records that have already been submitted for payment
    - Conduct your own audits internally
    - Obtain and convey confidence in your own knowledge
    - Monitor possible coding violations; take corrective action and re-teach at every level
    - Develop protocol to implement when request for records arrives

CMS MANDATED COMPLIANCE

CMS has mandated that Fraud, Waste, and Abuse (FWA) plus general compliance training be performed on an annual basis.

Both Medicare Parts C and D may have their own training guidelines, and initiation of and attesting to completion may be a condition of your contract.

Note: All new hires should have training within their first 90 days. The annual training can be completed any time between January 1–December 31 of any given contract year.

CMS has provided several options for compliance training which provide certification of fulfilling the requirement. Both FWA and general compliance training is available in either web-based training,

or through downloadable documents which can be incorporated into existing practice documents.

Note: While not all staff is required to have training, those with decision-making roles, claims processors and management should be well-versed in conditions of practice compliance.

As part of your training, read:

- Medicare Managed Care Manual: Compliance Program Guidelines and
- Prescription Drug Benefit Manual: Compliance Program Guidelines made available by CMS at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

Additional resources

- MLN fraud and abuse products available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf
- MAC webinar participation available from each MAC website listed at aao.org/practice-management/coding/updates-resources

BEST PRACTICE TIPS

1. Do not apply one payer's rules or perceived rules to all payers
   a. Support physicians by updating them immediately with payer guideline changes
   b. Participate with free payer listservs
2. Share weekly updates with all who need to know
3. Preauthorize, predetermine, pre-certify as necessary
   a. May need to research based on patient insurance
   b. Use practice management software for efficient processes

c. While preauthorization, etc., does not guarantee payment, you are guaranteed no payment without it
4. Verify patient insurance prior to examinations, including the type of service the patient is requesting
   a. Electronic eligibility check
   b. Programs such as Eylea4you, vendor eligibility online
   c. Rate yourself where you are right now
5. Research and report reasons for claim denials to eliminate repetitive errors
   a. Top reasons practices have denials
   b. Understanding why denials take place
   c. Injury report for WC claims—payment denied without this report
   d. Communicate to staff and physicians to eliminate persistent errors
6. Have policies and procedures in place to verify correct claim submission and any resubmissions
   a. Compliance plan
   b. Resubmit claims within 48 hours as payment is already delayed
   c. Weekly track corrected claims until payment is received
7. Keep physicians informed of AR standing
   a. Accountability
   b. Checks and balances
   c. Practice dashboard
8. Use Academy tools and resources to appropriately bill
   a. Accountability
   b. Do not guess (research before claim submission)
   c. Just because it is paid, doesn't mean it was paid correctly—always chance of recoupment when policy is not verified by payer
   d. Discuss policy for those commercial payers that do not have written policy
   e. Everyone has an opinion, but are they following policy—always go to a trusted source
   f. Collect deductibles, copayment at time of service
9. Do not change CPT codes without physician approval
10. Obtain ABN only when necessary on Medicare Part B patients only
    a. When you are not sure either by diagnosis or frequency if the service is covered
    b. Anything oculofacial that could be deemed cosmetic
11. Confirm where patient is "living while they heal"
    a. SNF impacts billing

    b. Has patient recently been hospitalized or receiving physical therapy?
    c. Hospice care

AUDIT TRIGGERS

1. Billing under any other National Physician Identifier (NPI) but your own, even if the physician signs off on your charts
2. Charging patients extra fees which are in violation of your contract with the payer and have ethical ramifications
    a. Late fees
    b. Cancellation fees
    c. Charging for paperwork
    d. Routine refill fees
3. Billing inherently bilateral tests
    a. One eye to the payer
    b. ABN and bill the other eye to patient
4. Modifier -59 explosion
    a. Unbundling injections at time of surgery
    b. Unbundling fundus photo and SCODI or OCT
5. Excessive use and abuse of ABN
6. Injecting Avastin and billing for Lucentis
7. Ignoring 28-day rule in anti-VEGF drugs
8. Improper out-of-pocket expenses to patient for premium IOLs
    a. Billing for laser assisted cataract surgery
    b. Billing for monovision or blending vision
    c. Billing for use of ORA with a standard IOL
9. Billing assistant surgeon to patients when not a covered benefit
10. Billing place of service office when procedure took place in facility for higher site-of-service differential payment
11. Billing modifier -25 with every established patient and all minor procedures
    a. While medically necessary, if the established patient exam is performed solely to confirm the need for the minor procedure, the exam is not separately payable for the minor procedure.