

Put on Your Audit Armor, Part 1

It's not a matter of *if* but *when* a third-party payer sends you a request for records. And when that day arrives, having a written protocol in place will help to ease your angst. Here's how to get started.

Be Audit Ready: Create Written Protocol

Use the protocol below as a starting point, and customize it to fit your practice.

You receive a request for records. What do you do next?

1. Do not toss the envelope. It shows the postmark date. The letter inside may be dated much earlier than the date when you received the request.

2. Determine the type of audit or investigation. The government has assigned auditing duties to several types of organization, each with its own type of audit. These include the following:

- **CERT:** Comprehensive Error Rate Testing
- **OIG:** Office of Inspector General investigation
- **RA and RAC:** Recovery Audit (RA) and Recovery Audit Contractor (RAC)
- **SMRC:** Supplemental Medical Review Contractor
- **TPE:** Targeted Probe and Educate
- **ZPIC:** Zone Program Integrity Contractor

The mechanics of the audit may vary, depending on which type of audit is performed.

Two Real-Life Scenarios

Scenario 1: The dutiful but ill-informed staff member. A staff member opens the mail and finds an audit request for 40 charts. In an effort to be helpful, he compiles what he perceives to be the appropriate documentation. He submits it without telling the physician.

The audit results are not favorable, and a substantial refund is requested. Now the employee needs to plan for an appeal or a refund and must tell the physician. If the refund is not made within the allotted time frame, future payments will be withheld until the recoupment is paid in full. This can have some awkward repercussions. Suppose, for instance, the physician's partner submits the next few claims to this payer. It will be the partner who is impacted when the payer withholds payment for those claims. Patients may also be affected, as the practice won't be able to post a payment to a patient's account if actual funds aren't available for deposit.

Scenario 2: Kicking the can down the road. A request for 30 records is received. Rather than putting her best foot forward and making sure all the documentation that the auditor requested is submitted, the practice administrator determines that the practice will just send in records and hope for the best, knowing that the practice can always appeal. While appealing denied claims is always an option, it is a costly one. Best practice is to review the request and carefully compile the documentation. When you send the documentation, include a cover letter that can provide further explanation and can help set the tone for the audit.

3. Identify the due date for sending records. Respond within the time limits provided, or immediately request an extension. Make sure you document written confirmation of new due date.

4. Look for the common theme. Does the auditor seem to be zeroing in on a particular level of E&M or Eye visit code? A consistent modifier? A particular testing service? A high-

volume surgery? Is it a single date of service versus a series of encounters?

5. Note the date of service requested. Make sure that you are gathering documentation for the correct date of service.

6. Check the records for signatures. For paper charts, is the physician signature present and identifiable? If signatures are illegible, immediately prepare a signature log. Include the names of all who document in the medical record and identify their title (i.e., MD, DO, OD, technician, scribe, receptionist,



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etc.). If the signature is missing from the medical documentation, it is acceptable for the author of the medical record entry to add a signed attestation that he or she had entered the original information into the record.

If you use electronic health records (EHRs), provide documentation that the physician signature is “secure” and nobody else has or uses the physician password. Most audits also request EHR signature protocol. Without an identifiable, secure physician signature, the auditors do not have to complete the actual audit—they can just deny payment.

7. Provide a list of abbreviations used. Don't assume that the auditor will understand the abbreviations used in your records.

8. Check whether LCD(s) apply. If the payer has a Local Coverage Determination (LCD) on a test or surgery performed, quote chapter and verse from that LCD. Be sure to use the LCD that was in place at the time the test or surgery took place.

9. Make sure tests are fully documented. If testing services are part of the audit, make sure there is a written order that identifies by name what test and which eye(s). Furthermore, the medical necessity for the test should be obvious in the medical record; the physician should provide the interpretation and report as soon as possible; and if the delegated test falls under direct supervision, make sure the payer is aware that one of the practice's physicians was on site during the test.

10. Self-audit. If the auditor is looking at E&M or Eye visit codes, audit internally before submitting the documentation, so you can gauge your worst-case scenario. Next, you can estimate how much money the auditor might seek to recoup and plan accordingly.

11. Make sure that a physician reviews the documentation. Physicians should have the opportunity to review all records before that documentation is sent to the auditor.

With paper charts, if the handwriting is not readily legible, physicians should take the time to dictate (not embellish) the notes. Include the actual

chart note plus the dictation. After all, only that which can be read can be audited.

With EHR, check whether all fields are populated. For example, if documentation shows only those body systems that have a problem and not those that are normal, you won't receive credit for reviewing 10 or more systems. Work with the vendor to make sure all fields show when the record is printed.

12. Remember that the Academy is here for you. Email coding@aao.org.

Codequest 2018

Strengthen your audit armor. Stay up to date with shifting regulations by attending Codequest 2018, a half-day event that will be tailored to the region where you practice.

New for Codequest's 2018 program. Audit-proof your documentation with payer-specific checklists for the top surgical procedures for each subspecialty. Learn about new CPT, HCPCS, and ICD-10 codes as well as new CCI edits. Get tips on coding for telemedicine, blepharoplasty, and much more.

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- Columbia, S.C. (Friday, Jan. 12)
- Nashville, Tenn. (Saturday, Jan. 13)
- Southern California (Friday, Jan. 19)
- Little Rock, Ark. (Thursday, Jan. 25)
- Northern California (Friday, Jan. 26)
- Lubbock, Texas (Friday, Feb. 2)
- San Marcos, Texas (Saturday, Feb. 3)
- Greensboro, N.C. (Saturday, Feb. 3)
- St. Paul, Minn. (Saturday, Feb. 17)
- Salt Lake City, Utah (Saturday, March 3)
- Manhattan, N.Y. (Thursday, March 15)
- Long Island, N.Y. (Friday, March 16)
- Detroit, Mich. (Saturday, March 17)
- Rochester, N.Y. (Thursday, March 22)
- Albany, N.Y. (Friday, March 23)
- Dallas, Texas (Saturday, March 24)

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