

Practically speaking: Reducing your audit risk

by Betsy Nicoletti, CPC

How can a surgical practice decrease its audit risk? The stock answer is: by implementing a comprehensive and robust compliance program, by attending coding education classes annually, and by keeping abreast of new regulations. But what specific activities and inquiries should a surgical practice make within its own compliance work plan?

We often advise surgical practices to employ a three-pronged strategy: analyze and check your practice's use of modifiers, compare all the physician's evaluation and management (E/M) coding profiles with one another and with industry benchmarks, and pay attention to hot topics related to surgical billing.

Check your practice's use of modifiers

Modifiers tell the payor the circumstances surrounding the provision of care, but do not change the description of the Current Procedural Terminology (CPT)* code to which they are appended. Surgeons use modifiers -24, -25, and -57 on E/M services to indicate that the service should be paid in addition to the global surgical payment. Since these modifiers bypass the claims editing system, and allow a physician to be paid separately from the global payment, their use is monitored by payors. An unusual use of modifiers that impacts payment will increase the chance of a payor audit. Payors will pay these claims initially; each claim is adjudicated and paid (or not) based solely on the information on the claim. Later, however, the payors, both private and governmental, will analyze the composite paid claims data. A higher-than-average use of modifiers will attract attention, and not the kind of attention a surgical practice wants. General surgeons ap-

pend modifier -24 to 3.11 percent of their E/M services; modifier -25 to 3.84 percent of their E/M claims; and modifier -57 to 1.71 percent of their E/M services, for claims submitted to Medicare according to the most current data available.[†] If a practice finds a significantly higher usage of these modifiers, staff should review the notes to be sure they follow CPT and Medicare rules.

Compare and monitor E/M coding profiles

It's oft-repeated advice to analyze E/M profiles, and many groups routinely collect this data. What do we do with this data? First, be sure to show the physicians the results, comparing each physician's profile with all the other physicians in the group, as well as the national and state Centers for Medicare and Medicaid utilization data. Where to get the CMS data? KarenZupko & Associates E & M Analyzer tool compares a practice's E/M coding patterns against general surgery-specific state and national code utilization figures, using CMS' most recently published claims database. Go to <http://www.karenzupko.com> for more information.

Once a comparison of the practice's code usage has been conducted—what is the next step? Do something with the results. Instead of performing random audits, focus audit efforts on codes that are over- or underrepresented. If the documentation doesn't support the code selected, and the physician coding profile varies significantly from the norm, provide increased coding education for the physician and increase the number of audits. Physicians need feedback: show them their results, payor requests, and comparative data frequently.

Pay attention

It is important to be aware of the following hot topics to reduce the compliance risk:

- *Location of service errors.* For the exact same service (for example, a CPT code), payors

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.

[†]MIT Solutions, Inc. Available at: www.mitsi.org. Accessed June 11, 2010.

pay physicians more for the service when it is performed in a non-facility setting, such as a physician office, rather than in a facility setting, such as an ambulatory surgical center, outpatient department, emergency department, or inpatient hospital. Incorrectly reporting the place of service as performed in the office will result in collecting more than the practice is entitled to collect.

- *Incorrect diagnosis codes.* Submitting a claim to Medicare for an E/M service prior to a colonoscopy screening is a significant error. Medicare does not pay for this as a separate and distinct service. Reporting an incorrect diagnosis code in order to receive payment would be considered purposefully collecting money from the Medicare program to which a practice is not entitled. Cigna, one Medicare administrative contractor (MAC), has a local coverage determination policy that explicitly states:

A provider preparing to perform a screening colonoscopy cannot also bill for a pre-procedure visit to determine the suitability of the patient for the colonoscopy. These E/M services, to include consultations, are not separately payable. While the law specifically provides for a screening colonoscopy, it does not also specifically provide for a separate screening visit prior to the procedure. Although no separate payment can be made for these visits currently, the fee schedule payment for all procedures, including colonoscopy, contains payment for the usual pre-procedure work associated with it. This reflects the principle that each procedure has an evaluative component.[‡]

Once the decision to operate is made, a surgeon may not bill for a subsequent visit for the purpose of completing a history and physical. After the decision for the operation is made, an E/M service scheduled for the purpose of doing a history and physical, completing paperwork, and obtaining informed consent may not be billed separately. Payment for those activities is included in the payment for the surgical package. This visit

would be easy to identify by analyzing paid claims data, searching for an E/M service between an initial visit and the operation, and matching it with the same diagnosis code. ^①

[‡]Centers for Medicare & Medicaid Services. Medicare Coverage Database. License for use of physicians' *Current Procedural Terminology*, fourth ed. Available at: http://www.cms.gov/mcd/viewlcd.asp?lcd_id=5774&lcd_version=28&show=all. Accessed June 11, 2010.

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