

Attachment A

Preparing for Payer Audits ACEP Reimbursement Committee 2016

Recommendation:

The American College of Emergency Physicians developed this document to provide its members basic guidance on preparing for payer audits. Due to differences in regional/state/and jurisdictional precepts, rules and regulations, legal guidance should be sought from a qualified attorney in the relevant locality as early in the payer audit process as possible. Health care providers should comply with the lawful service performance/documentation/and coding policies of a payer with whom they contractually participate. The information provided in this document should be used as a guideline only.

Note: Additional information pertaining to commercial plan audits and recoupment demands has been included in this document under the sub-heading **Commercial Plan Audits**

I. Why look at governmental audits?

The incidence of governmental audits, by both Medicare and state Medicaid programs, has significantly increased over the last several years. As a result of growing pressure to improve accountability and reduce costs for federally funded medical care, CMS has increased the frequency of random and focused audits in an attempt to identify potential billing fraud. The enhanced recapture of payments for charts that are either poorly documented by the provider or coded to a higher level than a governmental auditor would agree with will help support federally and state run medical programs. Careful scrutiny of what occurs during governmental audits is paramount in identifying common patterns that characterize the audit process, as well as high-risk documentation habits, controversial codes and reimbursement practices that have historically been questioned by CMS sanctioned auditors.

II. Are we seeing any increase in audit frequency?

Yes. Two areas have contributed to the increased frequency of governmental audits: (i) the success of the past Medicare Recovery Audit Contractor's (RAC) demonstration project;

and (ii) an enhanced call for accountability and cost-saving measures within recent federal legislation, including the Affordable Care Act (ACA). These audits are viewed by CMS, HHS, and the OIG as critical to the preservation and sustainability of the Medicare trust fund.

The general perception held by the President, Congress, and regulatory governmental leaders are that billions of dollars in health care expenditures are not only unnecessary, but may be fraudulent as well. Many of the proposed health care reform programs are to be financed with the savings that will be realized by curtailing any perceived fraud and abuse.

While ED-related care accounts for less than 2% of health care spending, it is not the primary target of governmental audits. RAC contractors, who are reimbursed on a percentage of recovery, do pay particular attention to Emergency Medicine because of the high volume of patient encounters that are a characteristic of the specialty. This large number of patient visits has the potential of leading to higher-dollar recoveries, especially given the possible extrapolation of recovery amounts to a larger volume of governmental beneficiaries.

As important, if not maybe a bit more so, is the fact that historically hospitals have been a primary focus of audits due to the larger per patient total “ticket price” for facility care and also the staged development of RAC foci (i.e., started with facilities first). Quite often, hospitals depend upon physician documentation to help substantiate their services. Accordingly, if an audit can call into question physician service documentation then the opportunity for a “two for one” (i.e., recoupment from both the facility and the practitioner) presents itself.

Commercial Plan Audits

Because of the success of previous government payer demonstration projects at recouping tax dollars, commercial plans are also beginning to use these techniques in an attempt to recover what the plans consider to be ‘overpayments’ on previously paid claims. Commercial audits have become increasingly prevalent and oppressive. A nation payer recently issued a number of letters to emergency physician groups stating that a review of recent medical records revealed up-coding and a refund for overpayments was requested. The “error” rate was apparently based on a small number of purportedly random samples, and the statistical validity of these audits as applied to the underlying medical services has not been definitively demonstrated. The results were extrapolated over several years ostensibly to determine the amount of “overpayment” over that multi-year period. In some cases the calculated amounts were small, but for others they were in the millions of dollars. The plan advised that if United Healthcare did not receive a response to these audits and recoupment demands, then “[Payer] may consider [the provider] in agreement with these [audit] findings”.

III. What types of cases are payers focusing on?

Audits are intended to uncover instances of improper or insufficient chart documentation, suspect billing or coding practices, and/or improper Medicare payments. These audits are frequently triggered by reports that identify providers who are outliers as compared to their peers within a particular contractor state or region. The reports focus on Evaluation and Management (E/M) code distributions, and also highlight Critical Care and, less frequently, various procedure codes. If a clinician's E/M code level distribution (CPT® Codes 99281-99285 and 99291) varies by a certain percentage from the average distribution profile as determined by Medicare or Medicaid, that clinician and the ED Group to which the physician belongs might be targeted for a focused audit. Recently, emergency medicine E/M codes 99285 and 99291 have been the most commonly investigated by both Medicare and Medicaid. In fact, Critical Care has been specifically highlighted by the Office of Inspector General's (OIG) in its annually published work plan. Those services involving diagnostic testing in the ED have likewise also been targeted.

Most audits begin with the standard letter identifying specific cases to be collated and forwarded to the payer. It is important to note that the legal copy of the ED medical record is in the facility's custody (in whatever media format). Sometimes the payer has already accessed and audited the legal copies of the medical records and the first the emergency physician, ED Group or ED billing operation hears of the audit is a letter of the findings from these charts combined with a repayment requirement.

It is important to note that in any payer audit, anything can come under scrutiny, irrespective of whatever the payer might indicate to be the focus at the outset or request for various charts.

IV. What factors generate a governmental audit?

Medical review audits occur for a variety of reasons including atypical billing and coding patterns, anonymous complaints to CMS, variant E/M code distributions, and unusual volumes of various procedural codes. Medical review audits occur most commonly when a provider's frequency distribution for billed codes appears to be significantly different from the historical norms of peer data for a particular state or region. This is especially true for higher acuity, higher allowable payment codes including 99285 and Critical Care (99291). Also, the sharing of information between Medicare and Medicaid, and even between government and commercial payers, has been continually increasing.

V. Factors Driving Increased Scrutiny of Claims

The following passages are excerpts from an overview of a CMS Press Release that was originally released in 11/2010; the passages are included to demonstrate governmental directions related to audits.

“NEW STANDARDS HELPING LOWER MEDICARE IMPROPER PAYMENT RATES FOR 2010”

IMPROPER PAYMENT RATE REDUCTIONS ARE PART OF ADMINISTRATION EFFORTS TO ELIMINATE ERRORS AND PREVENT WASTE AND FRAUD IN MEDICARE AND MEDICAID

Following the Obama Administration’s work to more accurately account for improper payments and a renewed focus on fighting waste, fraud and abuse, the 2010 error rate for Medicare claims declined in 2010 and is on track for a 50 percent reduction by 2012. The error rate for Medicare Advantage also declined and a new component measure was developed and reported for the Part D program. The Centers for Medicare & Medicaid Services (CMS) also reported today the first three-year review of the Medicaid error rate.

“The Administration is committed to strengthening Medicare, Medicaid and the Children’s Health Insurance Program and we’re working hard to fight fraud, protect taxpayer dollars and drive the improper payment rate down,” said Health and Human Services Secretary Kathleen Sebelius. “Last year we changed how we calculate the error rate in fee-for-service Medicare to more accurately reflect improper payments and enhanced our efforts to fight waste, fraud and abuse. This year’s lower rate reflects those changes and our focus on protecting Medicare.”

The Medicare and Medicaid improper payment rates are issued annually as part of the U.S. Department of Health and Human Services (HHS) Agency Financial Report. The Medicare fee-for-service error rate dropped to 10.5 percent or \$34.3 billion in estimated improper claims payments. The 2009 error rate was 12.4 percent, or \$35.4 billion.

In addition, for 2010:

- The Medicare Advantage, or Part C, error rate, based on payment year 2008, is 14.1 percent, or \$13.6 billion, a reduction from last year’s rate of 15.4 percent, or \$12.0 billion.*
- CMS has made strides in developing a Medicare Part D composite error estimate based on a series of payment error sources. This year, an additional measure was developed and a total of four component error estimates are being reported. CMS plans to report a composite error estimate for Part D beginning in FY*

2011. The four components are: 1) a Part D payment system error of 0.1 percent, 2) a low-income subsidy payment error of 0.1 percent, 3) payment error related to Medicaid status for dual eligible Part D enrollees of 1.8 percent, and 4) payment error related to prescription drug event data validation of 12.7 percent.

- The majority of this final component error estimate was due to missing prescription documentation. Program experience has shown that response rates to this type of documentation request will improve over time.
- The Medicaid error rate is 9.4 percent, or \$22.5 billion in estimated improper payments. This rate reflects a three-year average of the 2008, 2009, and 2010 rates which were 10.5 percent, 8.7 percent and 9.0 percent respectively. Only one-third of the states are reviewed each year.
- While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid or CHIP, they do provide HHS, the Centers for Medicare & Medicaid Services (CMS), and states with a more complete assessment of how many errors need to be fixed.

“Over the past year we have improved the processes we use to review Medicare and Medicaid payments in an effort to identify if there are specific issues that need to be addressed,” said CMS Administrator Donald M. Berwick, M.D. “The President has directed HHS and CMS to cut the fee for service error rate in half by 2012. This is a priority for CMS and we are on our way towards achieving it.”

CMS requires adherence to the documentation requirements outlined in Medicare regulation, statute, and policy, rather than allowing for clinical review judgment based on billing history and other available information. They have reiterated that the primary causes of errors in the Medicare FFS program for 2010 are insufficient documentation and medically unnecessary services.

CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training and education outreach. “We are enhancing our efforts to educate and inform doctors, hospitals and other health care providers about the comprehensive requirements to help lower the number of errors and improper payments, not only across Medicare, but also in Medicaid and CHIP,” said Berwick.

“Notice of New Interest Rate for Medicare Overpayments and Underpayments” – FY 2011. New rate is 11.25%. Effective Date: January 24, 2011

Overview of new audit emphasis:

Federal Government Payers: There are at least 10 audit programs being conducted by the federal government. The reason is mainly financial (more \$ going out than coming in from tax dollars). The three (3) main areas being focused on are:

1-Coding: Recovery Audit Contractor (RAC) Audits are picking up most in frequency according to several sources. Suggestion by American Health Information Management Association (AHIMA) is for companies to perform their own mock RAC audits. Instead of running quality coding reviews—review records for RAC-related errors. This will reveal weak spots and allow time for corrections.

2-Privacy & Security: There is much greater coordination now when someone reports a privacy breach. Heavy fines have been reported. Suggestion is to conduct internal audits to see if processes are compliant with federal privacy laws. Be cautioned on overly strict policies—some written policies have been found to be unachievable. Make sure staff can actually follow policies, in practice. Self-reporting any breaches and implementing immediate corrective action is new focus. HIPAA is now extended to Business Associates.

3-Fraud & Abuse: Zone Program Integrity Contractor (**ZPIC**) is the main fraud program. It scans all CMS benefit programs for suspicious claims. ZPIC looks at billing trends and patterns and flags claims that are higher than the majority of other providers in the area. ZPICs are going after blatant fraud or billing patterns that might indicate a culture of either inadvertent or deliberate lax coding standards, while RAC audits are primarily focused on administrative errors.

While official rules are not yet out, payers and billers need to be on the lookout for identity theft fraud cases. Requests for records can be related to medical identity theft. Now is the time to audit record release policies and provide training on how to detect fraudulent record requests.

Gone are the days of audits revolving around just providing documentation that proves a patient received services. Today, payers want proof the services were warranted. Clinical providers need to

document in such a way that can adequately tell a patient's story months after discharge.¹

There are also different types of structural audits. Retrospective audits review cases where the patient services have been provided and the coding and subsequent billing have been performed. Prospective audits, on the other hand, are done after patient services have been provided, code choices have been made but prior to claim submission (when the self-audit is performed by the practice/billing company) or prior to payment (when the audit is performed by a payer).

Commercial Plan Audits: What Triggers a Commercial Plan Audit?

Audits by commercial plans may be triggered:

- a) by reports or internal analyses suggesting that a physician or a group of physicians is an outlier (e.g., reporting critical care codes, certain procedure codes, or high acuity evaluation and management codes (99285) more frequently than their peers),
- b) by repeated perceived claims submission errors, or atypical billing and coding patterns
- c) by plan contract negotiations or renegotiations, or
- d) by internal changes in payer bundling or claims management policies (which payers sometimes attempt to apply retroactively), or
- e) by reports from individuals (e.g., patient complaints, employer requests, or whistle blowers).

And sometimes, audits just randomly occur.

VI. What are the various types of Medicare and Medicaid audits?

The following is a list of the most common types of audits performed by Medicare and Medicaid. Focus, frequency, and consequences for each type of audit are addressed as well.

Medicare

- 1. ERRP (Error Rate Reduction Plan):** Medicare Contractors are responsible for reviewing the “error rates” in their jurisdiction and must develop an Error Rate Reduction Plan. The basis of this program is the review of medical records prior to payment to determine where an error may have occurred.

- 2. CERT Audits (Comprehensive Error Rate Testing):** CERT audits target providers with high cost, high volume, significant changes and/or grossly aberrant billing patterns.

¹ Source: American Health Information Management Association (AHIMA)

- a. **Summary of the CERT Program:** [Pub. 100-8, Chapter 12](#), is a federally mandated, program integrity activity that was established by the Centers for Medicare and Medicaid Services (CMS) to monitor the accuracy with which Medicare claims are billed and paid. Through this program, national, contractor specific, contractor type, provider type and service type error rates are gathered and mined. The data that is abstracted via the CERT program provides CMS and its Medicare claims processing contractors with valuable information regarding the sources of errors. This information is utilized by CMS in the form of corrective actions intended to prevent billing, payment, and processing errors. In addition, the CERT error rates are used by CMS to measure progress towards its performance goals.
- b. **Process:** CERT randomly selects a sample of approximately 50,000 claims submitted to Medicare Administrative Contractors (MACs) during each reporting period. They request medical records from the health care providers that submitted the claims in the sample. Where medical records were submitted by the provider, claims and the associated medical records in the sample are reviewed to see if the claims complied with Medicare coverage, coding, and billing rules, and, if not, errors are assigned to the claims. Where medical records were not submitted by the provider, cases are classified as a no documentation claim and counted as an error.

Descriptions of errors can be found on the claims status website. MAC's then have seven days to respond. If no information is received, it will be counted as a full payment error. Providers with errors are sent overpayment letters/notices that mandate adjustments for claims that were overpaid or underpaid.

The CERT program cannot be considered a program that indicates a measure of fraud. Since the CERT program uses random samples to select claims, reviewers are often unable to see provider billing patterns that indicate potential fraud when making payment determinations. For this reason, the CERT program does not, and cannot, label a claim as fraudulent.

3. **ZPIC Audits (Zone Program Integrity Contractors):** CMS is replacing its Program Safeguard Contractors (PSC's) with seven regional ZPICs. The ZPICs help ensure that payments are appropriate and consistent with Medicare and Medicaid coverage and coding policy. ZPICs perform data analysis aimed at identifying potential problem areas, investigate potential fraud, and develop fraud cases for civil and criminal referral.

ZPIC looks at billing trends and patterns and flags claims that are higher than those submitted by the majority of other providers in an area. These are the most serious of audits and, if contacted by ZPIC, providers should seek legal counsel as this is an

indication that CMS suspects fraud. ZPIC's serve as law enforcement liaisons and can impose administrative actions such as suspensions, overpayment collections, and referrals to law enforcement and CMS for further sanctions.

- 4. RAC Audits (Recovery Audit Contractors Program):** RAC's use third-party contractors to identify waste, errors and abuse. RACs have uncovered improper payments of more than \$1 billion during a three-year pilot program. The Government Accounting Office (GAO) found that CMS pilot programs failed to implement corrective action on 60% of most significant infractions that resulted in improper payments. The pilot program revealed the following:
- a. 42% of overpayments were **coded incorrectly**
 - b. 32% were **deemed medically unnecessary or an incorrect service**
 - c. 9% had **insufficient documentation**, and
 - d. 17% were listed as "Other."

The known enforcement audit focus areas for RAC's² are the following:

- a. Payments for diagnostic X-rays in hospital emergency departments (volume).
- b. Place of service errors (facility vs. non-facility).
- c. Evaluation and Management (E /M) services during global surgery periods.
- d. Areas with a high density of Independent Diagnostic Testing Facilities (IDTFs) (utilization, volume, ordering):
 - Enrollment standards for IDTFs (technologists, equipment, supervision)
 - Physician reassignment of benefits (fraudulent use of NPIs)
 - Payment for services ordered or referred by excluded providers
 - Duplicate payments for global/TC billing in hospital.

Medicaid

- 1. MIP Audits (Medicaid Integrity Program):** The Deficit Reduction Act (DRA) provides for CMS' first-ever national strategy to detect fraud and abuse in the joint state and federal Medicaid programs. The MIP program provides oversight and technical assistance to State Medicaid agencies.

Numerous techniques are used to target Medicaid claims for audit. Among these techniques are the following:

- Computer targeting
- Surge and intersect reports
- Surveillance utilization review systems
- Aberrant provider behavior
- Referrals
- Direct complaints
- Whistleblowers.

²McKesson research

- 2. MIC Audits (Medicaid Integrity Contractors):** MIC is a companion program to the MIP program described above. This program relies on external contractors to perform audits of the various state Medicaid programs. The contractors conduct data mining and develop reporting tools across Medicaid.

A general overview of the MIC program can be reviewed at:

http://www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp.

A fact sheet about the program can be reviewed at:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Provider-Audits/Downloads/MIP-Audit-Fact-Sheet.pdf>

The following areas are targeted by the MIC program:

- Provider eligibility
- Billing for services not provided
- Reimbursements for unapproved drugs
- Duplicate billing
- Providing services that are not deemed medically necessary
- Providing services that may compromise the quality of care
- Excessive payments and “up-coding” for higher reimbursement of billed procedures
- Billing for services provided by unlicensed or untrained personnel
- Payments for unapproved transportation services
- Medicaid eligibility in multiple states
- Contingency fee payments to consultants and service providers
- Excessive Medicaid administrative costs
- Providing false certifications in the claims process.

- 3. PERM (Payment Error Rate Measurement):** This initiative, which also relies on independent contractors, was implemented to measure improper payment in the Medicaid program and the State Children’s Health Insurance Program (SCHIP) and is further described at the following web site: <http://www.cms.hhs.gov/perm/>. CMS uses a seventeen-state rotation for the PERM program. Each state is reviewed once every three years and can prepare.

There are three contractor groups that measure improper payments through statistical calculations, and then collect medical records and review claims. The beneficiary eligibility is a major focus, as are high dollar overpayments.

Error rates for each state will be established and will result in penalty for providers on a sliding scale. Rates for 2008 reviewed states ranged from 0.59% to 20.84%. States with larger managed care programs had the lowest error rates. Most errors have been found to be eligibility errors, pricing errors (data entry), non-covered

service errors, and insufficient or no documentation errors, though the latter is no decreasing in frequency.

- 4. Medicaid RAC (Recovery Audit Contractors):** This initiative uses third-party contractors to identify waste, errors and abuse for each Medicaid program. These programs were started in 2012 and are variable between states. Each state can set its own parameters for a variety of issues it wishes to see addressed by the audit contractor. The approaches by each state Medicaid program can be highly locally dependent.

Commercial Plan Audits: Types of Commercial Plan Audits

Commercial audits can generally be divided into two categories: contracted claims (i.e., in-network claims or claims by physicians who have signed the payer's participation agreement), and non-contracted claims (i.e. out-of-network claims), and two formats: reviews and formal audits. Claims reviews can be a preliminary step commercial plans use to decide whether to conduct formal audits, but may not be subject to the payer's sampling policies related to formal audits. Reviews of claims can, and generally should, also be challenged. When commercial plans conduct formal audits of contracted claims, they should follow the approach outlined in the provider-payer contract; so one of the first things that providers should do when informed that their contracted claims are or have been audited is to review the contract terms related to audits and recoupments with or without extrapolation, if they exist. Occasionally, plans may offer an 'extrapolated' settlement (often based on informal audits which may involve non-representative sampling) to forestall a full blown audit. Sometimes the contract language references payer policies or procedures that are not explicitly written in the contract itself. Such policies/procedures must also be obtained if an audit is performed.

Some other examples of commercial payer audit strategies include:

- Financial accuracy audits performed to ensure that claims are paid according to contract language and the pre-arranged fee schedule.
- Random audits performed to look for member eligibility and incorrect payments, among other issues.
- Historical claim audits performed to review claims for inappropriate payments for services such as follow-up services provided during a pre-determined global period.

When plans audit either contracted or non-contracted claims, they must comply with respective State regulations governing audits and 'overpayment' recovery (and underpayment correction). Your State medical society can be a good resource for information about the commercial audit appeals process for payers in your State. An

attorney can also assist in obtaining such information, as well as participating in the contract review process.

Commercial insurance carriers often hire audit contractors, companies that perform audits (and sometimes manage audit appeals using their own appeals process) on behalf of the plan.

VII. Preparing for the Inevitable: What to do before you are audited

There are a number of steps that ED Groups, ED physicians, and ED billing and coding vendors can take to help prevent an audit and make the audit process easier should an audit occur. The most important preventative measure is for each member of the group to provide thorough accurate documentation for each patient seen in the ED. Sufficient documentation of history, exam, and medical decision making allows coders to code the most appropriate E/M code for the service provided. Furthermore, careful documentation provides the content needed during the audit process to successfully defend the level of service coded and subsequently billed.

In addition to excellent documentation, creating, and then implementing, a compliance plan and program with processes to support quality documentation, coding, and billing will help ensure positive operational processes and successful future audit outcomes. Establishment of a formal compliance plan and program can be time consuming, but there are a number of software products on the market that can be utilized to organize policies, track audits and audit results, and drive compliance tasks that will benefit an organization.

The ED physician group and its coding and billing vendor will want to ensure the presence of a detailed compliance plan and program that includes routine internal and external self-audits, feedback to the physicians regarding documentation quality, and a routine re-auditing plan to assess the effectiveness of provider and coder education efforts. The plan should include very specific written coding policies that underscore an Evaluation and Management code choice methodology, as well as detailed information regarding utilization policies for various procedure codes, modifiers, PQRS, and diagnostic codes. Good communication with the managers and staff that perform coding and billing is integral to the plan's success and must be integrated with ongoing education for both coders and physicians.

Please note that while quality/PQRS-like issues presently tend to be nominal in current provider audits, more than likely the focus on these will become more prominent in the future. Some compliance attention should be directed toward these requirements by the emergency medicine providers since hospitals already face increasingly significant penalties for payer-defined "poor quality" determinations.

Components of a compliance infrastructure will assist ED physicians to proactively position themselves for successful audit outcomes. An effective compliance plan will define how

compliance is managed by your ED group and your billing and coding representative. The Office of Inspector General (OIG) has identified the seven components of an effective compliance plan for third-party medical billing companies in the following document:

<http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf>

These seven components should be fully integrated into the coding and billing operation as well as the physician group practice. These components – which are basic to ensuring compliant coding and optimizing outcomes in an audit situation – are as follows:

1. Implementing written policies, procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Enforcing standards through well publicized disciplinary guidelines;
6. Conducting internal monitoring and auditing; and
7. Responding promptly to detected offenses and developing corrective action.

To help distinguish between the Compliance Plan and Program, the Compliance Plan is what an organization says it's going to do. The Compliance Procedures are what an organization actually does. The Compliance Plan and Procedures must match. The worst possible circumstance is to have one out of synch with the other, especially if the Plan specifications are deemed to be more appropriate than the actual Procedures.

Part of the Compliance Plan/Program should address some process to assure, on at least a sampling basis, that the copies of the medical records used to code the practitioners' services and the copies of ostensibly the same records archived by the facility are in fact coincident. The Plan/Program should also address what to do upon discovery of coding/billing errors during usual operations or internal reviews (e.g., self-reporting, look back period for similar errors, the potential for failure to refund overpayments as setting up allegations of fraud). Whenever the Compliance Plan is amended, document/archive the deliberation rationale as to why a change was made.

Documented coding policies are an excellent way to create consistency in documentation and coding. Since not all CMS policies are easily understood, an organization's written custom coding policies can bring clarity to potential gray areas. Groups will need to work with their respective coding/billing vendor to negotiate guidelines for areas in coding that may mandate specific directions from each company. Creating more specific documentation requirements for code assignment gives coders the support they need for accurate coding and helps provide a framework for any feedback that is relayed to the ED physicians. Written policies also provide a format for ED physicians to communicate their standards and expectations.

Periodic coder and physician education is important as codes and regulations change annually at a minimum, with specific coding and documentation clarifications and new interpretations published frequently. Documenting and coding that follows current

regulations and interpretations is a primary requirement to help ensure any successful audit rebuttal.

Routine self-audits will identify problem areas and opportunities for improvement in terms of enhanced revenue and mitigation of risk. Educational efforts should target areas of concern that are identified in these internal audits. General audit results and improvements can be communicated in staff meetings. Ongoing discussions based on various scenarios - even just ten minutes a month - will increase consistency in documentation and coding quality. Deficient or less than optimum documentation can be identified along with specific data elements that could have been documented to create a chart that can easily be defended in any future audit. The Compliance Plan should also address how any underpayments or overpayments resulting from incorrect coding found during internal audits will be addressed.

Do not stop at simply raising areas of concern with the ED physicians. Routine re-audits will reveal if educational efforts surrounding problem areas resulted in improvements or if additional training is mandated.

Creating a culture of openness and fostering feedback and frequent two-way communication between coders/coding management and the ED physicians or the practice management company is essential for ensuring high quality documentation and coding. In the past, many ED physician groups had little interplay with their coding and billing operations, but given the current intensity of payer scrutiny and the resulting demand for compliance, communication has become critical. A physician group that is engaged in regular communication with billing and coding has established a foundation to support compliance and prevent future adverse audit outcomes.

Recently CMS has been emphasizing that individual owners/officers/governance members/managers can have personal liability for an organization's coding/billing deficiencies. Since an effective Compliance Plan/Program can help mitigate this possibility, it is important to do the appropriate research necessary to create an effective Compliance Plan/Program.

The fact is that there are endless numbers of formal and informal educational resources available to ED Groups, and billing and coding organizations. ACEP provides a wealth of information about such courses on the ACEP website, as does CMS. Publications are available from many coding and ED-related organizations that can help ED physicians and coders quickly sort through changes that apply directly to the emergency department.

Other important aspects of an organization's Compliance Plan and Program can be accessed by reviewing the ACEP document related to Compliance Plans and Programs using the following URL: <http://www.acep.org/content.aspx?id=32156&list=1&fid=2290>

Processes that detail a timely standardized response to an audit notification are a crucial first step in determining overall audit success. The payer will provide instructions and a deadline for responding to the audit request. Once the charts are pulled and documentation has been provided to the payer, your organization will need to perform a detailed audit on the same records and create a comprehensive report on each. A comprehensive response format is described in the sections that follow.

Commercial Plan Audits: Preparing for Commercial Plan Audits

It is not a question of whether an audit will happen, the question is when. The topic of preparing for audits is well covered in the Section immediately above (Section VII). In addition, when contracts are negotiated with payers; providers should consider the potential impact of audits, and the contract language proposed by the plan related to audits and recoupment demands. Contract payment terms, such as case rates or case-limit rates (where the payment is the lesser charge or the payment limit), may substantially reduce the risk of claims audits related to coding and documentation, but expertise is advisable in assessing such rates. It may also be helpful to identify, in advance, the regulations in your State related to this issue.

Similar to preventing government audits, in order to prevent commercial payer audits, the best strategy is to follow payer rules and to provide substantiating physician documentation. The following medical record documentation requirements are cited by some commercial payers:

- All documentation must be in English.
- All entries must be legible, dated and signed by the performing provider.
- The selection of the E/M code must be supported in the clinical record. The AMA CPT descriptors of key and contributory components will often, but not always be used.
- The services provided must be clearly documented in the record with all pertinent information regarding the patient's condition in order to substantiate medical necessity for the services provided.
- Medically necessary diagnostic lab and x-ray results must be included in the medical record and for any abnormal finding there must be an explicit notation of a follow-up plan.

In evaluating inappropriate coding and billing, commercial payers consider many of the same issues and services that CMS evaluates. Claim reviews may include a look at any or all of the following:

- Emergency Department E/M services

- Observation E/M services
- Critical Care E/M services
- Ancillary services
- Procedures
- Modifier Use
- Unbundling of services
- Inappropriate reporting of services during the global period
- Medical necessity
- -25 modifier usage
- Illegibility.

VIII. What should be included in your initial comprehensive response?

Initially, responding to any notification of an audit has some potential complications that must be addressed. When responding to requests for charts or other supporting documentation, the ED group, billing company or the individual clinician must follow the specific procedure as mandated by the individual payer. These procedures may include options such as faxing documents, uploading documents electronically, etc. Maintaining complete copies of all responses and proof of receipt by the payer is essential. (In some members' experience, faxing does seem to improve the timing of responses; however, be aware that the text can become distorted and cause illegibility issues, so if faxing be doubly sure to follow up with the payer to make sure all the documents were received properly and are legible). It may be helpful to provide verbatim transcriptions of charts, when they are not entirely legible, to the auditor.

The information that follows is one suggested audit response format, based upon the Current Procedure Terminology or CPT Manual, the 1995 Medicare Documentation Guidelines, and Marshfield Clinic Tool. CPT is the fundamental basis for coding noted by Medicare in the 1995 Documentation Guidelines. The Marshfield Clinic Tool is one that was developed in the mid-1990s and includes three Tables that can help in determining the level of Medical Decision Making (MDM). A comprehensive audit response should include the following information for each record that is being audited.

Medical Record Review Comprehensive Audit Response Template

Patient Demographic Information		
Name		
MR#/Hospital Account Number		
Date of Service		
History		
Chief Compliant:		
HPI:		
ROS:		
PFSH		
Exam		
Exam:		
Medical Decision Making		
Tables for MDM Determination	Table Components	Points/Level of Each Table
Number of Diagnoses or Treatment Options		
Amount & complexity of data reviewed		
Risk of complications and/or morbidity or mortality		
MDM Level		
Clinical Summary of Case		
Case Severity		
Code Choice Summary		
History		
Exam		
MDM		
CPT Example for Selected Code Level		
EMTALA-related Care		
Medical Necessity of Ancillary Studies Ordered and Therapeutic		

Interventions	
Suggested CPT Code Choice	
ED Admission Date & Time (i.e. Triage Time or first documented time on the chart):	
Discharge Date & Time from ED:	
Observation order Date & Time if applicable:	
Disposition (i.e. hospital admission, transfer, discharge or deceased):	

Heading Definitions

The following information is intended to further clarify each of the main headings that should be included in a comprehensive audit response.

- **Patient Demographic Information (name, medical record number or hospital account number):** A minimum of one of these items should be included for each record. Inclusion of this information in your audit response should not be considered a HIPAA violation since communication is related to a specific governmental audit and both provider and payer are covered entities.
- **Date of Service:** Inclusion of the DOS provides additional documentation that the correct record is being reviewed as some patients are often seen on more than one DOS.
- **History:** Your audit response should note the History level chosen for the record in question as either: Problem Focused, Extended Problem Focused, Detailed or Comprehensive.
 - a. **Chief Complaint:** Your audit response should include the CC as it appears in the clinician’s note.
 - b. **HPI:** This section should list the HPI elements that were documented along with the total number of elements (e.g., Severity, Quality and Timing listed for total of three (3) HPI elements documented in the record).
 - c. **ROS:** The ROS section should include the systems that are documented (e.g., Eye, ENT, Respiratory, Cardiovascular, GI, GU) along with the total number of systems documented on the chart (in this case six (6) systems documented). If the pertinent systems related to the chief complaint are

reviewed, a comment on the addition of a phrase very closely similar to “All other systems reviewed and negative” should also be included.

- **PFSH:** The PFSH section should include at least one historical fact from each of the relevant Past, Family or Social History sections even though the separate historical areas may not be separately labeled as “Past History”, “Family History” or “Social History.”
- **Exam:** The Exam section should either list the Body Areas or (preferably) the Organ Systems that are documented on the chart. Including the number of systems that were reviewed and found on the chart is acceptable too.
- **Medical Decision Making:** Using the Medicare audit tool as listed on the CMS web site with the MDM related items on the charts helps delineate your choice of MDM level. Using the tables as initially described in the “Marshfield Clinic Tool” (Tables A and B) is common practice in the emergency medicine coding community and is also used and therefore acceptable to many governmental auditors, although interpretational differences do arise. Confirming with the governmental payers that they do indeed use this tool, or a similar tool, to screen chart contents for diagnostic orders or management options is imperative. (NOTE: Non-governmental payers tend to vary more widely in utilization/interpretation of the Medicare audit tool, especially when the tool differs from CPT.)

Please remember to focus your responses to any audit related to what the payer in question is requiring you to use when determining E/M coding levels. There may be some variance between the various Medicare contractors as an example. Of course, Medicaid carriers who are ostensibly responsible for administering their individual program, can choose Medicare, CPT or any direction they may elect to accept for E/M code selection. Commercial payers can also elect to use Medicare, CPT or their own principles which is especially important when you have a participation contract with the select commercial payer who is auditing you.

Tables for MDM Determination	Table Components	Points/Level of Each Table
Number of Diagnoses or Treatment Options	Was a new problem to the clinician demonstrated and what, if any, were the components of any additional work-up?	List why you gave 1 to 4 points. Was the patient one with a new problem to the clinician and was an additional work-up beyond the history and exam performed?
Amount & complexity of data reviewed	List the following orders: lab, x-ray, Special Studies,	List all rows that are applicable and the points

	EKGs as examples. List if any communications are documented with performing physicians (radiology mostly), persons other than the patient, or other healthcare providers. Also identify if any of the studies listed above were visualized by the clinician and if an old record was reviewed.	assigned for each row. Finally list the total points attained for this table.
Risk of complications and/or morbidity or mortality	Consider listing the types and numbers of ancillary studies ordered and the therapeutic interventions provided since these help to define the level of risk. Also include if the patient was admitted or transferred.	List the Risk level and why this level was chosen
MDM Level		Determine the highest levels of two out of three of the tables above, and list the level of MDM: Minimal, Low, Low Moderate, High Moderate or High.

- Clinical Case Summary:** We suggest working directly with the clinician who originally saw the patient and documented the record being reviewed. If that is not feasible, then work with the ED Medical Director, ED group’s medical director or the medical director of your billing and coding entity. This clinician should describe each case from their perspective in a manner similar to how they would present the patient to a teaching physician or to a consulting or admitting physician. The patient encounter should be discussed in great detail, and should include conversations about the ancillary studies ordered, the therapy instated and the disposition of the patient. If the patient was admitted, the importance of this disposition and the potential morbidity or mortality to the patient had they been discharged should also be summarized. The same goes if the patient was ultimately transferred.

- **Case Severity:** The clinician should consider focusing on the material in the CPT Manual that designates the severity (Nature of the Presenting Problem; NOPP) of each of the Emergency Department Evaluation and Management code levels:
 - 99281: Usually, the presenting problem(s) are self-limited or minor.
 - 99282: Usually, the presenting problem(s) are of low or moderate severity.
 - 99283: Usually, the presenting problems are of moderate severity.
 - 99284: Usually, the presenting problems are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
 - 99285: Usually, the presenting problems are of high severity and pose an immediate significant threat to life or physiologic function.

CPT notes that, “The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M services.”³ (NOTE: CPT does not ascribe typical times to the ED E/M codes.)

NOPP helps define the severity of each case. CPT defines NOPP as “...a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.”⁴ Much of the definition relates to the patient’s initial presentation but it also deals with current diseases, conditions, illnesses or injuries for which the patient may seek care or which might act as comorbidities. Symptoms relate to the history received and subsequently recorded, whereas the signs and findings refer to what the clinician found and then recorded during the patient exam and following diagnostic testing.

- **Code Choice Summary:** Consider listing the levels attained for History, Exam and the MDM. For example:
 - History: Comprehensive
 - Exam: Comprehensive
 - MDM: High

Then include the appropriate Evaluation and Management code given the History, Exam and MDM that is documented on the chart. Be sure to add any other procedures that were performed and the appropriate modifiers for each.

- **CPT Clinical Examples (Note: It is a good idea to list the edition, year, Appendix and page in the CPT Manual that is being reviewed such as CPT Manual, Professional Edition, Appendix C – Clinical Examples pgs. 599 to 600 for the chosen code level. Also, the CPT Edition referenced should be for the same year as the Date of Service for the respective chart that is being reviewed).** If the

³ 2012 CPT Manual, Professional Edition, pg. 9.

⁴ Ibid, pg. 7

example that you reference in your audit response template is a level below your chosen E/M level, you should explain why the particular case in question was more intensive and therefore mandated a higher E/M code choice. If it is hard to defend the higher E/M level, then you may consider not including examples from the CPT manual. If an example in the CPT Manual is similar to the case you are reviewing, it should be included in your response.

10. EMTALA-related Care: Many governmental auditors may not be aware of EMTALA and its requirements. It may be helpful to educate the auditor about federally mandated services, and how the emergency department is required to provide a medical screening exam to determine if a medical emergency exists. This includes any medically necessary studies ordered along with therapeutic intervention meant to help stabilize the patient. EMTALA requires a service but does not really affect the level of coding or service provided.

11. Medical Necessity of Ancillary Studies and Therapeutic Interventions ordered: This section should contain a summary of the differential diagnoses that were entertained by the clinician when the various ancillary studies or therapeutic interventions were ordered. This differential diagnosis can be further explained to better assist a governmental auditor in understanding the significance and severity of each case. This section should be constructed with the assistance of your medical director or the clinician involved in the case that is being reviewed.

IX. Potential Responses to Auditor Down-coding Determinations

Some payer auditors frequently cite reasons for down-coding charts that are not common in the emergency medicine coding industry. This section identifies the most common reasons that auditors cite for down-coding records, and recommends strategies for each that should be worked into audit responses.

Some of the reasons that many coders and auditors cite as reasons for down-coding of emergency medicine records include:

1. Medical Necessity: Frequently, auditors' responses state that they do not believe that either the ancillary studies or the therapeutic interventions ordered were medically necessary given the patient encounter in question. Since the various medical directors employed by government payers are frequently not trained or experienced in the practice of emergency medicine, they may tend to concur with their auditor's line of reasoning.

"Medical Necessity" is defined as: "Healthcare services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or

rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is:

- a. In accordance with generally accepted standards or medical practice;
- b. Clinically appropriate in terms of type, frequency, extent, site and duration; and
- c. Not primarily for the convenience of the patient, physician, or other health care provider.”

In the ED, a patient can present with one or more complaint(s) and/or medical conditions. The clinician (emergency physician, Physician’s Assistant or Nurse Practitioner) addresses the chief complaint(s), elicits a history, perhaps reviews the nurse’s notes, and in the process develops an early impression of possible diagnoses. The practitioner performs an exam, and refines the differential diagnoses. The clinician determines what ancillary studies are required to rule out this working list of potential diagnoses. In addition, the working differential diagnoses also lead to the therapeutic interventions that need to be administered to the patient while the ancillary studies are being performed. The working differential diagnoses are developed throughout the historical review and a physical exam intermixed with the provider’s clinical training and experience

These working differential diagnoses drive the medical necessity for the ancillary studies and therapeutic interventions ordered at the time of visit. This list of diagnoses is based on direct patient contact that should not later be second guessed by someone who evaluates a chart well after the date and time of service. In addition, the payer’s auditor who is likely not a practicing emergency medicine clinician or the payer’s medical director who probably is not residency trained or clinically experienced in emergency medicine, may not be able to accurately determine the medical necessity of an emergency clinician’s care in many cases. Only the actual emergency clinician who determined the working differential diagnosis that drives the ordering of appropriate ancillary studies and therapeutic interventions should determine medical necessity of each case reviewed.

- 2. How should the ancillary study workup or therapeutic intervention determine the level of Medical Decision Making?** Along with History and Exam, Medical Decision Making (MDM) is one of the key components of code selection. The documentation of the key components of History and Exam along with the ancillary studies and the therapeutic interventions ordered must all be medically necessary for each case. The level of MDM should be based on the definitions of MDM as presented in the *AMA’s - Current Procedural Terminology* and the *1995 - Medicare Documentation Guidelines*.

The AMA Current Procedural Terminology, (CPT) and page 10 of the 1995 Medicare Documentation Guidelines each states:

“Medical Decision Making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- 1. The number of possible diagnoses and/or the number of management options that must be considered;*
- 2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and*
- 3. The risk or significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.”*

Given these statements and the uniqueness of the practice of emergency medicine, the following summaries and conclusions can be reached:

MDM Definition - Subsection One:

- **The complexity of attempting to establish a diagnosis relies in part on ancillary studies such as laboratory, x-rays, and/or Special Studies (CT scans, MRIs, Ultrasounds, V/Q scans, IVPs, etc.) ordered.** These studies are ordered by the emergency clinician to investigate the potential presence of any plausible diagnoses from the “working differential diagnoses” the provider considers while obtaining the patient’s history and/or performing the physical exam.
- There is NO mention of a required minimum number of ancillary studies that must be considered or ordered in order to establish a diagnosis. The ancillary studies that the clinician plans are medically necessary and take into account the standard of care in the community, the clinical training and experience of the emergency medicine provider, and medico-legal considerations for the local area, the state, and the country.
- Planned ancillary studies can certainly be performed during the emergency medical visit and not await the conclusion of the patient encounter in the emergency department. Every phrase in these references verifies the application of MDM level to the patient visit in its entirety, and does NOT include timeframes following this visit such as a referral to other clinicians after the emergency visit disposition has been made. Furthermore, it is sometimes useful to remind the auditor that the ability to obtain necessary diagnostic results during the patient encounter is both effective and efficient patient care. For example, it’s not unusual in office-based practice that diagnostic testing is decided at the time of the initial visit; samples are obtained in the office or the patient is referred to another location for testing; and the patient is scheduled for a follow-up office visit at which time the results will be addressed.

MDM Definition - Subsection Two:

- Review of medical records, communications with other relatives or other healthcare providers, and visualization and interpretation of various studies are also included in this area of MDM.

MDM Definition – Subsection Three:

- This subsection focuses on the potential for increasing morbidity, co-morbidity, and mortality of the patient’s medical condition(s).
- This subsection also directly relates to those procedures that were performed, and the management options that were ordered to treat or further evaluate any presenting problem(s).
- Management options in the emergency department generally include many of the following:
 - Oral, rectal, topical, sublingual, nasal, eye or ear medications.
 - IM, subcutaneous or IV medications.
 - Nebulizer or inhaler treatments.
 - BiPap or CPAP.
 - Laceration repair or incision and drainage of various abscesses.
 - Endotracheal intubation, non-tunneled catheter insertion or other procedures such as spinal taps or thoracostomy tube insertion.
 - Determining the patient’s final dispositions including discharge, admission to hospital, placement in observation, and transfer to another facility or pronouncement of death.
 - Determining where the patient should be admitted to including the ICU, CCU, and SICU, regular bed or telemetry.
- The cases that have the highest potential for significant complications, morbidity, and co-morbidities are the ones where comprehensive workups and therapies are provided in the ED. These types of cases includes patients presenting with chest pain, abdominal pain, shortness of breath, changing mental status, or other conditions that may require ancillary studies and therapeutic interventions such as IV fluids, medications, nebulizers and the like. These patients may ultimately be discharged after their workup and/or therapy depending on how they respond to therapy and the results of their studies.
- Patients who require admission as an inpatient or transfer to another facility for admission are very frequently cases with a threat of mortality or significant morbidity. Of course, inpatient admission is not an absolute indicator for more complex MDM. Quite often, potentially serious presentations requiring substantive investigation with eventual discharge away from the ED demand the same extent of MDM as patients who are admitted as inpatients. In fact, sometimes such discharged patients involve a little higher risk.

Generally, regarding a patient's medical condition and managements, page 11 of the 1995 Documentation Guidelines states:

Number of Diagnoses or Management Options

The number of diagnoses or management options and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that of an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator or complexity of diagnostic or management problems.

Given these statements and the uniqueness of the practice of emergency medicine, the following conclusions can be reached:

- a. Of prime importance are the number and types of problems addressed DURING the encounter, not after the encounter.
- b. The complexity of establishing a diagnosis is related to the number and types of laboratory studies, x-ray series, and Special Studies that are ordered by the clinician. Generally, with increasing case severity the number, intensity, and types of orders increase.
- c. The MDM complexity of the management options selected by the physician is generally determined by the types, numbers, and routes of administration of various medications. In addition, the ordering of IV fluids and the speed of infusion, the number and types of nebulizers given, the procedures performed, and the final dispositions of the patient combine to elevate the severity level of a case.
- d. Decision making for a diagnosed problem (as is seen during established visits in Family Practice, Internal Medicine, Pediatric, and other office visits) is frequently easier than decision making for an undiagnosed problem or problems like those commonly seen in most emergency department visits. Undiagnosed problems have an enhanced level of MDM as compared to established visits in an office setting where the clinician is aware of the patient's condition due to routine office visits.

The 1995 Documentation Guidelines also state:

DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

Given these statements and the uniqueness of the practice of emergency medicine, the following summaries and conclusions can be reached:

- a. The statement above does not mandate that the clinician list all or any “working differential diagnoses” for the studies ordered or the therapy provided. Implied documentation indicates that the clinician who elects to order various medically necessary studies has a differential diagnoses in mind when these studies are ordered. The case-specific differential diagnoses are derived due to the clinician’s residency training and clinical experience. The appropriate “working differential diagnoses” can generally be ascertained by other clinicians with similar training and experience.
 - b. Even though these “working differential diagnoses” do NOT technically have to be documented on the chart, documenting them should help the hospital incorporate select diagnoses when ordering the various studies, and assists the clinician in future audit defense based on medical necessity.
 - c. The results of these ancillary studies permit the clinician to establish a more exact primary impression or principal diagnosis at the conclusion of the visit.
3. **“No acute distress”**: Emergency medicine coders and auditors are commonly swayed in code choice when a clinician documents “No acute distress” in the constitutional part of the exam. Coders and auditors are often under the impression that this statement indicates that the patient in question does not require extensive therapy or workup, and that the patient’s presentation does not pose an immediate threat to life or physiologic function.

To the contrary, emergency physicians and other ED healthcare personnel (e.g., Non-physician Practitioners (NPP), nurses) are trained to use this statement to represent that a patient does not require immediate airway management that would potentially necessitate endotracheal intubation or other lifesaving interventions such as immediate IV access for fluids and/or IV medication. The entire medical record including comments from other ancillary personnel such as the ED nurse should be used in addition to such “no acute distress” documentation since all areas of the chart can be used to substantiate the patient’s condition and level of services required and performed. This statement does not in any way exclude this case from being a high risk, high severity case with an immediate threat to life or physiologic/bodily function. In some circumstances having this

statement on the chart might weaken “Critical Care” code selection, but should have no impact on the choice of CPT Code 99285.

- 4. Emergent Hospital Admission:** The majority of emergency medicine coders and auditors have limited to no clinical experience in emergency medicine. They are not familiar with the medical decision making steps that are performed by the clinician and result in the decision to request hospital admission post-evaluation and management in the ED. Clinicians request admission for these patients because they believe that these patients run a high risk of increased morbidity and mortality if discharged from the hospital setting. Because of the high incidence across the nation of boarding admitted patients in the emergency department, the clinician must, out of necessity, be very selective before making a request for admission. Clinicians understand that admitting patients may mandate that they occupy beds in the ED for an extended time period, sometimes for days following initial evaluation and management. These cases are therefore most commonly high severity cases with an immediate threat to life or physiologic/bodily function.
- 5. Dynamically Evolving Standard of Care:** Many coders and auditors are unaware of the changing standard of care in the practice of emergency medicine, and how it directly relates to the increase in the number and percentage of comprehensive workups and therapies performed in the emergency department. These more extensive workups and increased therapeutic interventions are performed to avoid inpatient admissions that would have been deemed mandatory only a few years ago. The type of patient described above is commonly one with abdominal, flank or chest pain, shortness of breath, or changing neurologic status. Just a few years ago, this patient would have been emergently admitted for a workup and ongoing inpatient therapy for intractable pain, shortness of breath, or changing neurological status. Currently, instead of admitting these patients, the emergency clinician orders comprehensive workups including various Special Studies such as CT scans, Ultrasounds, and MRIs - in addition to providing initial therapy - all in an attempt to mitigate the need to admit the patient to the hospital. These cases, even without an emergent inpatient admission, represent cases that are of high severity with an immediate threat to life and physiologic function and requiring extensive workups and initial therapy.
- 6. Normal or Negative Studies:** Coders and auditors should not be influenced by normal or negative results on laboratory studies, x-rays, or Special Studies such as CT scans, Ultrasounds, or MRIs. These ancillary studies are ordered to rule out and/or verify the existence of various working differential diagnoses that are being considered by the clinician. In that context, both positive and negative findings have significant, substantial informational content. In a very high percentage of cases, ancillary studies ordered by the emergency medical clinician are medically necessary and are used to thoroughly explore the causes of the many chief complaints and/or presenting problems that are seen daily in the nation’s

emergency departments. Negative or normal lab studies, x-rays, and Special Studies should in no way diminish either the overall significance of the case as a high severity one, or decrease the extensive differential diagnoses that these studies have ruled out. Coders and auditors reviewing cases with negative or normal lab studies, x-rays, and Special Studies should not automatically assume these cases are of low to moderate severity when the majority is in fact high severity cases with an immediate threat to life or physiologic/bodily function.

- 7. Basing Code Choice Solely on the Chief Complaint or the Presenting Problems:** Sometimes coders and auditors select an E/M code based solely on the chief complaint or presenting problem. It would certainly be less risky for both the patient and the clinician if things were that straightforward. While the presenting problem is often an important determinant of case severity, sometimes it's not. And it usually takes an astute clinician to make the determination. For example, a patient with a chief complaint of a sore throat may go from a mild case to a moderate case if the clinician asks the patient to gargle with salt water, or take OTC Tylenol™ for pain and temperature. If that same patient eventually required IV fluids, IV medications, CT scans of the neck for peritonsillar or retropharyngeal abscesses that may require drainage in the Operating Room with emergency admission. Along with a comprehensive History and Exam, the clinician's medical decision making efforts regarding ancillary study workups, therapeutic interventions, and dispositions must influence a coder/auditor's final Evaluation and Management code choice. Focusing solely on the chief complaint to choose a final code level inappropriately discounts the differential diagnoses, the therapies selected, the workup activities of the clinician, and the decision to admit that is made in an attempt to prevent increased patient morbidity and possible mortality.
- 8. Basing Code Choice on Final Diagnosis.** Coders and auditors frequently select an E/M code choice based solely on the final or principal diagnosis that is submitted via electronic transmission or paper claim. This code choice methodology is not appropriate because it does not consider the actual therapeutic and diagnostic efforts of the clinician. As illustrated in the example of the patient who presents with a sore throat, the patient may have a final diagnosis of acute pharyngitis or posterior pharyngeal cellulitis only after the clinician had ruled out an extensive peritonsillar or retropharyngeal abscess with a CT of the neck and administration of IV fluids and IV meds including pain meds and an antibiotic. Along with a comprehensive History and Exam, the clinician's efforts should influence a coder/auditor's final Evaluation and Management code choice. Focusing on the final diagnosis to choose a final code level discounts the differential diagnosis, the therapy that was provided, and the activities of the clinician that were intended to prevent increased patient morbidity and possible mortality.
- 9. Using the time it takes to workup, treat, and then finally determine the patient's disposition.** Throughput time in an emergency department is variable and

inconsistent. Patients are managed by way of a triage or sorting process where the more acute patients are evaluated and treated before the less sick patients. EMS or Rescue patients can arrive at any time, potentially disrupting patient flow through the emergency department. A department may have a throughput time of 2.5 hours as an average, but this can increase given large patient volumes, higher acuity patients, and the inability to move admitted patients into the hospital proper thus tying up patient care rooms that would otherwise be open to other patients seeking emergency care.

Some coders and auditors have reviewed various patient records and have noticed that triage, workup, therapy, and disposition took an exceptional number of hours. These same individuals have responded by saying that “If the time of workup and care took that long, the patient could not have been that sick and subsequently should not have been coded at the highest Evaluation and Management levels.” This statement and similar statements are inconsistent with CPT coding precepts that preclude the use of time to determine the Emergency Department Services Evaluation and Management codes, and they fail to acknowledge the extensive workups, therapy, and final patient dispositions of these high severity cases. These patients had conditions that warranted large workups and may have also mandated therapy in the emergency department. Regardless of the amount of time that passed from triage to disposition, the correct documentation of the History and Exam intermixed with the high level of Medical Decision Making allows the choice of the higher level E/M codes since these cases are high severity cases with an immediate threat to life and physiologic function. Time should not be a factor in code choice for emergency medicine E/M codes.

10. “Sudden and Serious” - a condition that warrants further investigation or therapy.

Various payers have used the term “sudden and serious” during chart audits. A patient may have a condition that has been present for several days before he or she decides to visit the emergency department, prompting payers to determine that the case could not have warranted the ancillary studies and therapeutic interventions that were ordered. If the presenting problem was not sudden and serious, the payer maintains that medical necessity was not present to justify the work-up, interventions, or the level of service reported.

When evaluating and managing patient conditions that have been present for multiple days, it is critical to document the reasons why the patient problem warranted the necessary workup and therapy. Additionally, if the condition worsened with increasing severity or a change in symptoms, it is imperative to document as much in the initial areas of the chart.

Commercial Plan Audits: Responding to Commercial Plan Audits

This topic is well covered in the first part of this Section above. However, responding to commercial claims audits and recoupment demands will likely rely on different, and not necessarily published, procedures and rules. At least 24 states restrict or otherwise place requirements on a payer's ability to recoup overpayments. For example, a number of states impose specific time limits for payer overpayment recoveries. Also, payers might be required to grant due process rights to physician practices when these practices wish to dispute alleged overpayments, and States frequently require payers to give the physician practice advance notice and detailed information prior to recouping funds. Therefore one of the first questions that should be addressed when you are notified of an audit or repayment demand is: has the plan or its audit contractor exceeded the time frame allowed by regulation in your state, or in your contract with the plan, for seeking repayment. However, most such regulations (and contract terms) often contain a time-limit exception when fraud is suspected, or for self-funded plans.

In some states, larger capitated medical groups can be delegated to pay the claims of in-network and even out-of-network providers. These are so-called Risk Bearing Organizations (RBOs). Note, if your practice has to look to RBOs for payment, these RBOs may or may not be subject to the same regulatory oversight that their contracting health plans are subject to, and they may have their own audit and appeals processes. As capitated groups, these RBOs have a smaller portion of the insurance premium to work with, and thus can be even more aggressive than their contracting plans in terms of attempting to reduce their costs for emergency care services. They may also be using less well trained or non-credentialed claims managers or coding reviewers, resulting in even more disputes with providers over coding issues. (Note, when RBOs fail to comply with State payment or audit regulations, and regulatory oversight of these RBOs are uncertain or inconsistent, it may be possible to hold the health plan responsible under the concept of negligent delegation.

If the provider is contracted with the commercial payer, the rights and obligations for both parties specified or referenced as payer policy within the contract typically cover the conduct of retrospective audits, and hopefully procedural protections for the provider. Physicians should aggressively pursue their rights and understand their limitations under their contracts. If audits are not specifically addressed in the contract, physicians should look to general provisions addressing offsets or adjustments that allow the payer to deduct payments otherwise due to physicians or adjust contract payments. Provisions of the contract that address medical necessity may also greatly impact the audit results, especially if the contract gives the payer full discretion in determining the medical necessity of a particular service. Provisions dealing with access to medical records should also be reviewed. These provisions may either protect physicians from inappropriate health insurer requests for access to records or give health insurers free access to the requested health records.

As with government payer audits, commercial plan audits typically begin with a time-sensitive request for documentation. There are generally no limitations on the number of records that a private payer may request. Depending on your state law or your participation contract, there may be limitations on the period of time that may be audited. In addition, you may be requested to sign a document indicating that the records provided constitute the entire medical record, which may restrict your right to provide supplementation of the records on appeal. Given that there can be significant consequences (including substantial financial penalties and/or criminal proceedings) emanating from a records request, ceding rights, and adverse audit outcomes, it is advisable to obtain legal advice early on in the response process. Clearly notices from a commercial plan alleging possible criminal misconduct on the part of the provider should always be handled by an attorney.

When the practice becomes aware of a records request/audit notice, this should be brought to the immediate attention of your compliance officer or appropriate designee. This individual should quickly decide who will act as the primary intermediary to the payer or its representative. This helps to assure that things do not “fall through the cracks” regarding meeting deadlines, etc. It would be advisable for this individual to contact the plan directly (by certified mail) to clarify the steps for responding to the records request notice and the audit. It could also be helpful to establish a primary contact at the offices of the plan or audit contractor. This person would become the main conduit for all information related to the specific audit in question.

Many audits have strict deadlines for a response. Unfortunately, audit notices are sometimes sent to the hospital instead of the provider and that can reduce the amount of precious time needed to respond to an audit. In some instances a payer can have already obtained the legal copy of the medical records from the hospital. Therefore it can be helpful to maintain good relations with the hospital’s Medical Records department, and agree to inform each other of such notices if appropriate.

Sometimes a provider may receive a letter from a payer that seems intended to ‘educate’ the provider. The letter may state “the utilization of high level emergency E&M services is significantly higher than those of your like-specialty and geographical peer group.” The letter can be a warning that an audit is forthcoming. It would be wise to respond to these letters in the same manner as an official audit notification. A comment in the government segment of this Section bears repeating: before responding to a request for multiple records from a commercial plan, it is important to attempt to obtain a very detailed explanation as to the purpose and intent of the records review, the specific information that the payer needs, and whether or not the plan intends to disclose any of the information to a third party. However, lack of such explanations may not relieve the provider of the obligation to provide these records, especially in contracted claims situations.

All correspondence with the plan or auditing contractor should be dated and page stamped, and either copied or scanned prior to submission. You should also send all documents by certified mail or another delivery mechanism that provides tracking and verification of receipt. Be sure to retain receipt verification. When providing medical records in response to an audit request, it is important to understand how the commercial payer determines whether the documentation in the record supports the coding of your claims (and the qualifications of the claims reviewer), and to make sure that, as much as possible, all the components of the medical record containing these elements of documentation are provided. A review of the payer's specific documentation and coding policies, especially if readily available, might be helpful in this effort. Like government payers, commercial payers can choose to apply different coding and documentation standards to your claims, and not infrequently will apply a combination of NCCI (National Correct Coding Initiative; a Medicare perspective), CPT, and plan-specific coding rules.

In addition to the recommendations regarding responding to a government request, it may also help to understand that one of the most frequent issues in dispute between commercial plans and emergency care providers is the determination of the level of E/M services coded in the claim, in part because commercial plans may feel no compulsion to adopt or comply with either Medicare or CPT coding rules. Commercial payers frequently do not understand that the few clinical examples in the AMA CPT coding manual for the 99281-99285 codes are supposed to represent the 'median' or typical level of acuity and nature of presenting problem (NOPP) for these codes, and not the threshold for these codes. Audited claims may be 'down-coded' by plan auditors based on this mistaken assumption. Another approach that commercial plans often use in the initial review or formal audit of claims is to down-code the E/M service primarily on the basis of the final diagnosis on the claim, rather than on a consideration of all of the elements of medical decision-making included in the medical record. The government segment of this document provides an excellent review of the issues related to documentation that supports E/M service coding.

Commercial plan audits are also subject to HIPAA rules, and though these rules do not require patients to authorize the release of private health information to the patient's insurer that pays for the service(s) for purposes of conducting an audit, physicians are responsible for ensuring that only the "minimum necessary" information is made available. However, it's usually to the benefit of the practice group to provide as much relevant information as possible in order to support the claim, and most often the insurer has already received a claim with indications of diagnoses and services. If the situation is one of prospective review, and/or there is something in the documentation of a sensitive nature that does not readily pertain to the claim at hand; legal advice should be obtained.

Once the practice learns that a commercial plan is initiating an audit or has an ongoing audit, it could be helpful for the provider group or its attorney to contact the plan for clarification of the purpose, focus, and nature of the audit. Inquiries to the health insurer at this point would mostly likely be procedural, since the retrospective audit is probably

still in its initial phase—that is, the health insurer suspects (e.g. through a review) that some billing or payment errors have been made, but the scope of, and reasons for, such occurrences may not have yet been determined.

Assessing the risk of adverse findings from a commercial audit:

Once a practice learns a commercial plan audit is occurring, it should assess the potential for financial and legal liabilities. These are usually predicated on whether the audit is focused on E/M documentation and coding, or on a particular code or code combination used by your coders, or on some particular aspect of your coding that is out of the norm for you're a practitioner's indicated specialty. Because in certain instances such reviews are discoverable, whether such assessment is performed totally in-house, by some external entity, or a combination of the two should be discussed with your attorney, and hopefully, protected under attorney-client privilege. These risk-analyses should be performed, on a chart-by-chart basis, using coding guidelines specific to the payer if they are available, and also to compare the charts and claims against your own internal coding guidelines, but only under the direct auspices of your compliance program director or attorney. Outside consultants may be used to assess this risk and the appropriateness of you billing office's claims coding, if you wish. These risk assessments may in certain instances be discoverable. Since commercial plan revenues often form the bulk of ED group revenues, commercial plan audits can have significant impact on group finances.

Analyzing commercial plan audit findings:

Once a commercial plan has received the requested medical records and completed the audit, the plan will typically provide a report of their findings, along with a demand letter for recoupment of any overpayments identified. It is likely that the commercial plan's audit findings will differ significantly from what you or your billing entity believes are the appropriate way to code the documentation of the cases assessed in the audit. Like government auditors, commercial auditors, and their audit contractors, may not be trained or experienced in coding emergency care claims, assessing medical necessity in ED care, or understanding the implications of EMTALA. Section VIII and IX identify the steps that should be taken in analyzing the audit results for each claim assessed in the audit against the documentation in the record and your initial coding of the claim, and responding to the audit report, with special emphasis on E/M level coding disputes. Chart summaries, as mentioned on page 22, and completed Marshfield Clinic coding tools are very helpful in getting commercial plans to recognize your billing expertise in ED claims coding, and in demonstrating your claims coding compliance process. Whether or not you agree with the auditor's reasoning, you should assess the statistical and mathematical validity of the repayment demand. Some payers will initiate recoupments directly from future payments of different claims than those that were audited. This can be particularly problematic when it comes to claims accounting procedures.

If the plan has identified claims coding errors that your analysis reveals were in fact coded incorrectly, you should submit repayment to the plan and advise the plan of any corrective action plan you intend to make to ensure that these errors will not be repeated. Many emergency medicine groups believe that paying an entire modest recoupment demand amount is the easiest and least time-consuming option, but failing to appeal, without any change in billing patterns, could result in a continual cycle of similar documentation requests, claims denials, and recoupment demands.

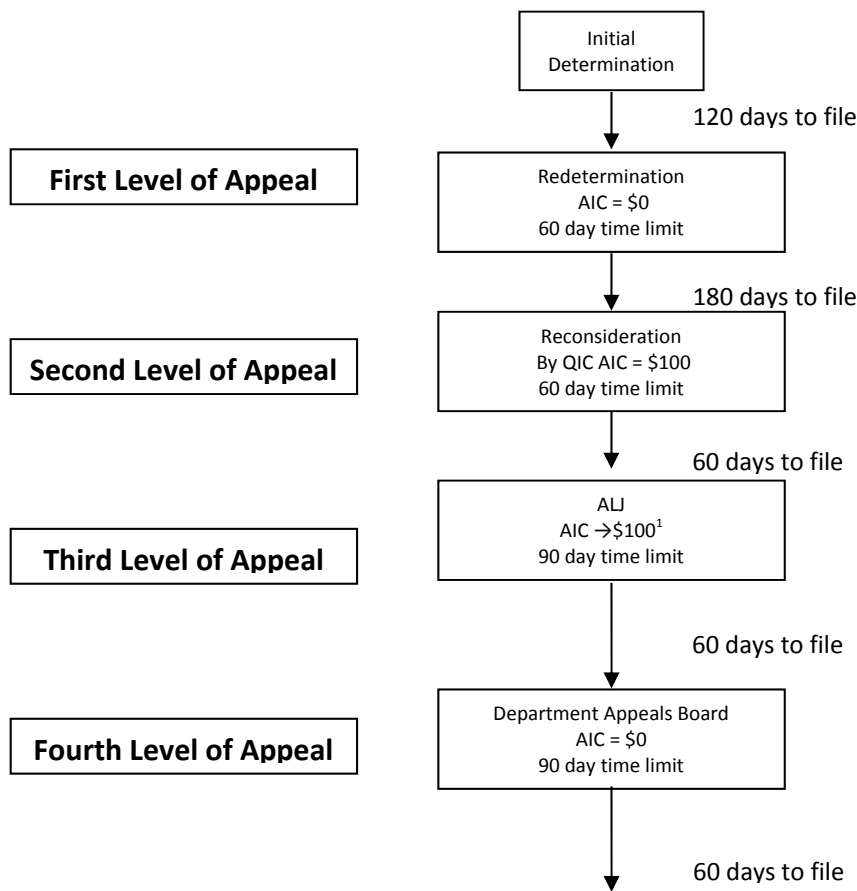
X. What are the next steps if the governmental auditors continue to reject your responses?

NOTE: Because failure to compile and submit certain information at an early level of appeal can foreclose the opportunity to present such information at a later appeal stage, it is advisable to involve legal assistance in your appeal preparation process as early on as feasible.

The order of the response mandated by CMS and illustrated below is:

1. First Level of Appeal: Redetermination
2. Second Level of Appeal: Reconsideration
3. Third Level of Appeal: Hearing by an administrative Law Judge
4. Fourth Level of Appeal: Review by the Medicare Appeals Council
5. Fifth Level of Appeal: Judicial Review in Federal District Court.

Part B or Physician's Fee-For-Service Medicare Appeals



As illustrated above, there are five levels of appeal for Medicare following the initial determination. The initial determination is the first step in the Medicare claims appeal process and represents the opening response to the claim by the Medicare contractor. The initial determination will likely be in the form of a Medicare Summary Notice (MSN) or as part of a future Remittance Advice. It is important to note if the denial was based on a technical deficiency such as missing signatures, incorrect demographics or incomplete paperwork since these claims might be considered non-appealable as they represent an incomplete claim. The initial determination is binding unless reversed in subsequent appeals.

The first level appeal is called a **Redetermination** and replaces the former Part B's review process. While this was previously performed at the carrier level, it is now handled by each specific MAC. The previous Carrier fair hearing process at this level has been abolished as of January 2006. Prior to 2006 provider testimony was allowed whereas the "new rules" do not allow provider testimony until much later in the process.

To start the **Redetermination** process, CMS Form 20027 should be completed and returned to the contractor who issued the initial determination. A copy of CMS Form 20027 can be downloaded here:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS20027.pdf>

The regulations and steps for **Redetermination** are as follow:

- Requests must be made within 120 days of the initial determination.
- The contractor has 60 days to respond, but has no right to escalate to the next level if the contractor does not issue a decision within a 60-day time frame.
- The contractor has more latitude to dismiss appeals for technical or procedural defects.
- The **Redetermination** review must be conducted by an individual other than the one who made the initial determination.
- No monetary threshold is required.

It is estimated that 60% of claims are favorably reviewed at the **Redetermination** level.

The second level is called **Reconsideration** and occurs at the Qualified Independent Contractor Level (QIC). Two QICs exist for Part B. Q2 Administrators (www.q2a.com) covers the South Jurisdiction while First Coast Service Options (www.fcsso.com) covers the North Jurisdiction.

To start the **Reconsideration** process, CMS Form 20033 should be completed. A copy of CMS Form 20033 can be downloaded here:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS20033.pdf>

There are certain regulations that must be followed during the **Reconsideration** process including:

- A response must be sent within 180 days of receipt of the **Redetermination**.
- QICs should complete the appeal decision with 60 days of receipt of CMS form 20033.
- Provider testimony is not allowed because testimony exists “on the record (ORT)” so the review is conducted using submitted documentation.
- All evidence is required at the QIC level. New evidence cannot be considered at higher level of appeals.
- **Reconsideration** is considered the last opportunity to submit evidence.
- Medical necessity must be determined by panels of physicians or other “appropriate health care professionals.”
- The QIC may obtain evidence on its own.
- QICs are not bound by Local Carrier Decisions (LCDs), Local Medical Review Policy (LMRPs), or CMS program guidance; however, QICs must give substantial deference to the provider.
- No monetary threshold is required.

The third level of Appeal is considered by an **Administrative Law Judge (ALJ)**. The ALJ resides within the Department of Health and Human Services (DHHS) Office of Medicare Hearings and Appeals (OMHA). There are four regional centers for DHHS ALJs.

To start the **Administrative Law Judge** process, CMS Form 20034A/B should be completed. A copy of CMS Form 20034A/B can be downloaded here:

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20034ab.pdf>

There are certain regulations that must be followed during the **Reconsideration** process.

- The Amount in Controversy (AIC) must be at least \$130 and is adjusted for inflation. Claims may be aggregated.
- An appeal must be submitted within 60 days of the **Redetermination**. The regulations and steps are as follows:
 - Your response should specify which **Redetermination** from the QIC is being appealed.
 - ALJ must decide within 90 days of the receipt of the form at the OMHA’s office.
 - The QICs may participate in ALJ hearings.
 - There is an option for the provider who is appealing to appear in person.
 - Any new evidence can be submitted only for good cause.
 - Oral testimony is allowed.

- The petitioner may request a prehearing conference.

The fourth level of appeal is with the **Medicare Appeals Council**. The **Medicare Appeals Council** was formerly a part of the Social Security Appeals Council, but is now consolidated with the DHHS Departmental Appeals Board. Examples of Appeals Council's decisions can be reviewed at: www.hhs.gov/dab/macdecision

There are certain regulations that must be followed during the **Medicare Appeals Council** process included:

- An appeal must be submitted within 60 days of receipt of notice of the ALJ decision.
- May file briefs and other written statements.
- Medical Appeals Council must make a ruling within 90 days.
- Oral arguments are allowed in special cases.
- The minimum amount in controversy (AIC) may be \$0.

The fifth and highest level of appeal is with the **Federal Court**. There are certain regulations that must be followed during the **Federal Court of Appeals** process. The regulations and steps are as follows:

- An appeal must be submitted within 60 days of the Medicare Appeals Council's decision.
- The minimum Amount in Controversy (AIC) must be greater than \$1,260 which is adjusted annually for inflation beginning in 2005.
- You must file the complaint in the district where the provider is located or in Washington, D.C.
- The defendant is the Secretary of HHS.
- Both parties are provided the opportunities to present their positions.
- Inadequately developed cases will probably be sent back to a lower level of appeal.

Levels of Appeals for Medicaid Denials: Unfortunately, the process of appeals for Medicaid denials is not as clearly defined as is the case with Medicare appeals. The appeals process is determined per state regulations and may be entangled with the state's managed care regulations.

Commercial Plan Audits: Appealing Commercial Plan Audit Findings

Unlike CMS related audits, which have five levels of appeals following an initial audit determination, commercial plans may have fewer steps and fewer options to obtain reconsideration, depending on the contract terms, the plan's appeals policies, or the availability of State sponsored claims 'independent' dispute resolution programs. If the plan's auditors have made substantively incorrect judgments regarding medical necessity, complexity, documentation, coding, etc., the likelihood of overturning a decision on appeal should be fairly good, especially for non-contracted claims. For contracted claims, a lot will depend upon what the practice agreed to do per the executed participation agreement.

Given correct coding by the practice, physicians will want to aggressively appeal the payer action. In appealing a down-code or denial, ED physicians may argue that the payer rules are inconsistent with CMS published guidelines. Unfortunately, commercial payers are not required to follow CMS rules. (It is very helpful to discuss and document the commercial payer's coding and billing guidelines in the contracting process, and even insist that these standards are included in contract terms.) During the initial appeal discussion, if the ED physician is unable to successfully argue that the submitted coding was correct, the appeal may be escalated to the level of the payer's medical director.

Responding to a commercial audit-generated recoupment demand:

Typically, commercial plan audits result in demands for repayment of previously 'overpaid' claims. Sometimes these demands are generated at the onset, when a review of the claims suggests 'overpayment', even before the formal audit of the medical records are conducted. Not infrequently, these demands for overpayment are extrapolated from a small sampling of claims to an entire range of claims submitted over several months or years to the payer. Unlike an overpayment recovery request for an individual claim (which is well covered in the AMA Practice Management Center document 'Questions to consider when addressing payer overpayment recovery requests on individual claims')[See Resources below], recoupment demands that are based on the findings of claims audits often involve the extrapolation of audit findings to hundreds, even thousands, of previously paid claims, and this can seriously undermine a practice's financial viability.

The PAI document entitled 'Medical Audits, What Physicians Need to Know' (pp. 11-13) [See Recourses below] provides an excellent and very thorough discussion of extrapolation in audit recoupment demands. Key points are:

- 1) errors by the plan in extrapolating overpayments offer the provider avenues to appeal these demands;
- 2) if the claims chosen for review are not selected based on statistically valid random sampling, the estimated 'overpayment' is likely to be based on higher than average overpayment amounts;
- 3) test the average paid amount for all claims for this payer against the average paid amount for the audited claims to test randomness
- 4) extrapolation should be based on the median overpayment amount, not the average overpayment amount
- 5) claims paid \$0 (denied payments) and other statistically identified outliers should be excluded from the universe of extrapolated claims

In addition, extrapolation assumes that all of the claims in the universe of claims to which the median overpayment amount has been applied have all been coded in the same way, using the same coding methodology. If your claims coding has changed during that period, this may be a valid way to limit extrapolation. Of course, you will likely have to explain and justify the reasons for the coding change.

Reporting unfair commercial insurer business practices:

You should consider contacting your State medical associations and state ACEP chapters to alert them to any unfair health insurer practices. You can also file a complaint through the AMA's Health Insurer Complaint Form (HPCF). Visit www.ama-assn.org/go/click and complain to access this form. You may also want to alert the government agency that regulates insurance in their State. These agencies may provide remedies that benefit physicians. The National Association of Insurance Commissioners' website, www.naic.org, provides links to each State's insurance regulatory agency.

Billing Errors and Omissions Insurance:

Insurance companies offer products to protect physicians and healthcare organizations from defense costs, fines and penalties as a result of a legal action. The coverage can include cost related to billing errors and omissions. The insurance can cover individuals, employees, officers, directors and partners. The limits of liability coverage can range from \$250,000 to \$5,000,000. Typical deductibles are from \$1,000-\$25,000. Billing Errors & Omissions Insurance will not cover intentionally fraudulent or criminal acts. The premiums for coverage can vary, but expect to spend a few thousand dollars for individual coverage. Billing Errors and Omissions Insurance is frequently packaged in with insurance for Health Insurance Portability and Accountability (HIPAA), Stark Law and Emergency Medical Treatment and Labor Act (EMTALA) regulation violations.

Resources for dealing with commercial plan audits:

AMA members and their practice staff can e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance, call **(800) 621-8335** and ask for the AMA Practice Management Center, or visit <http://www.ama-assn.org/go/pmc> to access the AMA Practice Management Center website.

The Physicians Advocacy Institute (PAI) has also published a white paper entitled "Medical Audits: What Physicians Need to Know" which can be accessed at http://www.ncmedsoc.org/pages/fraud_abuse/PAIMedicalAudits.pdf.7

Advocacy

Due to the importance of State laws regarding contracting and health care insurers, much of the advocacy regarding commercial plan, beneficiary, and provider relationships occurs at the State level. Some Chapters have been especially active in this arena (e.g., California/ACEP). Check with your State chapter to determine its available resources, and especially if you are interested in assisting in its advocacy efforts.

XI. What can be done to adjust or enhance provider documentation to foster successful audit outcomes?

- 1. Re-emphasize proper History and Physical Exam:** Appropriate history and physical exam documentation for the level of care that is coded and billed helps provide a good starting point during any governmental audit. Emergency physicians should use any available tools meant to appropriately enhance chart documentation. Such tools can consist of paper or electronic templated charts, or hand held laminated cards that list all requirements for each section of the history and exam. Tools help remind physicians to document key elements of the history and exam performed, and, if properly used, result in fully-documented charts that will assist coders in assigning appropriate code choice; proper documentation also provides a sound starting point for successful audit defense.

Professional coders are key contributors to a successful documentation, coding, and billing process. A coder's training enables recognition and identification of repeat documentation errors and/or omissions in the history and exam sections of charts. Coders are also able to identify and consult regarding charts exhibiting poor documentation of Past, Family, and/or Social History, or failure on the part of providers to comment on the review of nursing notes, pertinent vital signs, chief complaints, and presenting problems. Poor documentation of one or more key elements of a history and/or exam can result in substantial down-coding despite significant professional efforts on behalf of providers, and contributes to the potential for poor audit outcomes.

- 2. MDM Documentation:** Medical Decision Making refers to the complexity of establishing diagnoses and/or selecting management options. MDM includes the various areas that are addressed in the CPT manual. Providers should focus on proper documentation of MDM in addition to providing an appropriate history and physical exam documentation for the level of care that is coded. The various areas of MDM include:
 - a. The ancillary studies considered and those ordered including laboratory studies, x-rays, Special Studies and EKGs.
 - b. Any medications considered and those ordered for therapy. This encompasses a broad list including IV, IM, subcutaneous, oral, rectal, topic, eye, ear and other medications including those found in nebulizers. The particular medications, route of administration, and frequency should always be documented by the provider.
 - c. IV fluid administration.
 - d. Old record reviews including review of prior admissions and discharge summaries, surgeries, EKGs, lab results, x-ray interpretations, procedures such as cardiac catheterizations, and Special Studies including echocardiograms, CT scans, Ultrasounds, and MRIs.

- e. Conversations with physicians performing diagnostic studies. If the ED clinician discussed an interpretation with a radiologist, as an example, a summary of this conversation should appear on the chart.
- f. Communications with other healthcare providers. This is an extensive list and encompasses the patient's PCP, the admitting or consulting physician, poison control professionals, the psych evaluator, and EMS or rescue
- g. Communication with family members or others such as police or fire professionals.
- h. Direct visualization and independent interpretation of images, tracings, or specimens. This is commonly seen in proper documentation that indicates to all who review the chart that the clinician has directly "looked at the study" and has either reviewed the interpretation of the primary interpreting physician (usually the radiologist) or has performed primary interpretation of the study.

Proper documentation of all of these areas enables coders to select appropriate codes given the services that were provided and helps providers and coding and compliance leadership with audit defense.

- 3. Documenting necessity for tests/treatments:** Medical Necessity documentation summarizes the rationale for ordering various ancillary studies including CTs, Ultrasounds, MRIs, and for performing such procedures as lumbar punctures, non-tunneled catheters, thoracotomy tubes, thoracenteses and peritonealcenteses. Documentation that explains why the clinician ordered these various studies and performed certain procedures is the best protection against governmental auditors who commonly underplay the reasons why the studies were ordered. This includes the differential diagnoses that were entertained by the clinician prior to ordering these studies and performing the various procedures. Documentation that explicitly states those conditions that were being ruled out by the clinician makes it difficult for future auditors and their medical directors to downplay the severity of a case and the reasons why the clinician chose a particular management path.

Payers and auditors, who are usually not clinicians, do not typically know why certain tests or interventions are necessary for a patient. The emergency physician must document the differential diagnoses that lead to the ordering of significant and expensive studies, and the performance of procedures intended to help establish a final diagnosis.

Often there is not a clear connection between the documented history and physical exam and the tests that are ordered because no explanation or differential diagnoses are listed on the record. A chart that reads "Gradual onset of typical migraine headache, patient in no acute distress" may not justify labs, CT scans, MRIs, or a lumbar puncture. Adding the following statement, however, may help summarize the necessity of such a workup: "While this headache is similar in character to previous headaches, the symptoms are much more severe with an

onset that was more abrupt. Therefore, I feel it is more prudent to CT and perform a lumbar puncture to evaluate for life-threatening conditions such as subarachnoid hemorrhage.”

4. **Chart Summaries:** This is an excellent way for a provider to demonstrate to the auditor why a patient required the level of workup and intervention that was ordered and completed. Summarizing thoughts and actions in a few brief sentences can help prevent denied payments and/or chart reviews. A sample summary statement might read: "The patient presented to the ED with signs/symptoms suggestive of _____, which because of its threat to the patient's health caused me to initiate an immediate evaluation and treatment plan that included _____, _____ and _____. The conclusion of this patient interaction revealed the patient to be ___(stabilized/ in need of further specialty consultation and/or admission/ in need of further evaluation or treatment as an inpatient/in need of further evaluation or treatment as an outpatient/ in need of admission to the OR/ICU/etc because of _____)."
5. **Caution Regarding Templated Paper Charts and Electronic Medical Records:** As documentation methods make it easier to record events, it is imperative that providers are careful to document only those services which were actually performed in the current encounter.

XII. Avoiding an Audit

It is no secret that avoiding an audit is far more preferable than responding to one! Here are some suggestions on how to appropriately manage your business and avoid being the target of an audit.

1. **Proper ED chart documentation:** Proper documentation of an ED chart is a must. At a minimum, providers should follow published AMA and CMS guidelines for chart documentation. Such guidance can be found online at ACEP’s website at www.acep.org.
2. **Proper coding and billing:** Appropriate coding and billing of ED charts is the second most important step in the patient-to-bill process. Very few emergency physicians are knowledgeable enough about coding to code their own charts while concurrently avoiding mistakes and guaranteeing efficient patient flow. The majority of emergency physician groups utilize coding and billing companies, whose staff members are usually experts in both. Particular knowledge of the multiple compliance considerations, coding rules, patient privacy laws, billing regulations, and payer policies are vitally important in correctly navigating coding and billing processes.

3. **Internal audits:** Regular internal self-audits ensure that coding and billing operations comply with existing laws, regulations, and polices. They also help to guarantee proper reimbursement for emergency physician services. An effective coding/billing operation should have an internal audit plan that ensures compliance and maximum reimbursement.
4. **External audits:** Even the best of coding/billing operations should have their work reviewed by an external self-auditor via regular coding and billing processes reviews by industry experts. External auditing is standard in the healthcare industry and provides the final layer of protection against unknown or overlooked areas of importance. Of course the results of any external self-audit must be shared with the medical group and practitioners.
5. **Easily identifiable documentation errors that should be adjusted include the following:**
 - a. **Improved legibility.** Auditors commonly cite illegibility as the reason for rejection of the various key elements of the history, exam, and MDM. Illegibility can also lead to down-coding, and may impact subsequent billing of any procedures that were performed. All emergency medicine providers must make a concerted effort to have legible written notations on every chart that is not generated by electronic means, or risk loss of legitimate revenue for the many services provided to patients.
 - b. **Signing of charts, attestation of the use of scribes and services provided in conjunction with NPPs.** All charts must be signed by the clinician who provided the care. Depending upon state law, if an NPP provides the care under the supervision of the attending emergency physician, the physician must sign the chart. One of the key areas that can quickly put a claim at risk is the lack of authenticated records/signatures. With the advent of the EHR, charts might be processed before the provider has time to sign off or in some cases, the EHR does not have the proper elements to ensure conformance to a valid signature entry. These EHR related and signature process related issues should be addressed preemptively to avoid these triggers of audits and recoupments.

Additionally, when using scribes, the document must include the name of the scribe who provided the information on the chart, and the physician must attest to the use of the scribe and to the accuracy of the statements included in the chart.

6. **As reviewed prior in the document, we suggest making a special effort to document the more important aspects of Medical Decision Making and Medical Necessity.** These include documentation of the following:

- a. Any communications with other healthcare providers such as consulting or admitting physicians, EMS/rescue, poison control, psych evaluator, case manager, and others.
- b. Visualization and listing an interpretation for EKGs, all x-rays, CT scans, ultrasounds, MRIs, wet mounts, and stool guaiac.
- c. All conversations with family members.
- d. What you found on old record reviews.
- e. The working diagnoses considered, and those used when ordering all ancillary studies and therapeutic interventions.
- f. The severity of the case from the provider's perspective and whether the high severity case does or does not have an immediate threat to life or physiologic function.

7. Documenting any re-evaluations of the patient for such things like shortness of breath, various pain severities, and nausea post-therapeutic interventions. This exercise is not only a help in the medico-legal realm, but it also enhances the decision making provided by the clinician. Documenting date and time of each of these events is also very important.

8. Correction of problems/outliers: Persistent outliers can usually be educated to correct their deficiencies. Specific courses are available both online and in person to address problematic documentation. Additionally, most billing and coding contractors will provide one-on-one instruction for struggling providers. With additional training, most providers will make positive strides toward producing compliant documentation.

XIII. Minimizing the Potential Adverse Effects of an Audit

1. Compliance Plan and Program: A well-written Compliance Plan and implemented Program should be based on the OIG Model Compliance Plan (for both physicians/physician groups and coding/billing companies). It is important for all entities involved in coding and/or billing operations to have such a plan/program, as it is the first step in proving to the auditing authorities that you intend to follow proper coding and billing processes and procedures.

The OIG Model Compliance Plan can be accessed here: <http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf>

Actually using the plan for internal audits, though, is the next imperative for internal compliance. A good compliance plan identifies processes and/or procedures that are to be followed in a step-by-step manner. Documentation of use of the plan in oversight and correction is the final step in the use of a compliance plan, and can mitigate penalties that may be levied against a group who is found to be inadvertently coding and billing inappropriately.

- 2. Audit Response:** An ED Group's response to an audit will set the tone for the audit and the auditor's findings. Some specific suggestions that will help to ensure the success of an audit include:
- a. Suggest that groups/clinicians consult with their legal advisors, in order to preserve appeal material rights, as early in the process as feasible
 - b. Promptness: Respond promptly, and in advance of any recommended deadlines.
 - c. Politeness: Written and verbal responses should be fashioned in a manner that is polite and non- belligerent.
 - d. Thoroughness - Your response should include detailed explanations for the rationale behind your decisions. It is not the auditor's job to "read between the lines." References that support your reasoning should be included in your response.
 - e. Be "teachable"- Ensure the auditor that you are using your very best efforts to follow an extremely complex set of rules and policies and, if you have incorrectly interpreted one, that you would appreciate their assistance in explaining the rule to you.
 - f. Be the expert - Many auditors have very little training and/or experience in clinical medicine and some have limited experience in specific emergency medicine coding or billing. If you do have particular expertise (especially if you employ certified coders and professional billing services), remind the auditing entity that you have special expertise (e.g., millions of charts) and that you maintain this expertise via ongoing education and training.
 - g. It is imperative that you include the respective clinician and/or group's medical director in any appeals discussions. Having the clinician and/or medical director contribute medical knowledge, especially related to medical necessity and severity of the case, is critical to the overall success of the appeals process.
 - h. Extend an "Open House" invitation - Extension of a sincere invitation to the auditing entity to visit your coding/billing operations demonstrates that you want to promote a spirit of teamwork and that you have nothing to hide.

XIV: Conclusions

While the information in this document will help minimize audit exposure, the chances remain high that eventually all groups will be audited by either governmental or non-governmental payers. The best defense is a well-documented chart that is precisely coded to CPT guidelines and the appropriate CMS documentation guidelines and regulations.

Having a chart professionally coded and/or reviewed by a Certified Professional Coder can be useful for emergency physicians who are trying to comply with an ever changing myriad of coding guidelines. Internal auditing by your billing and coding company and external

self-audits from other coding professionals can help find problems and allow you to correct them, thus lowering your risk when faced with a payer audit. Prompt review and creation of a comprehensive response that includes detailed information for each of the charts being audited may shorten the appeals process. In addition, a robust compliance plan and program may ultimately also mitigate various adverse rulings and/or consequences from the payers... as long as you are following it.

RAC auditors are motivated by incentive payments that are tied directly to any “savings” generated by down coding charts. Many governmental and non-governmental auditors are not professional coders (and neither are many emergency physicians). Most payer auditors have minimal to no clinical experience, though they usually do have coding and prior auditing experience. RAC auditors rely then on their medical directors to help them with medical issues, medical necessity, and severity of each case.

Though not widely recognized by auditors, most emergency patients are more complex than the usual office patient thus again making it imperative to document the patient’s complexity along with the medical necessity for both the studies and therapeutic interventions ordered. Having the emergency clinicians provide appropriate chart documentation to include listing of their working differential diagnoses while also stating a case’s level of severity will help counter a variance in opinion generated by the payer’s personnel or medical director.

Successful defense of a chart that demonstrates insufficient documentation of the History or Exam is very difficult. Appropriate documentation of these areas is critical because insufficient documentation makes audit defense a difficult task, and because it may generate more extensive future audits. Pay particular attention to proper History and Exam documentation with all your emergency medicine providers. Frequent remedial training is warranted to diminish the percentage of records that contain poorly documented History and Exam sections.

Documentation of medical decision-making also has a distinct influence on code choice. Many physicians do not properly document their work beyond a history, physical, notation of the results of studies, and a final diagnosis. Emergency physicians should remember to document the medical necessity for diagnostic studies and therapeutic interventions. They must also document old record reviews, conversations with family, EMS, clinicians interpreting any studies obtained, independent visualization and interpretation of imaging studies/ tracings/ specimens, and consultations sought for further assistance, admission, or transfer.

When audited, physicians must demonstrate E/M code selection(s) as being logical and systematic while following current clinical and governmental guidelines and regulations. And all of this must be evident from the documented complete medical record. Review of the history and exam, along with a detailed explanation of the medical decision-making, is critical to successful audit defense. Obtaining advice from a medical director or another

physician with extensive clinical experience will help generate a defense strategy related to medical necessity and case severity.

Pre-planning and an immediate comprehensive response are critical following an audit request. Preparation of a comprehensive and well-strategized response will help in achieving audit success, and will diminish the chances of future audits from that specific payer. Consideration of all mandated response dates and demonstration of a willingness to fully cooperate with all parties involved including other group members, coding staff, and payer staff members will ensure the best possible audit outcomes.

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