

A simple review may save your practice loads of money.

CHART AUDIT:

Is Your Practice Billing What It Should?

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Could any of the following mistakes occur in your practice on a given day? You forget to charge for CLIA-waived lab tests even though your supplier charged you for the test kits, you inject a patient with 10 units of a drug but only bill for one unit, or you perform four minor surgical procedures but forget to note them on the encounter form. These simple mistakes are costly, and repeatedly forgetting to bill for services like these could cost you tens of thousands of dollars by the end of the year.

A simple chart audit can help you remedy these and other costly problems. This article will guide you through the process.

Getting started

A chart audit will help you understand the following:

- How well you capture charges for all services,
- How well your staff follows up on denied claims,
- Whether code selection, charge entry, claims submission and payment processes are accurate,
- The cause of any problems found in the above.

The type of chart audit described in this article is simple enough that any practice can perform it without hiring a consultant. You can use the “Charge capture tool” shown on page 18 to complete your audit, or download a modifiable version from the online version of this article at <http://www.aafp.org/fpm/20090300/15char.html>. ►

■ A chart audit can identify where you are making costly, repeated mistakes.

■ Before you begin, identify areas of concern, and focus the audit on these areas.

Before starting the audit, your practice's physicians and office manager should identify potential areas of concern. Do most of your denials seem to come from one payer? Does one physician in your practice generate significantly less revenue than the others? Perhaps you'd just like to know how your practice is doing as a whole. Discussing these issues before you begin the audit will help bring focus to your analysis.

Collect and analyze the information

Once you've identified the areas you'd like to focus on, it is time to begin collecting the data. See "Audit of office services," below, for a summary of this process.

Choose the date. Select a single day to review – a typical office day that is at least 90

days in the past. This increases the likelihood that all, or almost all, of the charges for that date have been paid and enables you to review denials, appeals and the follow-up work related to these charges. If you must choose a date on which one of your physicians or other providers was not in the office, use data from the day before or after for that clinician.

Gather documentation. Print an accurate appointment list for the date of service you have chosen to review. Print or photocopy the superbills, account detail and relevant portions of the medical records for each patient seen that day.

Organize the data. Using a worksheet like the sample on page 18, enter the data for each encounter. Enter the patient's identification number, the services documented in the patient's medical record, the services indicated on the superbill, the services entered into the patient account and submitted to the payer, and those that the practice was ultimately paid for.

Compare the services listed and review any discrepancies. Are there unbilled lab services, minor procedures documented but not reflected on the superbill, or patient visits provided but not charged for? Are certain services repeatedly rejected? Is one payer more problematic than the rest? How well is your staff following up on unpaid claims? To better understand the sources of some of these problems, you'll need to consult explanations of benefits (EOBs) and any notes related to the patient's account that have been captured in your billing system.

Consider out-of-office procedures separately. The process is slightly more complicated for out-of-office procedures but no less important (see "Audit of out-of-office services" on page 17).

Act on what you find

After completing the audit, share the results with the other physicians and staff in your practice. Address any patterns you've identified that are costing the practice revenue, and discuss solutions that will improve the process. Some common problems include the following:

Denials that your office can prevent. These include denials due to patients' eligibility status, coding errors and submitting a claim past the filing deadline.

Eligibility denials can be reduced to zero by

AUDIT OF OFFICE SERVICES

The purpose of this activity is to check the accuracy of the charge-capture procedure in the office, specifically whether the practice is billing for all services that were performed. The audit will reconcile the actual services performed and documented in the medical record with the patient account and the superbill to identify unbilled services, services billed with the wrong procedure code and charges billed for services not performed. The accuracy of diagnosis coding will also be audited. Follow these steps:

1. Select a day to audit from three months ago.
2. Print a patient list from that day's appointment schedule.
3. Pull the superbills for that day.
4. Print out the patient account detail for *only* the date of service you're auditing.
5. Pull the patient charts for that day.
6. Using the audit tool like the one shown on page 18, record the pertinent data in each field.
7. If all or part of the claim was denied or if the amount of payment seems lower than the fee schedule amount, consult the explanation of benefits for more information.
8. Compare the diagnosis codes from the superbill, patient account and medical record and note any differences or discrepancies.
9. Summarize discrepancies on a separate page, noting the dollar amounts of unbilled charges or others that should have been paid.
10. Act on what you find.

Repeatedly forgetting to bill for services like these could cost you **tens of thousands** of dollars by the end of the year.

checking on the patient's eligibility before the visit. Call the insurance company's automated line, check its Web site or use services such as those provided by Emdeon.com, tevixMD.com and Allscripts.com, which are specifically designed to check multiple insurance companies' eligibility files. You should first check with your practice management system company to see if your system includes an interface to a designated list of vendors.

Coding errors can be identified and corrected prior to claim submission by using software that runs the same edits as insurance companies. These edits identify errors related to bundling, diagnosis coding, medical necessity and modifier use.

If you find recurring problems with denials due to late filing, research whether you received the correct information from the patient. For example, if the patient has two insurances, check to make sure you have billed the primary insurance. If the patient gave you incorrect information, the payer may waive the filing deadline. Try to renegotiate your payer contracts with 120- to 180-day filing limits, and include a clause that allows you to bill patients if they give you incorrect information that prevents you from making a successful claim.

Denials resulting from incorrect processing by the insurer. Your office may have correctly submitted 10 units of service, but the company may have processed only one. Or the

AUDIT OF OUT-OF-OFFICE SERVICES

Many practices find that charge capture for out-of-office services is less complete and less accurate than for in-office services. A superbill is usually generated for services provided in the office, but for hospital and nursing home visits, many practices rely on the physician's memory and less formal record keeping, which can result in lost charges. It is a good idea to audit out-of-office services continuously, making improvements in your charge-capture process as you go, until you've established a system that works well enough to justify less frequent audits. Follow these steps:

1. Collect outside data related to the week's charges as they arrive: notes from consultants, information from the nursing home, and information from the hospital related to emergency department care, admissions, etc. Keep a copy of this documentation in a folder, or enter it into a log. A simple listing is sufficient. Later, you will compare the charges submitted by the physician with this information.
2. After one week, compare the charges that were entered into the billing system with the documentation that you collected. Note whether a charge was entered for each service, and make a list of the charges that were missed.
3. Look for patterns in your list: Are all the missing charges for one provider? Are all the missing charges for one type of service?
4. Act on what you find.

company may have paid only one line of service when two were submitted. Be systematic about appealing these kinds of denials, and if they are repetitive, contact your customer service representative. Consider whether participating with the plan is worthwhile.

Lab and other ancillary services not billed. Use a back-up system for capturing lab charges. If you have an in-office lab, maintain a log of all tests performed and have your billing staff review that log to make sure all lab tests were charged. ➤

About the Author

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Article Web Address: <http://www.aafp.org/fpm/20090300/15char.html>

If the results of the assessment show that one physician or other provider has the lion’s share of missed charges or errors, address the issue head on.

Minor surgical procedures not billed or billed incorrectly. Institute a separate charge slip for minor surgical procedures that lists codes and descriptors for the procedures your practice provides. (For example, see *FPM*’s “Common skin procedure form” available for download at <http://www.aafp.org/fpm/20060900/skinprocedures.pdf>.)

Office visits not billed. Perform a daily reconciliation of superbills with appointments.

Medications billed with incorrect units. In some practices, the nurse or medical assistant has never seen or used the Healthcare Common Procedures Coding System (HCPCS) book, which lists medications and their dosages. Whoever draws up the medication and gives the shot should know how to look up units of

medications and document them correctly in the medical record and on the superbill.

One provider’s charges repeatedly not billed. If the results of the assessment show that one physician or other provider has the lion’s share of missed charges or errors, address the issue head on. He or she might benefit from some CME courses focused on coding or a few sessions with someone in your practice who is most expert in coding.

Uncovering fraud

If your chart audit uncovers fraud, the first thing you need to do is take your compliance plan off the shelf and review the policy your practice already has in place. Many groups

Choose a date 90 days in the past to review.

Collect the necessary data and documentation, and enter it into a worksheet like the one shown here.

Review the services listed, and pay attention to any discrepancies.

EXAMPLE USE OF CHARGE CAPTURE TOOL

Using a charge capture tool like the one shown here, you can complete the chart audit described in this article. Download a modifiable version of this tool from the online version of this article at <http://www.aafp.org/fpm/20090300/15char.html>.

Patient ID	Provider initials	Date of service	Procedure codes from superbill	Procedure codes from patient account	Procedures documented in medical record	
1	BAN	5/8/08	99213	None	Office visit	
2	JAL	5/8/08	Not found	None	New patient visit, quick strep test	
3	BAN	5/8/08	99396 82270 90718	Same	Same, plus vaccine administration	
4	BAN	5/8/08	99214 17000	Same	Same	
5	DNA	5/8/08	99214	Same	Same	
6	BAN	5/8/08	99213	Same	Same, plus wet mount and KOH prep	

adopted a plan when the Department of Health & Human Services Office of Inspector General recommended back in 1999 that physician practices do so. If your practice still doesn't have a plan in place, it is important that you prepare one. For more information on creating a compliance plan, see "Are You Prepared to Defend Your Coding?" (<http://www.aafp.org/fpm/20050600/17arey.html>) and "Seven Steps to Medicare Compliance" (<http://www.aafp.org/fpm/20010100/41seve.html>). The compliance plan typically appoints a compliance officer and outlines how to respond when questions or concerns arise. If you suspect fraud, or if you discover that you may have been inadvertently overpaid, you'll also need to contact a health care attorney for advice.

Worth your while

It is critically important to assess the way your business, physician partners and staff operate and to do so regularly. A chart audit is a key tool in this process, one that could significantly increase your practice's cash flow and prevent you from neglecting to charge for services performed and documented. **FPM**

Send comments to fpmedit@aafp.org.

OTHER TYPES OF AUDITS

Family medicine practices perform audits for many reasons. Some groups perform annual compliance audits to assess the accuracy of billing and coding and adherence to government and payer rules. A compliance audit may also be instituted by a payer because a physician's billing pattern triggered it or because a patient or whistle-blower has raised a concern.

It can be helpful for both compliance and financial reasons to periodically review whether evaluation and management (E/M) services are accurately coded. Some practices hire an outside auditor to do this work, while other groups have trained staff members to do the job. The Centers for Medicare & Medicaid Services Documentation Guidelines for Evaluation and Management Services are available at http://www.cms.hhs.gov/mlnedwebguide/25_emdoc.asp. Some Medicare carriers post their E/M audit sheets online as well.

Some practices also analyze coding variation among physicians, looking closely at coding profiles, productivity and so on. For tips on how to do this, see "How to Analyze Your E/M Coding Profile" at <http://www.aafp.org/fpm/20070400/39howt.html>.

Another useful type of review may focus on individual payers and the payments that result from these contracts. You might notice that the denial rate is higher with one payer than with all of the others or that claims processing times are longer for one payer. Perhaps you are reimbursed at less than the contracted amount for some services. Any of these problems calls for a focused review of that payer's performance.

	Procedures provided but not billed	Allowed charges for all procedures	Date and amount paid by insurance	Lost revenue	Need explanation of benefits?	Notes
	99213	\$85	None	\$85	No	Charge never entered
	99203 87880	\$128	None	\$128	No	Lost superbill
	90471	\$168	\$143 on 5/28/08	\$25	No	Service provided but not billed
	None	\$210	\$125 on 5/24/08	\$85	Yes	Two problems addressed, two diagnoses. E/M not paid because no modifier 25. Never resubmitted.
	None	\$125	None	\$125	Yes	Ineligible provider
	87210 87220	\$85	\$57 on 5/24/08	\$28	No	Services provided but not billed

Your compliance plan should outline how your practice will respond to concerns raised by the chart audit.

It is very important to assess how your business operates, and a chart audit is one tool that will help you do this.