Good Billing and Coding Strategies

A good strategy should include audits **BY RHONDA BUCKHOLTZ, CPC**

BILLING AND CODING audits are essential to the financial health of a medical practice. Audits may seem like a distraction from the daily responsibilities of patient care and payer requirements, but a properly executed auditing program should not be a burden. Here are nine essential points to consider when enacting an audit program:

1 Clarity is essential. A successful auditing program must specify the roles and responsibilities of staff or contractors, as well as the guidelines to which the program will adhere.

2 Monitor accounts receivable reports monthly. Look for payers with a pattern of slow payment. For any claims over 40 days old, staff should provide an explanation. If the delays are payer-related, a meeting or contract review is in order.

3 Do not allow the same person to open the mail, handle cash and deposits, and post money or perform write-offs. In smaller practices this may be difficult, but it can be achieved. For example, have a front desk person get the mail, open it and distribute it. Make sure the person handling co-pays creates a balance sheet every day that can be compared to the person posting the payments daily ledger. Don't allow the practice manager to sign checks if they also post payments. If you do, you are opening yourself up possible embezzlement issues.

4 Do not allow coding and billing staff to perform write offs for anything other than contractual arrangements. Instead, require that a manager give final approval. Often, A/R is "cleaned up" by hiding overdue balances in write-offs. Make sure that write-offs are assigned to an appropriate category, such as "timely filing," "non covered service," etc. In this way you easily can see where problems or revenue loss are occurring. In contrast, allowing one "dumping ground" for all write offs ties your hands and makes practice management reports of no value.

5 Perform an Explanation of Benefits audit. Monitor more closely those payers who are not reimbursing at contracted rates, and work with them to resolve inconsistencies. Setting up your practice management system to host each payer's fee schedule is a great way to alert the payment poster if the payment received was not as expected. Train staff not to ignore practice management alerts. Setting up your system for the first time will be time consuming, but systems are easy to maintain once established. Also, be sure that billing and coding staff have a current list of payers with whom you are contracted, and that contractual adjustments are not made for payers with whom you are not contracted.

6 Look at the cause for your denials. Is it a particular service or diagnosis code? Often this goes unnoticed but it can be an easy fix. Watch for payer trends, and develop policies and procedures to match payer and Office of the Inspector General areas of focus. Is a certain payer denying claims when modifiers are submitted? Or perhaps now you have claims being denied for services that were covered before? This ensures compliance and allows practices to determine which services to offer. Monitor local coverage determinations for changes and to be sure you are providing covered services.

7 When auditing EOBs, be sure that any denials have been resolved. If a denial has not been appealed, find out why and take action to correct the problem. Hold staff accountable for research and follow through on all issues.

8 Insist on consistency and follow-through. Audit reports should be submitted every month and reviewed by someone with the knowledge and authority to address problems. A report summary should be provided to physicians or other administration, depending on your practice layout.

9 Don't be afraid to ask questions of staff and contracted payers. Take the time to meet with the provider rep and your billing and coding staff to clear up any discrepancies. Only through due diligence of reporting systems and policies will your practice achieve a healthy bottom line.

Once developed, an audit program eventually will streamline and enhance revenue by ensuring clean claims, fewer denials, and faster payment. It also will prompt providers to improve clinical documentation as they become more alert to the importance of medical necessity and levels of specificity in supporting claims.

Defined roles promote a successful audit program, but don't tie your staff's hands. Instead, empower staff as well as management to help develop policies that promote compliance and revenue enhancement. Rely on key staff members to perform audits, insist on follow-up, and provide a high-level overview. Clinicians, in turn, will be free to continue providing excellent patient care.

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Ask the Expert

QUESTION: I was underpaid for a service by a payer. The check that accompanied the Explanation of Benefits states that the amount constitutes "payment in full." Does acceptance of the check mean that I wave my right to appeal the claim for additional payment?

ANSWER: No. If you strike out or otherwise delete that notation before cashing the check, acceptance of the check does not mean that the payer's liability on the claim is satisfied (Civil Code §1526). Thus, physicians who receive such checks should strike out the notation and pursue their appeal rights. For more information, see CMA On-Call document #0146, "Payment Denials by Managed Care Plans and IPAs."