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f you have been in practice management awhile, you know that “the best offense is a good defense.” This same defensive positioning applies to trying to comply with almost all of the general regulations that affect ophthalmology practices. You do your best to know what you are doing and you document your efforts.

To put up the best defense when it comes to the billing, coding, and collection process, you should be both “implementing a culture of compliance” and then following through on that culture by conducting periodic self-audits thereafter. The purpose of those periodic self-audits is both to check that you are getting it right and to show your staff and potentially the government that you are serious about your own efforts to do your billing, coding, and collection correctly.

Given the government’s continued heightened emphasis in this area through its retention of its own auditors as well as RAC (Recovery Audit Contractor) auditors, the best way to know where you stand is critical self-reflection. To do this, you should be implementing some form of regular self-audit that helps you identify weaknesses in your processes before anyone else does. This article will help focus your efforts on how to self-audit.

Re: Compliance

Small- to medium-sized ophthalmology practices have several choices with regard to compliance: (1) do nothing; (2) purchase or download a “one size fits all” compliance plan (not much better than doing nothing); (3) over-invest in a comprehensive compliance program that will not address many of the main issues you encounter; (4) or build a cost-effective compliance plan customized to meet your ophthalmology practice’s needs. The right choice should be obvious. More than just having a compliance plan on the shelf, however, you need a working compliance plan that actually keeps your ophthalmology practice in compliance, which includes the periodic self-audit that enables your practice to identify specific risk areas (if any exist).

Identifying Specific Risk Areas

Coding and billing (including the accurate documentation of each) are the principal risk areas for any ophthalmology practice, regardless of size. Within the coding and documentation areas generally, ophthalmology practices have certain risks and issues relating to their use of E&M codes, eye codes, and consultations. They may also have co-management billing and coding issues.

Integral to any compliance plan would be a review of how non-physician providers (NPPs) such as optometrists and techs are billed. Whether the practice bills these NPPs in their own names or as “incident to” a physician provider, the billing and medical record should be clear as to what happened and what was intended.

Conducting the Self-Audit

To be effective, ophthalmology practices should know not only if the standards and procedures are correct, but also if they are, in fact, properly implemented. For example, you might be billing from an encounter form that does not have the full array of the codes your providers regularly use. Therefore, the “write-in codes” must be added by your providers. Are your providers using the proper and current codes? Do your providers know all of the elements necessary to use those “write-in codes”? The advent of EMR/EHR systems should eventually help with proper coding as practices and their
provides become more proficient with the use of their EMR/EHR systems.

The Office of the Inspector General (OIG) recommends that each practice conduct a baseline audit. From there, internal audits, or mini-reviews, of different aspects of the ophthalmology practice might be done quarterly, though the practice overall should be reviewed at least once per year. The practice’s audit manager maintains and shares the findings of these audits with the practice’s board of directors and recommends follow-up or corrective action plans.

Two Types of Reviews
We recommend performing at least two types of reviews.

1. Standards and procedures.
Generally, the protocols are reviewed for the following: claim development and submission, including documentation and coding, based on the most current CPT manuals; collection process including collection of deductibles, co-pays, and other out-of-pocket charges; practice contractual, ownership, and referral arrangements, including leases, service agreements, and joint venture arrangements; and practice income division arrangements.

2. Claims submission and collection process.
Generally, the actual bills and medical records are reviewed for the following: bills are coded properly and accurately reflect the services rendered as documented in the medical record; documentation is within recommended guidelines; services billed are reasonable, necessary, and in the most appropriate setting; the practice is refunding overpayments; posting is done accurately; adjustment codes are appropriately used when balances are written off; secondary insurances and self-pays are properly billed, and the practice’s courtesy policy is followed; deviations from normal practice patterns can be explained or eliminated; and no incentives exist to provide unnecessary services.

Practice self-audits should include a review of a statistically significant number of charts (typically no fewer than 10 federal program submissions or 20 total medical records per provider and more if problems are observed). These charts should be selected at random and matched to the following: encounter form(s), collection of co-payment/deductible, claim(s) submitted to first and secondary payers, payment, and explanation(s) of benefits for the selected patient charts. At a minimum, conduct: (a) a periodic review of all providers (top five to 10 CPT codes, expanding from there); and (b) a focused review of all newly hired providers. Since initially the intention is to expand and repeat the review process throughout the year, the idea is to keep each review manageable. Some ophthalmology practices take on too many charts per provider and become bogged down in the process, not completing even the first review. Instead, take a manageable sample size and expand the review only if the initial results warrant doing so.

After documenting the top codes in the self-audit, establish the parameters of the self-audit. Choosing the patient files for review is entirely up to the audit manager. The audit manager should use a random sampling of the files. Regardless of which method is used to randomly choose files for review, consistency is important. A common mistake in performing self-audits is to “cherry pick” individual files for review. The audit manager should avoid such “cherry picking,” as the practice will not get a true sense of its actual billing and coding compliance.

From planning to execution, document the methodology. This serves a number of purposes. First, documentation provides a roadmap for analysis after the self-audit is complete; this will prove useful in case the practice observes repeated errors. Second, when expanding or repeating an audit, you will easily know where you left off. Third, if a government agency conducts an audit, a documented compliance plan will help demonstrate that any billing error or overpayment is not intentional because a rational self-auditing process previously deployed showed no errors.

Assessing Exposure
The initial baseline self-audit assesses the areas (if any) where the ophthalmology practice should focus its attention. From there, the practice should seek to refocus its processes. Then, for each subsequent self-audit, ask a slightly different question: Were new risk areas discovered? Are there any changes over time? Can they be explained?

Self-auditing may seem time consuming and tedious, especially when the ophthalmology practice is not being investigated and the internal workings of the practice seem to be functioning well. However, being proactive and performing regular self-audits can assure your ophthalmology practice’s compliance with Medicare and other regulations and save you time and money down the road by expending a relatively small bit of time and money now.

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