

Coding and Billing Compliance

The practice complies with state and federal laws and regulations pertaining to billing, coding, and reimbursement and has implemented a Compliance Program to effectively articulate and demonstrate the organization's commitment to legal and ethical conduct and to become a function of daily operations. The practice conducts regular audits to identify and resolve any billing errors.

Policy

1. The practice has designated a Compliance Officer to oversee and monitor compliance with fraud and abuse laws, in addition to other regulations.
2. The practice employs a Certified Professional Coder (CPC) to ensure accurate billing and coding practices and to identify areas in need of improvement.
3. Auditing and monitoring is conducted to speed and optimize proper payment of claims; minimize billing and coding mistakes; reduce the potential for external audits; detect inaccuracies in billing and coding procedures; and identify deficiencies in medical record documentation.
4. The practice audits the claims submission process at least semi-annually. The practice audits physician and provider coding annually and as needed based on the results of each audit. The coding audit includes an analysis of the utilization of Evaluation and Management (E/M) codes. The data is compared to payer specific or other industry distribution standards for the practice specialty. Potential risk areas are identified based on the results of the comparison.
5. The practice monitors claims overpayments and adjustments on a monthly basis. Focus areas include significant changes in the number and/or types of claim rejections or adjustments; denials related to the medical necessity or validity of claims; and unusual volumes of charge or payment adjustments.
6. When necessary, corrective actions are imposed after consultation with the Compliance Committee and disciplinary actions are enforced according to the Compliance Program.
7. On an annual basis, the Office of Inspector General (OIG) Work Plan is analyzed to identify additional risk areas for the practice. The Medicare Quarterly Provider Compliance Newsletter is also used as guidance to address potential billing errors.
8. The Business Manager reviews claim rejections on a daily basis to ensure accurate claims processing. The Business Manager also monitors and communicates changes in specific payer reimbursement policies to relevant employees.
9. Employees are encouraged to communicate any concerns related to the integrity of the practice's billing and coding processes. The practice provides the means for employees to voice their concerns anonymously. Retaliation against employees who communicate concerns is prohibited.
10. The Compliance Officer provides new hire and annual training to physicians, providers, and employees involved in the billing process.
11. Internal auditing and monitoring is completed as follows:

Coding and Documentation Reviews

- a. Ten randomly selected records per physician and provider are reviewed. Reviews are based on established medical record documentation protocols. The results are shared with the individual physician and provider and additional training sessions are scheduled when warranted.

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- b. Follow up reviews are conducted based on a calculated error rate. If significant problems that potentially violate fraud and abuse laws are identified, a focused audit of thirty records is conducted.

Error Rate	Schedule for Follow-up Audit
≤10%	Annual
11-49%	6 months
50-74%	3 months
≥75%	1 month

- c. If the internal audit's findings merit further evaluation, the practice's legal counsel is consulted and retained, at the discretion of the Compliance Officer. If a statistically significant number of errors is discovered, the physician or provider may be subject to mandatory self-reporting.

Claims Submission Audit

- a. Using the random sample and results from the coding and documentation reviews, the practice audits the complete revenue cycle.
- b. The practice has developed an audit tool that analyzes the following:
- Procedure codes documented by the physician or provider
 - Procedure codes billed to the payer
 - Procedures provided and not billed
 - Procedures billed but not documented
 - Allowed amount and payment
 - Lost revenue or overpayment
- c. Payments received in error or overpayments of claims are returned to the patient or payer as soon as the error is identified.

Overpayments and Adjustments Reviews

- a. The practice runs credit balance and adjustment reports to review for any discrepancies. Payment postings are compared to the explanation of benefits to ensure accuracy.
- b. If a problem is identified that impacts a particular procedure, a comprehensive review of claims activity is performed.
- c. Payments received in error or overpayments of claims are returned to the patient or payer as soon as the error is identified.