Insurance Coding Audits:
What and How?

What actually happens when a practice gets audited?
Typically a practice receives a letter in the mail that they are being audited. This letter may or may not give the reason for the audit. For example, it may tell you that this is part of routine audits by Medicaid or it may tell you that according to their system analysis your practice is a coding outlier compared to other practices in your area.

What should you do?

1. You should alert your staff that if a letter arrives asking for audit materials that they should give it to the lead provider or office manager promptly.
2. Note the expected date of response to the audit. If this time is too short to comply with accurate information, contact them immediately and request an extension.
3. Note language regarding final submission materials and appeals. Some audit request letters contain language that you have only one chance to submit appropriate documentation and any subsequent information you provide will not be taken into consideration. If this is the case, you need to be 100% confident in the materials you submit.
4. When you do submit information, make sure it's inclusive and supportive of all the work done including the appropriate audit note, not the patient summary note.

What should you NOT do?

1. Do not have staff simply print out office notes they are requesting and submit them.
2. Do not panic. Get appropriate materials together and if you have been coding according to best practices you have nothing to fear.

How do audits work?

1. Typically payers ask for documentation of a specific list of patient visits over a specific time period.
2. The payer then uses that as a "representative" sample of your entire codes/visits submitted to the payer for a particular time.
3. If they believe that you coded inappropriately, they will use the percentage of inappropriate coding and ask for payment back for what they consider to be overpayment. Depending on state laws, this can go back for a year or more.

   Example: Payer Z notices that your practice codes more 99214 E/M visits than your colleagues in your region. They ask for notes for 10 specific visits from each of your 3 providers for a total of 30 notes.
   You submit them for review and they say that one of your providers was spot on and all 10 chart notes supported the documentation of 99214s. However, for the other two providers, only half of their notes (5 each) support a 99214 and the others should have

been 99213s. This means a third of the notes you submitted for audit “failed” and the payer claims you were overpaid for those visits.
The payer then states that they are going to take that representative sample and apply it to all 2,000 times you coded a 99214 during the audit year. They extrapolate that to say 1/3 of them were overpaid. And the difference between a 99213 and 99214 for your payer is $35. So do the math:
2,000 claims/visits x .33%= 660 visits.
660 visits x $35 = $23,1000

AND they may choose to go back more than one year, compounding this number.

How do they get the money back?
Typically they ask for the practice to send a check in that amount or alternatively they deduct it from future claims payments you send for other patient visits.

How does the practice get the money to pay the insurance payer?
This depends on your provider agreement. Do you have language in employment or partner contracts that specifically states whether providers will be responsible for any paybacks based on inappropriate coding? In the example above, should the provider with appropriate coding be penalized for the two who are not coding appropriately?
This is why EVERY provider who performs visits in your office needs to understand coding best practices and be responsible for the codes submitted.

What if we don’t agree with their assessment?

1. You may want to hire a consultant to argue your case and provide coding expertise.
2. Sometimes the practice and payer can agree to a “middle of the road” settlement number with provisions to improve provider education on coding if mistakes were made out of inadequate understanding of the coding.
3. You can ask to provide information on ALL of the visits or a larger sample size if you believe that the small number of chart notes submitted was not truly representative of the overall picture.

How can we feel confident with audits in the future?

1. Continuous education
2. Periodic internal/external reviews and oversight
3. Encourage providers to review their summary notes prior to finalizing to confirm the details of what they are documenting is aligned with the E/M coding level selected
4. Make sure every provider understands what goes into the audit note and periodically reviews examples