

Auditing Guidelines for Success

This is a document designed to educate and help Osteopathic Physicians to maneuver through an insurance audit. It includes common pitfalls to avoid, things to watch for and resources to use during an audit.

Why am I getting Audited?

There may be several reasons a Physician gets audited.

- 1) If you have signed an agreement with an insurance carrier you have agreed to be reviewed by them for accuracy in your documentation and billing. Medical review of claims is routinely done by insurers. An audit can be a way for insurance companies to recoup overpayments when honest mistakes are made in coding and billing by Physician offices.
- 2) If you have a high service volume (like Osteopathic Manipulative Treatment) in any one area, like a specialist usually would, you may be considered an outlier. This means that you use more than the average of a specific code, with less variation. Some insurers seem to fail to recognize that there is a specialty in Osteopathic Manipulative Medicine and as a result you may get flagged.
- 3) Many more physicians are being audited recently probably as a result of a 2012 OIG report that found an increase of 48% of payments for evaluation and management services for Medicare from 2001 to 2010. Much of this increase was more 99214 codes than before. This may be due to the institution of electronic medical records making it easier for physicians to document and harder for them to down code.
- 4) You use the 25 modifier that is required for all Osteopathic Manipulative Treatment billings. Medicare did a study that revealed that 34% of those Physicians using the 25 modifier were using it incorrectly. This stimulated insurance companies to target manipulating Osteopaths for audits.
- 5) Some insurances (or their software may anyway) have a differing opinion than the Osteopathic profession that an office visit cannot be billed on the same day as Osteopathic Manipulation is done. This flags an audit in their system.
- 6) You may be chosen because of previous nonconformity.
- 7) You may have just been selected at random.

What to do first when you are Audited.

Gather as much information as possible about the health plan conducting the audit.

- ✓ In your contract they will list how far back they can go for an audit. Be sure their request falls into this time period. By law in Oregon (Senate Bill 508) insurers

can request corrective adjustment of a payment going back further than 24 months but it may be less if it is in your insurance contract.

- ✓ Review in your contract their access to your medical records.
- ✓ Review contract provisions that address medical necessity.
- ✓ Be familiar with their auditing process; time lines, sequence of appeals
- ✓ Pay attention to deadlines
- ✓ Find out if the insurance carrier has a special form or format for submission of records

Contact state and national organizations for help and guidance. This also alerts medical associations of unfair health plan practices currently affecting physicians. A developing pattern may bring about initiatives to address the issues on a larger scale. (this is currently happening through the Osteopathic Physicians and Surgeons of Oregon (OPSO- a hard hit area) and the AOA)

- ✓ AOA Compliance and Payment Advocacy 800-621-1773 ext 8187 or 312-202-8282
Yolanda Doss ydoss@osteopathic.org
- ✓ AAO Diana Finley 317-879-1881 dfinley@academyofosteopathy.org
- ✓ OPSO David Walls 503-241-4927 davidw@opso.org

How to prepare your medical records for initial submission to a Health Plan.

- ✓ Alert your staff that many physicians are being audited or are having a post-payment review done. Let them know **YOU** need to review ANY and ALL records before they are sent to an insurance company. Be sure to include ALL records requested. Failure to submit all records requested can be costly and only you know all of what is needed (check for flow sheets, labs, prescriptions, anything you refer to in your notes).
- ✓ Review/audit your medical records before you send them or have a qualified person do it for you. (See CMS self-audit reference). If you have made an error rebill it correctly.

Common Pitfalls to check for in your notes and billings:

History

- Be sure your chief complaint is in quotations and in the patients words. (not your interpretation of what they said)
- Use the patient's chief complaint as your number one diagnosis not what you find later. (ex: use back pain not lumbar strain)
- When using the status of 3 chronic conditions for your HPI you still need to review other systems to count as ROS to obtain higher than a level 2 (problem focused) for history.

Examination

- Note some insurers don't see vitals as part of your exam so be careful in counting it in your coding. If you are unsure, to be sure to document another appropriate area of exam.

-For 1997 Guidelines each TART (tissue texture change, asymmetry, range of motion, tenderness) counts as one element or bullet in each of the regions (1) head and face, neck; 2) spine-thoracic, ribs, lumbar, sacrum pelvis, abdomen; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity.

For Complexity of Medical decision making: (See CMS audit worksheet)

1)a. Number of Problems:

Each diagnosis (including each somatic dysfunction) is worth at least 1 point. If a chronic pain patient comes in and you diagnose back pain, somatic dysfunction lumbar, sacrum, pelvis you have 4 diagnoses, each worth 1 point giving a total of 4 points. This is the maximum number you can have and qualifies as a level 5 for coding.

b. Management options:

Here is where your decision to treat with OMT counts. Usually you will have more points for diagnoses than management options and you only need one or the other so use your number of diagnoses.

2) Risk

a. Presenting Problems:

If a stable chronic pain patient is coming in for treatment and has two or more diagnoses (ex: back pain, somatic dysfunction lumbar) with or without acute exacerbation it falls into a moderate level of risk for problems. Essentially most patients with somatic dysfunction will fall into this level 4 risk since usually there are more than one somatic dysfunctions present. Since risk is based on the highest level in any one category (problems, data and management), this section can really bump up the overall coding.

b. Diagnostic Procedures Ordered:

Labs ordered must be documented with exactly what is ordered, when, why and what diagnoses go with them. The date that labs are billed **must** match when the test was done or results are received NOT when you order them or send them to the lab if you are preparing them.

c. Management Options:

Osteopathic Manipulative Treatment is level 3 or low risk just as is physical and occupational therapy.

Prescription drug management is level 4 or moderate risk while

Over the counter (OTC) supplement management is level 3 or low risk.

Discussion of DNR status is a level 5 or high risk.

✓ Transcribe- if you hand write your notes and they are hard to read consider submitting a

transcription along with your original notes. It is a common reason for denial of payment or request for refund

- ✓ Send supporting documents like your commonly used abbreviations and usage guides to your notes. (See section on resources that may support your records or educate the reviewer since Osteopathic coding is specialized and has additions to the main stream)
- ✓ You can request an onsite audit or being present for the audit review in the Health Plans office. This is desirable as it facilitates better communication between the physician and the auditors.
- ✓ Be sure to include any special forms the insurers require with your submission.
- ✓ Include a cover letter, signed by the attending physician, with your submission. This letter should expand on any missing or ambiguous information and should articulate on the appropriateness of the coding methodology used to report the services provided. Note any errors you made in the cover letter and any actions you are taking to correct them (they like you to be remorseful). Also in this letter let them know if you are using the 1995 or 1997 Documentation Guidelines.
- ✓ For any coding and billing errors, correct them and resubmit on a paper claim.
- ✓ Be sure to send ALL requested records (labs, flow sheets, summary pages-anything you refer to or ordered). Most Health Plans will not accept forgotten records that are not submitted with the first request. (they don't want you altering them)
- ✓ Keep a detailed record or a complete copy of what you send (they like to say that they haven't received records). An automatic number and date copier works well.
- ✓ Send your billing information for each service provided (HCFA).
- ✓ Send your packet certified mail.
- ✓ Have your billing person track these cases carefully. Develop a flow sheet for tracking these patients Insurers (like Regence BCBS) may take refunds from future payments with out warning and without the 30-60 days required notification either in full or partial payments. This is illegal. They may also not take the refund from the same patient. It can be a billing nightmare. Be proactive. (See resources for examples of tracking methods)

APPEALS

If the result of your first submission is unsatisfactory, do an Appeal. **DO NOT** just pay what they ask.

Get information

- ✓ Find out the specific appeal process for the auditing Health Plan from your contract or by phone call or correspondence. Some Health Plans are very difficult to get a hold of. Be persistent! For Regence BCBS find out your representative's contact information. They can be very helpful if only to give you the total number of denied reviews.
- ✓ Request and obtain from the Health Plan **exactly** what was incorrect in your

documentation, coding and billing records.

- ✓ Request specific written references used in determining the findings of the audit.
- ✓ Request all information in writing.
- ✓ Request any specific forms or format they want you to follow in submitting an Appeal. (Regence BCBS has a specific form. If your Appeal is submitted without it they may not accept or review your Appeal).
- ✓ Request a Pure Peer Review (same specialty reviewer)
- ✓ Know your State Statute for refunds to Health Plans. For example in Oregon, the Health Plan can only request a refund for overpayment within 24 months (or less if the contract specifies otherwise) after payment was made. The time line expands to when the insurer is coordinating benefits with another insurer (secondary insurance). If you fail to pay them in 30 days they can make a second request. If you fail to pay them in another 30 days (60 days from the initial notice) then they can collect the fee through offsets in future payments. If you contest the refund, do an Appeal, the Health Plan may not make a request for a refund to be paid earlier than 6 months after the initial request. (see resource section)
- ✓ Know that some Health Plans take money from your future payments earlier than they should and without warning. Alert your billers to this so they can watch for it. Should this happen report it to your state association and the AOA immediately as they are breaking the law. Track your audited accounts carefully. (see resource section)
- ✓ Ask Yolanda Doss at the AOA for any legal advice you think you need. She may refer you to a local lawyer if needed. Should you need one check the Bar Association for Lawyers who do Health Law.

Give information

Notify the AOA, AAO and your state association. This is essential to getting this resolved at the national level. Failure to get some resolution to this reimbursement issue jeopardizes the future of Osteopaths being able to perform Osteopathic Manipulation and get paid for it. If we lose this ability there will be no reason for students to learn and do Osteopathic Manipulative Treatment. This may lead to a drastic change in our profession as we know it. Include the following information when contacting associations and keep them updated as you go.

- ✓ NPI number
- ✓ Tax ID number
- ✓ Initial insurance request letter
- ✓ Any graphs or information the insurance company has told you about what is wrong.
- ✓ Costs incurred such as extra staff time, lawyer fees accountant fees, external auditor,

extra copying costs, etc (See tracking form and timeline in resource section).

- ✓ Amount of money withheld or refund request or paid back.
- ✓ If an external audit was done, their report.
- ✓ Any responses you have made to the insurance company.

Protect Yourself

- ✓ Know that you can easily obtain extensions on deadlines. Use these to prepare fully and give you time to get help from associations or other physicians.
- ✓ Notice in doing an Appeal you gain extra time in preparing your financials if you have to pay. Some specialty physicians are electing to go to a cash based practice and not bill Health Plans. This works well usually without too much interruption of practice and protects you from Health Plans taking your income. Be careful they may still request records and not pay your patients. It is not clear on whether insurers can audit you if you are out of network. Going to a cash based practice **is not** a good long term solution for our profession but offers small practitioners financial security while the bigger problem is being solved.
- ✓ If you are considering going to a cash based practice look at Health Plan contract's to determine how much notice you need to give them for withdrawal. Some are very long (up to a year) so you want to decide early on if this is the route for you. It works very effectively.
- ✓ It is unclear at this time what happens if you do not refund the Health Plans' requested funds and they can't take it from future payments. Arbitration may be indicated in your insurance contract.
- ✓ Consider hiring an experienced local lawyer (Check the Bar Association for a Health Law Lawyer)
- ✓ Consider hiring a coding consultant or getting an external audit with someone familiar with your specialty like OMT (You can find one by contacting your state or national organizations)
- ✓ Confer with your accountant
- ✓ Contact your malpractice carrier. You may have money and lawyers available to you under your plan (The Doctors Company in Oregon has this included at \$25,000 after a \$1000 deductible for audits including medicare and advantage plan patients).

Appeal Submission

- ✓ Transcribe- if you hand write your notes do this if you haven't already. Include the original note. Make references between your note and the transcription if you use tables or pictures and insert them in your transcription. If you have a lot of notes to appeal, make a transcription template or outline of your usual note so your staff can help write them up for you but always proof them yourself. Put your osteopathic

reasoning or educational items for your reviewer in your transcribed note. Try organizing it into pre-, intra- and post-service sections. Always review all of them yourself before sending them. (See example in the resource section)

- ✓ Preform and send a self- audit form for each note (see CMS audit form in resource section)
- ✓ Send supporting documents if you haven't already like your commonly used abbreviations, usage guides to your notes. (See section on resources that may support your records or educate the reviewer since Osteopathic coding is specialized and has additions to the main stream.)
- ✓ Include a cover letter, signed by the attending physician, with your submission. This letter should expand on any missing or ambiguous information and should articulate on the appropriateness of the coding methodology used to report the services provided. Note any errors you made in the cover letter and any actions you are taking to correct them (they like you to be remorseful). If you have specific issues for the denial that they tell you about address them using references. (See example Appeal letters in the resource section. Please add or edit for your own needs).
- ✓ For any coding and billing errors, correct them and resubmit on a paper claim.
- ✓ Keep a detailed recording or a complete copy of what you send all numbered (they like to say that they haven't received records).
- ✓ Send your packet certified mail.

Changes in Patient Charting

- Consider changing to electronic medical records.
- Consider becoming a participant in the osteopathic research network DO_Touch.net which provides a web based progress note that can be used for charting and research data submission.
- Consider type writing your notes.
- If you want to continue using paper notes, consider using a standardized method of charting available through the Academy of Osteopathy (www.academyofosteopathy.org) called the Outpatient Osteopathic SOAP Note Forms. (there are several available depending on your needs).

Resources/ References/ Supporting Documentation

AOA (www.osteopathic.org)

- [Audit Resource Center](#)
 - [OMT Coding Instructional Manual – August 2012](#)
 - [Position Paper on Evaluation and Management Services \(E/M\) with Osteopathic Manipulative Treatment \(OMT\)-revised 2006](#)
 - [Protocols for Osteopathic Manipulative Treatment, AOA Division of Socioeconomic Affairs-revised 1998](#)

- Modifier 25 Usage & Audits letter to Members & Affiliates-10-23-12
- [Letter to Yolanda Doss from AMA](#)
- [Billing for OMT with E/M: When Should They Be Billed Together?-August 2012 Audits – What you need to know](#)

AMA (www.ama-assn.org) policy finder

- [Health Care Financing Administration May, 1997- Documentation Guidelines](#)
- General Multi-System Examinations- Musculoskeletal section and Musculoskeletal Specialty Exam- Musculoskeletal section
- [Table of Risk](#)
- [Audit Worksheet CMS Trailblazer-revised September 2009](#)
- [AMA Practice Management Center](#)

Policies:

- [H-70.926: Reasonable Time Limitations on Post-Payment Audits and Recoupment by Third Party Payors](#)
- [H-320.948: Physicians' Experience with Retrospective Denial of Payment and Down coding by Managed Care Plan.](#)
- [H-335.981 Postpayment Review and Recoupment Specific to Medicare](#)

American Academy of Neurology (www.aan.com)

- [How to prepare for a health plan retrospective audit](#)
- [How to perform a physician practice internal billing audit- \[www.aan.com/go/practice/management\]\(http://www.aan.com/go/practice/management\)](#)

AAO (www.academyofosteopathy.org)

- [Letter on use of the 25 modifier and OMT, differences between Osteopathic, Physical Therapy and Chiropractic practice](#)
- [Osteopathic Manipulative Treatment with Evaluation and Management Glossary of Osteopathic Terminology Usage Guide](#)
- [Outpatient Osteopathic SOAP and SOS Notes Usage Guides](#)

OPSO and Members

- [Oregon workers compensation statute](#) – ORS 656.248 paragraph 8
- [Oregon Payment Recovery Statute](#) – ORS 743.912
- [Osteopathic Advantage-Audit Worksheet](#) (thanks to AI Turner)
- [Osteopathic Advantage- Cost Effectiveness](#) (thanks to AI Turner)
- [Osteopathic Advantage- Pre-service and Post-service Activity chart](#) (thanks to AI Turner)

Appeal Letters-examples. Thanks to:

- [Osteopathic Advantage / AI Turner](#)

- Sandra Sleszynski
- [Billing Tracking Form](#) (thanks to Sandra Sleszynski)
- Insurance Tracking Timeline Example (thanks to Sandra Sleszynski)
- SOAP Note Transcription example (thanks to Sandra Sleszynski)

Department of Health and Human Services

- Federal Register Vol. 76 Monday, No. 228 November 28, 2011, Part II Centers for Medicare and Medicaid Services
Office of Inspector General, Use of Modifier 25, November 2005 OEI-07-03-00470
- [Office of Inspector General, Coding Trends of Medicare Evaluation and Management Services, May 2012 OEI-04-10-00180](#)
[The Federal Register – Preservice/Postservice: Vol. 60, No.143, Wednesday July 26, 1995, page 38414](#)
- Current Procedural Terminology (CPT) 2007, AMA, Evaluation and Management Section
- Current Procedural Terminology (CPT) 2007, AMA, Osteopathic Manipulative Treatment section (CPT Codes 98925-98929)
- [Centers for Medicare & Medicaid Services \(CMS\), November 9, 2012, Change request 8033, CMS Manual System, Pub 100-08 Medicare Program Integrity, Transmittal 438. Documentation on use of limited space progress note templates, open ended progress note template and supplemental forms.](#)

St Antony's

[Medical Review Primer- What is a Medical Review?](#)

DO_Touch.net (research network)

A.T. Still Research Institute, Director Brian Degenhardt 660-626-2397,
bdenghardt@atsu.edu or Lisa Norman lnorman@atsu.edu

Other Suggestions

Make a list of your commonly used abbreviations

If you use a standardized SOAP NOTE, send the usage guide or make one specific to your notes

Glossary of Osteopathic Terminology.

References from The Foundations for Osteopathic Medicine textbook

Helpful Articles

Gamber, R., DO,MPH; et. al. “Cost-effective Osteopathic Manipulative Medicine: A Literature Review of Cost-effectiveness Analyses for Osteopathic

Treatment”, JAOA, Vol 105, No8, August 2005 pg. 357-367.
Anderson, Gunnar B.J., MD, PHD, Lucente, Tracy, MPH, Davis, Andrew M., MD,
MPH, Kappler, Robert E., DO, Lipton, James A., DO, and Leurgans, Sue,
PHD, “A Comparison of Osteopathic Spinal Manipulation with Standard Care
for Patients with Low Back Pain”, New England Journal of Medicine,
Vol. 341:1426-1431 (November 4, 1999).
Rose Raymond AOA Staff Editor, “Out-of-Network: Why some Dos don’t take
insurance”, The DO, www.do-online.org/TheDO/?p=125741&q=print

SPECIAL CONSIDERATIONS:

THE INSURANCE COMPANIES ARE DOING WHAT INSURANCE COMPANIES DO.

DO NOT TAKE THE AUDIT PERSONALLY

DO NOT GIVE IN. DO NOT GIVE UP.

DO NOT GIVE THE INSURANCE COMPANIES MONEY BECAUSE IT IS EASIER.
YOU PROVIDED THE SERVICE, YOU DESERVE TO BE PAID.

**REMEMBER, WE ARE CREATING A LEGACY FOR THE
OSTEOPATHIC PROFESSION OF THE FUTURE.**

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