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AANEM MEMBER RESOURCE:

The Importance of a Strong Coding & Billing Compliance Program

A well-planned compliance program, or a plan that sets forth the standards a business will follow, show auditors that a physician is making a good faith effort to submit claims appropriately. It can also help facilitate a better cash flow if claims are submitted correctly the first time.

Two essential elements of a compliance program are physician involvement and regular communications between physicians and office staff. The office staff must know which services are to be billed, how to resolve patient complaints, and when to refund monies collected inappropriately. A physician's participation will signal to auditors that the practice is committed to ensuring compliance with coding and billing rules.

Currently, there are no federal requirements that a compliance plan be in place. However, the lack of one or the presence of an ineffective compliance plan could be seen by auditors as a bad-faith effort to circumvent, rather than enforce, compliance. To mitigate the very real risks facing your practice, appoint a trustworthy staff member as your Compliance Officer and develop a compliance plan. Within this plan, the Compliance Officer should be responsible for the following:

1. Perform a quarterly internal audit by reviewing a random sample of 25 to 35 medical records per physician and compare those against claims forms and explanation of benefits or payment stubs. When reviewing the medical record, the following questions should be asked:
    a. Are necessary elements documented to support the level of care billed?
    b. If tests were ordered, was the reason for the test evident in the medical record?
    c. Does the medical record contain documentation to support ancillary services such as therapy?

2. Regularly review claim forms or transmittal documents (a computerized copy of the claim may need to be printed on paper for review):
    a. Were the appropriate CPT codes reported?
    b. Does the diagnosis on the claim match the diagnosis in the medical record?
    c. Did "unbundling" occur?
    d. Were the request and need for testing is documented?
    e. Were the evaluation findings are documented?

3. Make sure all staff responsible for posting charges and payments are properly trained.

4. Make sure all charts are neat and legible as illegible charts lead to improper diagnosis codes being assigned.

5. Check the number of claims being re-submitted each month for review or appeal; a high number could mean internal billing errors.

6. Occasionally review daily and weekly charges:
    a. Are all claimed services completed in the time frame specified?
    b. Were all services rendered?

7. Keep reference material of services you perform handy
    a. Medicare Part B Manual and newsletter
    b. Have all billing and coding staff (as well as physicians) review and initial industry specific newsletters.

8. Review and update waivers in place for services deemed “not medically necessary” by any carriers.

9. Refund money owed to Medicare or a Medicare patient promptly.

10. Review use of modifiers:
    a. Are they used properly?
    b. Make sure all staff is up to date on usage.

11. Review internal charge documents (e.g., Superbill):
    a. Are all codes current?

A compliance plan should be reviewed annually and include a tracking sheet that records the dates each step of the plan was reviewed/completed, and by whom.

Today, all medical practices are being scrutinized. By developing compliance policies and guidelines, and conducting internal audits, a practice can illustrate that it has met its full responsibility for accurate coding and billing.