WHITEPAPER

AAPC

Medical Audit Case Study

E/M, Procedures, DRG & More

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The year 2020 has been unprecedented in terms of what we, as compliance professionals, have had to overcome.

From the COVID-19 pandemic to changes in telemedicine services, as well as prepping for the new 2021 E/M guideline changes, it can feel like there's not enough time in a day. We are having to do more with less, while maintaining a watertight compliance program.

As we looked at the results of some of our E/M and procedural audits, where 200,000+ audits were submitted across the nation, we saw a common trend. The biggest pain point most clients identified was keeping up with increasing laws and regulations — with fewer resources. This includes providing training surrounding changing requirements, doing it with fewer qualified professionals, and in some cases, not having full support from upper echelon leadership.

Speaking of new regulations...

Let's break them down, shall we? Since March of this year, to accommodate new pandemic-friendly care models, there have been 3 major changes in telehealth, with nearly weekly notices for special exceptions. 346 new codes were added to the ICD-CM code set and 394 code changes were made to 2020 CPT®. The Centers for Medicare and Medicaid Services (CMS) will be making Hospital Pricing Transparency effective 1/1/2021, while also implementing sweeping changes to the overall E/M guidelines — but only for office visit codes 99201-99215. The Proposed Fee Schedule record is 1,353 pages. And that's before we received the Risk Adjustment Final Rule for Star Ratings in 2021 or the OIG Work Plan updates and quarterly Program for Evaluating Payment Patterns Electronic Report (PEPPER) results. If you're having trouble keeping up with all those acronyms, don't worry, organizations across the country are facing the same challenge. They lack the staff and/or expertise to make sense of all the changes. Coding and auditing become more complex by the day, yet resources are being reprioritized as budgets and revenue crash.

Additionally, many organizations face the challenge of bringing on and training new providers on compliance and coding guidelines. Hospital acquisition of private practice increased by 128%*, roughly 35,700 practices turning into 80,000. As you can imagine, this is a compliance storm, aimed at an industry barely above sea level.

There are currently no published “industry” standards for coding accuracy. Common pass rate thresholds for E&M are generally 80% for baseline audits and 90% or higher for seasoned compliance programs. AHIMA has suggested the ICD-10 CM pass rate threshold should be 95%, but not all organizations have adopted that standard. Pass rate requirements for surgical coding are almost nonexistent. And we know that CMS allows for a 5% error rate (financial impact).

That said, there doesn’t seem to be a “one size fits all” answer. Scoring is impacted by specialty, skill set and experience, an organization’s compliance program and many other factors. AAPC Audit Services conducted a case study spanning five years and multiple specialties to demonstrate that a targeted approach of **audit, educate, and re-audit** poses a long-term solution for improving coding accuracy. Findings of this case study are based on audit results compiled from a sampling of over 200,000 audited records. The time frame for comparison was from 2014 to 2019, with most audits being for medium to large organizations (with 100+ providers). This all-inclusive study proves the success of compliance-support audits, post-audit education (for both providers and coders), followed by re-audit. Scoring for these audits was based on code or unit, not dollars or RVU values, as these can fluctuate over time. By 2019, our audit sample data had expanded to include most specialties recognized as individual by CMS. As we have audited our clients over the years, we’ve come across many opportunities. Initially, we found most providers’ score around the 73% accuracy mark, with 21% of their E/M visits over-coded, and 6% under-coded. Overall, ICD-10-CM accuracy comes in at 83%. In an industry that thrives on perfection, there’s room for improvement. The example below shows how this impacts the bottom line:

Financial Impact to Practice- Primary Care		
Average number of visits per year		4,000
RVU weighted conversion factor		$35.82
Average RVU over-coding variance		1.05
4000 x 21% = 840 claims	X $37 (over-coded value)	$31,000 per year
4000 x 6% = 240 claims	X $29 (under-coded value)	$7,000 per year

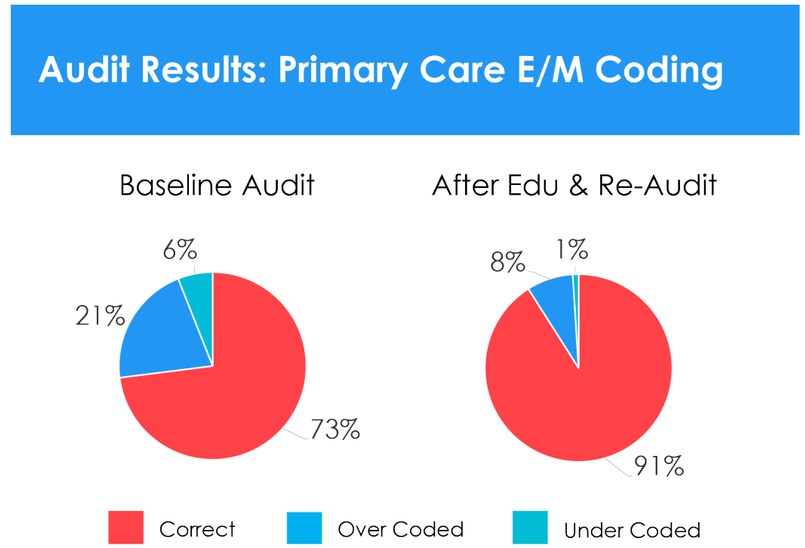
See the risk? You could be looking at a net loss of **$24,000 per year for each provider** in your organization.

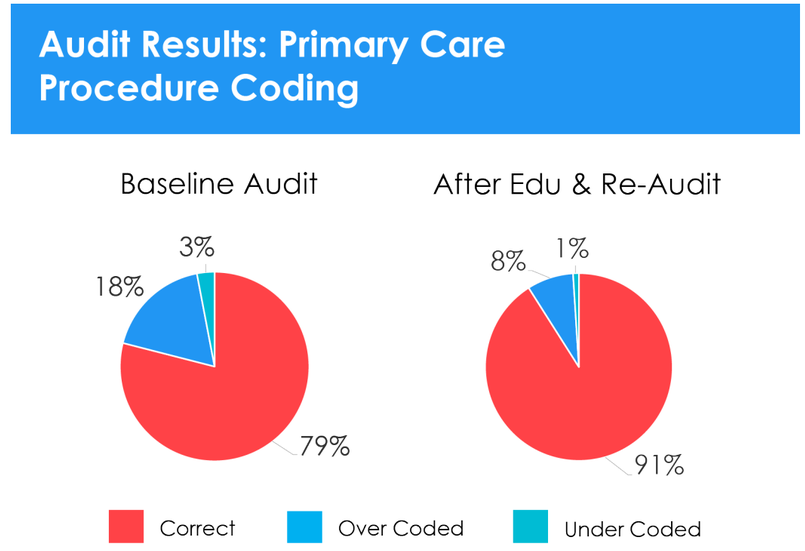
Audit Results: Primary Care E/M and Procedure Coding

The solution seems simple: build a program that educates and provides feedback to each provider. While most organizations make that effort, only 87% of audit results are brought back to the providers. 15% of compliance programs do not utilize written reports. So even if the work is getting done, a large portion of our target audience does not get the message.

There is some good news! A cycle of audit, educate, re-audit may seem repetitive, but AAPC Audit Services has demonstrated marked benefits in doing so. Over the past 5 years, we have analyzed thousands of audit results to determine if this repetitive cycle was of any value to our clients. We've all heard that "Repetition is the mother of retention." Now we know this adage is true. Take a few examples into consideration. For Primary Care, the audit program saw an increase in accuracy from 73% to 91%. In monetary terms, this was a reduction from net loss of $24,000 to $10,000, which lowered overall risk by 42%.

To break this down even further, procedural coding saw an increase in overall accuracy as well, from 79% to 88%. There was a 4% jump in procedures that were added. That's money left on the table that we were able to grab through the process of audit, educate, repeat.

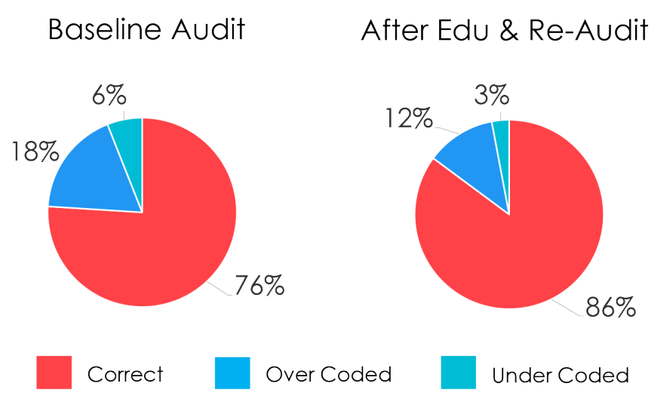




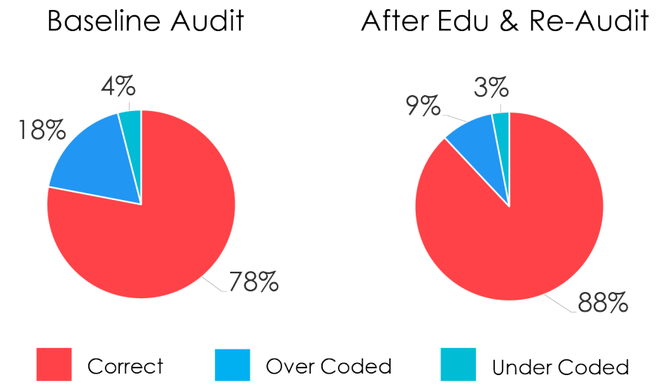
Audit Results: Specialty E/M and Procedure Coding

Specialists were not excluded from this case study, and we saw similar results from their repeat audits, up from 76% to 86% for E/M and from 78% to 88% for procedural coding. The biggest challenge our specialists face is that of under-documenting. Many times, the work is done but it never makes its way to the note. This is something post-audit education will help drive home. Again, “if it isn’t documented, did it happen?” We know it did — by reading the documentation that exists — but helping our providers realize the picture they’re painting needs a bit more color; we saw a fleshing out that helped them drive their coding accuracy.

Audit Results: Specialty E/M Coding



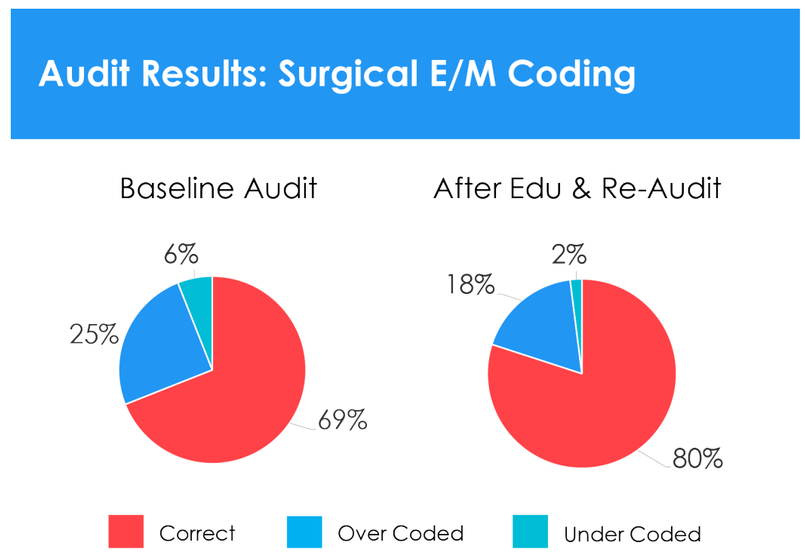
Audit Results: Specialty Office Procedure Coding

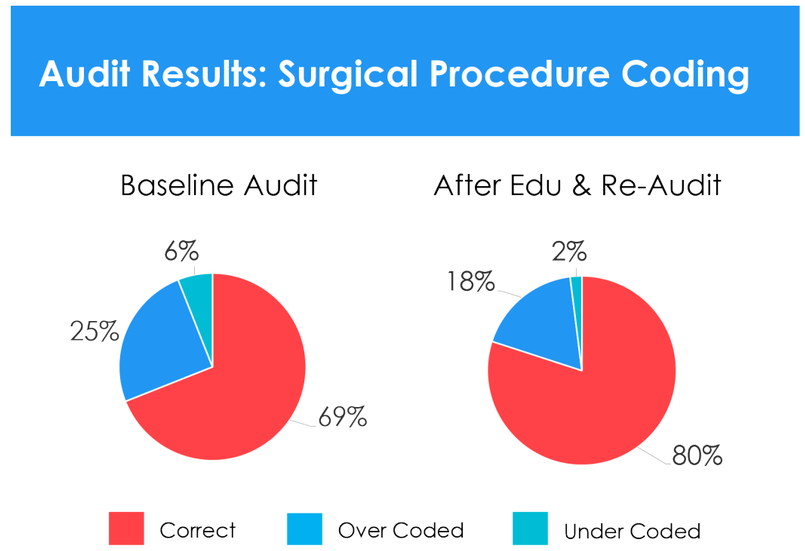


Audit Results: Specialty E/M and Procedure Coding

Surgical specialists saw even more of an improvement from their baseline upon re-audit, up from 69% to 80% accuracy. This was interesting to note, as surgical specialties typically perform their own coding, whereas other specialties have coder support. Not only that, most surgical practices have no formal, seasoned audit programs. Our audit was a true baseline, and we started laying the first foundations. Over 5 years, this averages out to a 2% increase in accuracy rate year over year, gaining improvement over time with repetitive education.

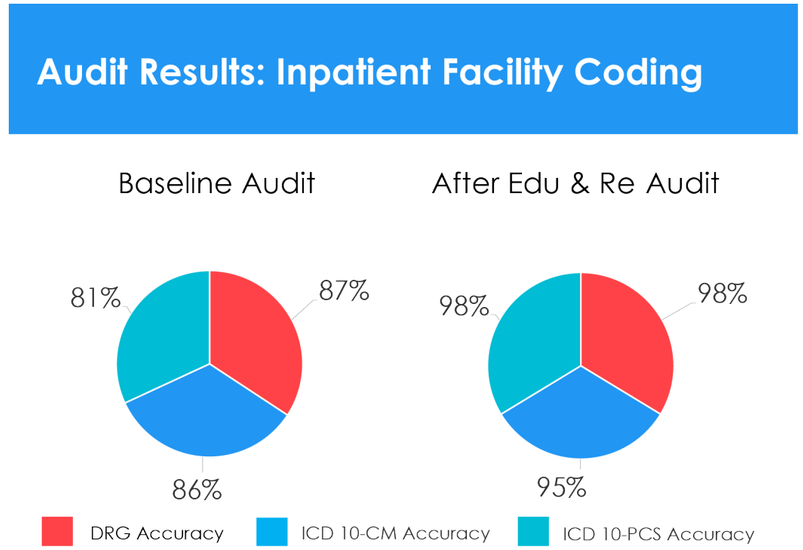
From a procedural standpoint, most surgeons were above the industry standard of 80%, but there was still a measurable increase from 81% to 90% accuracy. Given the fact that surgeons have a vast repertoire of codes to choose from, and that descriptions can be similar, it was impressive to see we started in a good place, made some tweaks that cut missed revenue from 6% to 3%, and reduced error rates from 13% to 7%.



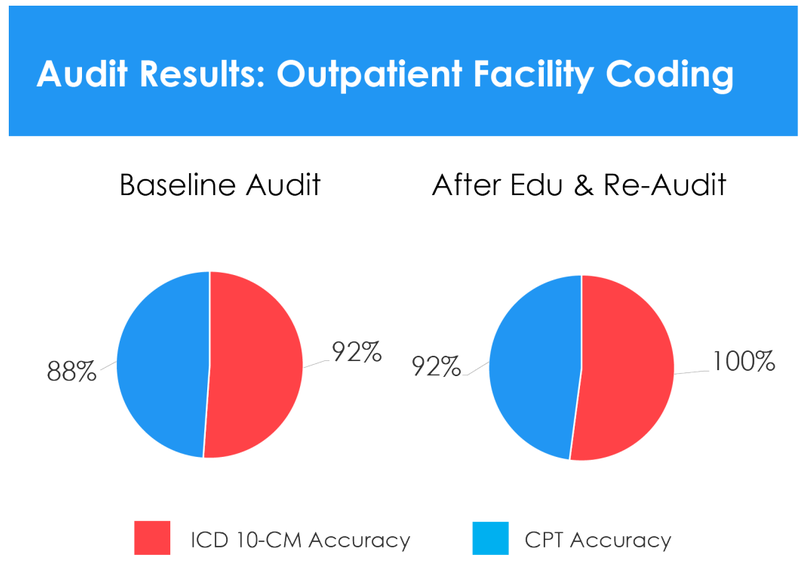


Audit Results: Inpatient and Outpatient Facility

For Inpatient Facility, after our repetitive audit process, we saw an increase in all three areas meeting or exceeding AHIMAs pass rate threshold of 95%. We began a study of efficacy three and a half years ago, and the results speak for themselves. Most hospital organizations have audit programs as part of a long-standing compliance plan. The gaps often come when new coders are brought onboard. Baseline accuracy for DRG assignment, ICD-10-CM, and ICD-10 PCS all saw an average increase of 10% with our repetitive audit program.



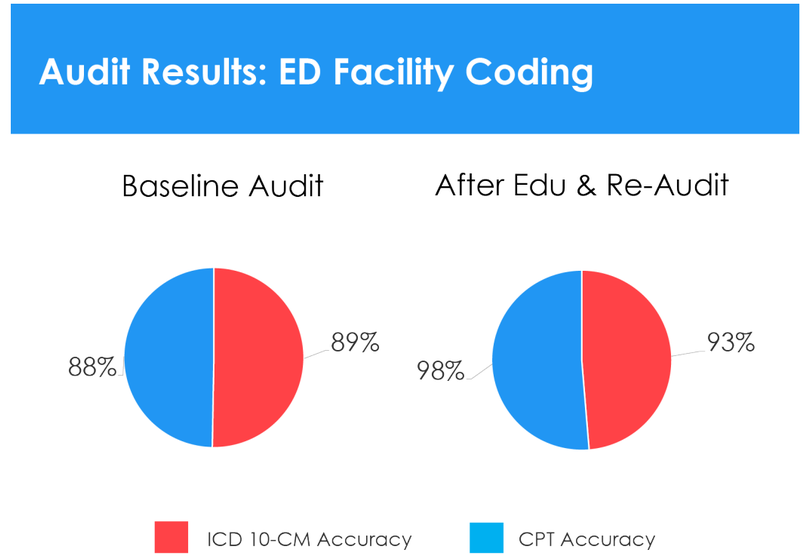
One of our larger successes was with outpatient facility audits. We achieved a 100% accuracy rate for CPT® assignment after education and re-audit!



Audit Results: ED Facility

Four years ago, we began a case study for ED Facility coding and once again we saw similar jumps in accuracy rates. Translating these improvements into percentages by which your organizational risk is reduced is a service that cannot be bought. Peace of mind has no price — and having a network of industry professionals that can provide this type of measurable improvement can make that possible.

How is this accomplished? I have been with AAPC Audit Services for nearly 6 years — the entire time of this case study— and I've heard the same feedback over and over again: this cycle provides proven results. According to our data, 55% of organizations we polled outsource their audits to an external vendor either partially or 100% of the time. They allow their vendor to do the "heavy lifting" associated with their programs. For less than the cost of one good, knowledgeable coder's full-time position, their entire audit program can be paid for annually. This gives them a wide range of benefits, including increased coding accuracy, identifying missed charges, and decreasing over-coding risk. Having access to a network of experts can help you rest easy, knowing that even the most obscure, challenging specialty coding is known. Our team has a solid structure in place from sampling, performing the audit, reporting, even post-audit education. A vendor can help to ensure you do not compromise on your compliance standards due to lack of manpower and time. We commonly see



organizations lower their standards to avoid conflict with providers, only conduct reviews every other year due to a shortage of staff, or even lowering their pass rate thresholds to void a higher number of re-auditing or remedial training that may be required. Worse yet, an overzealous coder might disallow certain services due to lack of documentation. When a vendor looks at the documentation, however, they may find it did meet CMS' minimum requirements and rather than disallowing the services, will provide education to both the coder and physician on the CMS requirements and how to improve the documentation for best practices.

Building a stronger compliance foundation involves developing clear audit guidelines, addressing industry changes, and exploring best solutions. Adding 3rd party subject matter experts with coders, auditors, support staff and upper managers can be an integral part of your support team. Our study has also proven that small, frequent audits reduce error and increase accuracy of claims submissions. It takes time to see the impact this has on your organization, and it's important to look at both short-term and long-term goals your organization wishes to accomplish by engaging external vendors.

Once this program is built, it needs a means to communicate its message. Implementing user-friendly, meaningful audit reports that are simple, clear, and direct, and taking a provider's perspective into consideration can help establish rapport and build trust. The reports should focus on consistent findings that stay away from "coder speak" and focus on accepted industry benchmarks. Personalizing these reports to be specialty-specific provide even greater benefit as you're more likely to listen to a message that is specifically for you. Once results have been generated, training should be provided that specifically indicates areas of opportunity for improvement, in accordance with recognized industry standards. And rather than implement a punitive approach when pass rates aren't met, they should be presented as goals to strive for in subsequent audits.

We cannot stress enough the importance of a compliance program that functions like a well-oiled machine. When you implement a cycle of audit training and re-audit, risk to your organization will decrease. And coming from a secure knowledge base with a reputation for excellence will only enhance your providers' engagement and trust in the program. If resources within your organization prohibit such, a plan a third-party vendor may be the ideal solution. Based on the evidence we have presented with this case study I'm sure you'll agree this route is worth considering.

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If you have questions about the upcoming E/M changes, are interested in a compliance audit, or are looking for customized training, AAPC Audit Services can help. Reach out today by email, phone or at aapc.com/business/

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