# Use These Preparedness Strategies to Protect Your Practice Against Payer Audits

These steps will also increase revenue.

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In order to get paid for the work they do, doctors and their staffs must stay informed regarding all the new regulations presented by the government and third-party payers. The old caveat "If it isn't documented, it wasn't done" applies even more in this era of electronic health records (EHRs) and data analytics.

Insurance companies deny claims for myriad reasons, and the Medicare Fraud Strike Force Teams use data analytics to prevent and combat healthcare fraud, waste, and abuse. If you bill a lot of one CPT code, it is almost guaranteed that it will eventually trigger an audit. There may be nothing wrong with your coding and documentation, but you will be subject to more scrutiny because payers run claims through analytics systems to identify patterns that fall outside the bell curve.

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Not only do audits improve the chances that your group is compliant with federal and state regulations, but internal audits can infuse new-found

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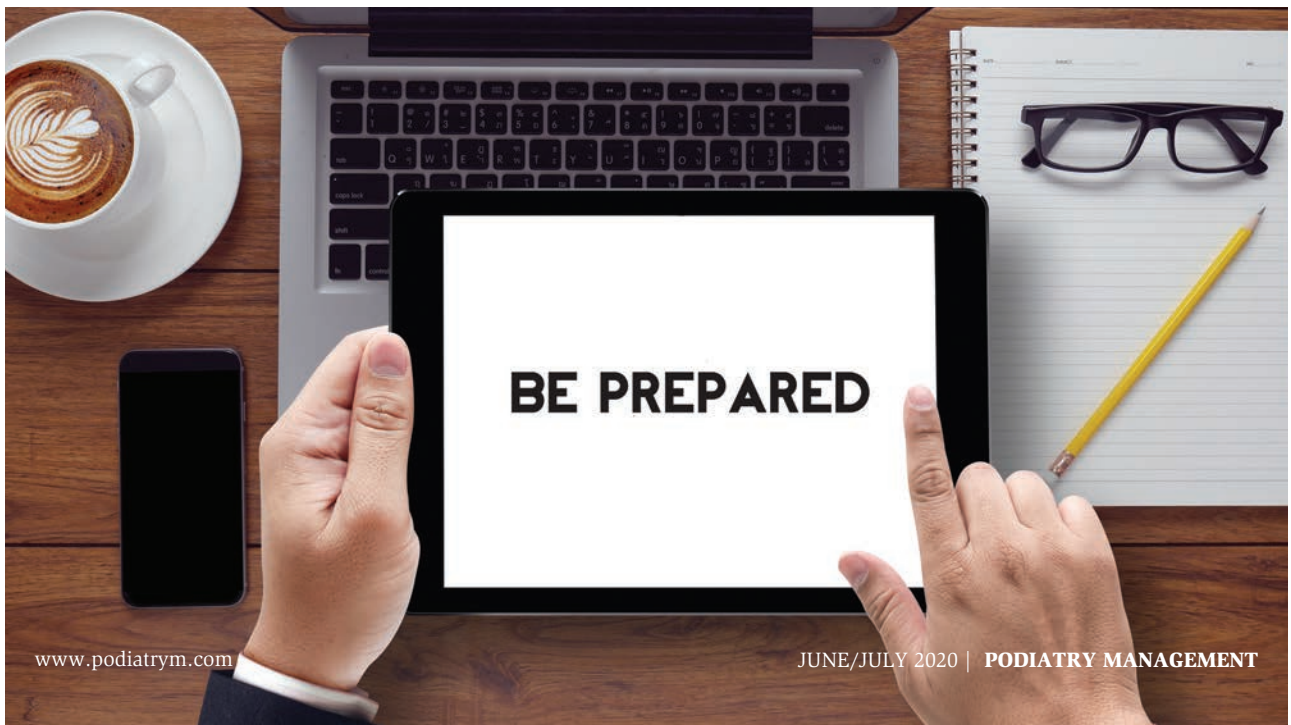

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cash into the practice by discovering revenue loss. There are many audits available that you can perform, including the Occupational Safety and Health Administration, Corporate Compliance business associate agreements, HIPAA, and revenue cycle management. Here's how to prepare for a potential audit by a third-party payer or the Medicare Fraud Strike Force.

**Policies and Procedures Manual**

If your staff members are not aware of your policies and procedures, they cannot adhere to them. Every practice should have written policies and procedures so all staff know how to handle every situation that occurs in the practice.

Written policies, checklists, and task assignments with back-up personnel for every task can prevent small tasks from falling through the cracks. Teamwork can make large tasks less daunting. With everyone on the team focused on the goal, small tasks get done quickly, and large ones seem easier. The end result is that the practice will run more smoothly and your bottom line will be healthier for it. Your manual should include performing quarterly self-audits so that you can find any errors on a timely basis.

A policies and procedures manual that is relegated to a shelf is useless. All staff must be trained in the policies when hired. Periodic reviews of the manual and updates as needed are vital. An annual review of the policies for all staff is recommended.

**Front Desk Staff Strategies**

The front desk staff is essential for checking in patients, collecting co-pays, and verifying insurance. Have staff verify insurance, confirm the copay, and review whether there is an unmet deductible. Many EHRs now perform this task in real time, and most insurance companies have a provider portal where benefits can be looked up.

Staff should check to see if patients have an outstanding balance. For patients who have a balance but cannot pay in full, this is a good time to refer them to your back office staff, who ideally can explain pre-established payment plans. Staff should communicate to patients that they are expected to pay in full or for an agreed-upon payment amount on the day of the visit.

***1) Mail paperwork to new patients ahead of their appointment.*** For patients who are new to the practice, send a welcome packet with all the paperwork they need to complete, by either U.S. mail or email. This will save time the day of the visit and will also give patients more time to ensure they get the details right. Include a copy of your office's payment policy and detail the accepted forms of payment. Remind patients to bring the completed paperwork along with their insurance card and copay. For self-pay patients, let them know the minimum payment you expect at the time of the visit, and be sure to point out that it might be more, depending on the services rendered.

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***2) Confirm insurance information is up-to-date.*** On the day of the visit, ask to see a copy of the patient's insurance card. Insurance plans change more frequently these days, and patients often forget to contact the office to update their files. If you submit a claim to the patient's old carrier, your practice will lose money, because staff will have to spend time sorting through returned claims, locating and updating patients' current information, and re-submitting claims with the hope that those re-submitted claims will eventually be paid.

***3) Double-check before patients leave the office.*** When patients get to check-out, your front desk still has to complete a few remaining billing tasks:

- Have the staff review the superbill or encounter form.
- Collect any additional money due from self-pay patients or for procedures that were performed beyond a standard office visit.
- Make it as easy as possible for patients to pay. Allow payments through mobile devices, credit cards, patient portals, and also by old-fashioned bank checks.
- If patients cannot pay in full, refer them to the back office to get on a payment plan.

**Begin the collections process even before the patient enters the door.**

***4) Conduct patient flow analyses regularly.*** Time is money, and any time there is a patient flow problem, it costs the practice. The office manager or practice manager should analyze patient flow for all services provided, find problems, and identify ways to streamline the processes. For example, a patient flow study could show how long it takes patients to complete the check-in process and be placed in the exam room. This will help you track and streamline processes at the front desk. A shorter check-in process can improve patient satisfaction and help keep providers from falling behind schedule.

**Back Office Strategies**

Much of the billing and collections work is done in the back office. When the back office staff takes its tasks seriously, processes proceed more smoothly throughout the practice, and your bottom-line will reflect that in increased revenue and decreased costs.

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***1) Train select employees to set up payment plans.*** Often, the front desk will discover the need to set up a payment plan with self-pay patients or patients with an outstanding balance. The actual arrangement, however, is made by the back office staff. It is crucial for these plans to be consistent and fair for all patients. You need to have one or two people in your back office who know how to set up plans correctly. Training back office staff also will alleviate the pressure on the front desk to make decisions about waiving payments when their familiarity with the patient and their emotions may cloud their decision-making.

***2) Reconcile encounter forms and bill claims daily.*** If there are any questions about the services rendered, seek clarification from the provider. Your billers should be knowledgeable about appropriate modifiers and when to use them. Make sure your billers are submitting clean claims. Clean claims get paid the first time around and stand up to a potential audit.

***3) Analyze insurance denials and develop processes to reduce them.*** Is there misuse of modifiers? Are denials related to medical necessity or outdated codes? If you make the effort to track the denials and see where you're making mistakes, the time spent will be rewarded with higher and prompter payments. Similarly, have processes in place for correcting and refiling denied claims in a timely manner.

***4) Follow up on accounts receivable daily.*** Run insurance aging reports and review anything more than 60 days old. You may have to call the payer in some cases, but most claims pay within 21 to 30 days of submission. If this is not the case, you need to investigate what's going on.

***5) Designate one person to follow up on patient balances.*** Your front office is making sure patients are aware of their balances. Someone in the back needs to be tasked with calling the patients and asking for payments. Many practices outsource this responsibility. It's less important who makes the calls than that follow-up is conducted on an ongoing and regular basis.

**Getting Paid Appropriately**

The following steps can ensure the practice receives appropriate payment for services rendered.

***1) Collect patients' portions of the balances at the time of service.*** Any biller can tell you the many challenges of calling and sending statements to get paid afterwards. For as many times as a patient will say the check is in the mail, you probably spent a good chunk of the outstanding balance just in postage.

**Compliance-friendly practices invest in education and provide access to resources and tools.**

***2) Use technology to know the insurance status before the patient is seen.*** Don't assume a patient's insurance is active just because she says so and hands you her card. Patients often are surprised to find that their insurance is inactive and that they were never notified. Alerting them to their inactive status gives them a chance to re-enroll. If you see a patient whose insurance went inactive, then know you're in for a battle to get paid. The insurance company won't do it, and the patient will argue it's the insurance company's responsibility.

***3) Code to the highest appropriate degree possible.*** Coding doesn't add any value to clinical outcomes and is a major time drain but, if you are contracted with insurance companies, you have to follow their rules. Document everything and code appropriately.

***4) Don't assume your billers know everything.*** The physician and practice are ultimately responsible for accurate billing. You need to check in and see that the billers are billing accurately. Medicare has become more aggressive in regulating fraud and abuse. You can't afford to not know what is going on with your billing.

***5) Review accounts receivable at least once a month.*** There should not be many claims that are more than 90 days. If there are, there is a problem and your cash flow is being affected. Find the problem and fix it.

***6) Follow up on past due balances.*** Any balance older than 30 days requires action. It may be a phone call to the insurance company or patient. It may be a review of online claim status. The insurance company has no incentive to pay you in a timely fashion.

***7) Fight denials.*** A determination that a service was "not medically necessary" and denied must be appealed and re-submitted with the supporting documentation. When you order a test, medication, hospitalization, or procedure, it's because the patient needs it.

**Create a Culture of Compliance**

Provide staff with the right training and tools. Ensure physicians understand coding accuracy, internal reviews, and feedback. Encourage, don't penalize, staff for asking questions about code choices or inconsistencies in documentation. The staff should know how to navigate the differences between CPT rules, guidelines, and payer policies, such as National Correct Coding Initiative edits.

Conduct an internal audit periodically, and analyze the audit results for outliers, overuse of codes, inadequate documentation, and other potential red flags that might trigger an audit.

Compliance-friendly practices invest in education and provide access to resources and tools. This includes buying CPT books annually, encouraging regular attendance at coding and billing webinars, and having physicians and staff members attend training.

**Work Smarter, Not Harder**

Consider embracing technology to boost your billing and collections efforts.

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New innovations may cost up-front time, effort, and money—but should save more time, effort, and money in the long run. Consider the following ways to make technology work for you.

**Go Paperless**

Most medical providers still invoice patients via paper, although paying bills by credit card via online patient portals can be second nature for patients who are used to online shopping and electronic check out. When that's not an option, it's easy to delay or even forget about paying the bill. Sending electronic invoices and accepting payments online can make a significant difference in your collections rate.

**Accept Payment on the Spot**

Because you have told patients that their copay or payment plan is expected at the time of service, make it easy for them to pay. Your chance of collecting a payment decreases the minute the patient walks out of your office. Accepting credit and debit cards is one of the best ways to boost your in-office payment rate, because fewer people carry cash these days. Be sure that you are compliant with the Payment Card Industry Data Security Standards (PCI DSS) regulations, and refrain from keeping patients' credit card information on file because of the increasing security risks involved. If you explain to patients that the minor inconvenience of having to enter their credit card information for every transaction is actually a security precaution, it should resolve any complaints as well as bolster their confidence about your stewardship of their data, both financial and medical.

**Consider Eligibility Verification Software**

Eligibility verification software is an under-used tool that can help with your collections. This innovative technology usually is an add-on to your EHR system that allows you to check a patient's eligibility, copay, and co-insurance. Some verification software can even notify you if a patient has met his or her deductible or, if not, the specific amount you need to collect after a visit. The software doesn't work for all plans, but it should work for many of your patients who are insured with big national payers.

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**Medicare Fraud Strike Force Teams**

Correct billing and compliance not only help your bottom line but can also keep you out of the crosshairs of the Medicare Fraud Strike Force teams. Medicare fraud is a serious offense, and these teams bring together the efforts of the Office of Inspector General, the Department of Justice, Office of the United States Attorney, the FBI, local law enforcement, and others. The teams use data analytics and the combined resources of federal, state, and local law enforcement entities to prevent and combat healthcare fraud, waste, and abuse. Strike Force teams have shut down healthcare fraud schemes around the country, arrested more than a thousand criminals, and recovered millions of taxpayer dollars.

**Conclusion**

Healthcare billing and reimbursement is more complicated than it has ever been before. Have procedures and policies in place and train staff to follow them. Turn to technology when possible.

Avoid having claims submitted and denied by ensuring documentation and billing are done correctly the first time. Be proactive in collecting co-payments and deductibles from patients at the time of service. Have payment plans in place for the self-insured and those who cannot pay their share of the bill at the time of service. Perform internal audits to discover problems before the OIG does it for you. It is important to recognize that self-audits can augment practices by unearthing revenue loss. **PM**

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