Transitioning from Coder to Auditor, *and Beyond*

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Presented by Linda Duckworth, CHC, CPC
Senior Managing Consultant and Compliance Officer

Disclaimer

The program is intended to be informational only. The speaker is not an authoritative source by law. Attendees are advised to reference payer specific provider manuals for verification prior to making changes to their coding, documentation and/or billing practices

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Setting our sights

- **Career advancement opportunities are expanding**
  - **Growing need for coders**
  - **Increased need for Auditors / Reviewers**
  - **Greater need for educators**
- **How do we prepare for them?**
  - **Ownership and opportunities**
- **How do we set ourselves apart from others?**
  - **Self promoting; materials and attitude**
- **What does a hiring manager look for in an Auditor?**
  - **Finding the right people**
  - **Confirming the candidate is right for the job**
  - **Making expectations known**

Lessons Along the Way…

- Insurance clerk
- Office manager
- Practice manager
- Auditor
- Compliance manager
- Educator
- Consultant

Career Opportunities – Coder or Auditor

Increasing payor oversight and input

- Commercial plans are becoming more active in scrutinizing coding patterns and challenging the codes
- Payors attempting more of a “team approach”
- Greater emphasis on data collection and preventive/quality measures

Career Opportunities – Coder or Auditor

Increasing payor oversight and input

- CERT continues
- Comparative Billing Reports continue
- Targeted Probe and Educate went live October 2017

- As long as they continue to get a good return on their investments, the likelihood of them reducing their efforts is fairly low
- All of this is also known as….

Career Opportunities – Coder or Auditor

Evolving and Growing

- Used to be 100% CPT driven
- Moving towards diagnosis related payments
- Quality indicators impact reimbursement
- Medicare used to offer no coverage for preventive services, but now expanding at a pace that is often difficult to keep up with

Career Opportunities – Coder or Auditor

Ever changing environment
Regulatory Issues; a Moving Target

- Incident-to
- PATH requirements
- Split/shared
- Scope of practice
- Supervision requirements
- Credentialing (correctly)
- Orders
- Validating signatures
- Medical Necessity
- MSP requirements
- Copy and paste
- ABN concerns (proper use)

Career Opportunities – Coder or Auditor

Ever changing environment
Thinking Outside the Box

- Revenue cycle enhancement
- EHR vendors
- Payors
- Contract negotiation
- Specialty organizations
- Facility coding/charge master
- Law firms
- Consulting companies
- Coding trainer
- Technical reviewer

Clinical Examples Family Practice

Item	Issue
POC labs	• Lack of necessity • no results
X-rays	• Billing technical component under the Non-physician to CMS (only a physician can supervise [bill for] the technical portion of x-rays) • Missing orders, or the number of views in the order • No interpretation and report – must read somewhat like a radiologist's report – reason for test, detail the findings
Cerumen removal	• 69209 Irrigation by nurse – no documentation found • 69210 This code requires physician skill, and use of instrumentation. Needs procedure note outlining the work involved.

Clinical Examples Family Practice

Item	Issue
Pediatric vaccine w/ counseling	• 90460 No mention of **counseling** on the vaccine **components.** Instead report with 90471/90472 (refer to AAP's table of vaccines for correct reporting of billing units)
Incident-to violations for CMS	• The non-physician; 1. Sees a new patient, bills under supervising physician 2. Addresses new problems, bills under the supervising 3. Makes changes to the treatment plan, and bills under the supervising **Just bill under the NPP's number!**
Split /Shared visits	• Level of Physician involvement fails to meet CMS billing requirements. Attestations added by the physician are often more consistent with Teaching Physician statement.
Preventive (general/annual) visits	• Missing the risk reduction/counseling portion. This is the greatest distinction between preventive and problem-oriented.

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Clinical Examples Family Practice

Item	Issue
Injections / venipuncture	• Incomplete physician order – missing or incomplete nursing documentation
Transitional Care Management	• Lacking the necessary components ○ Face to face / med reconciliation, etc.
Medicare Annual Wellness Visit	• Lacking the necessary components ○ Written schedule / plan of preventive services is often overlooked ○ List of current providers and suppliers missing
Modifier -25	• Qualifying circumstances not met ○ Amount of work is consistent with decision to perform a minor procedure ○ Amount of work, in addition to preventive, does not support a separate charge
Lesion removals	• Size and characteristics of lesions and technique omitted • Limiting the documentation to CPT descriptions

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Clinical Examples Family Practice

Item	Issue/Recommendation
99204	• History and/or exam is not comprehensive
Medical Necessity	• Not enough consideration is given to the **nature of the presenting problem, and/or the number of treatment options**. **This carries a considerable amount of weight in an audit.**
Copy/ Paste	• Visit, to visit to visit, stagnant information – must edit text so that its accurate, and applicable to the visit.

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EMR

- The organization needs a "fresh set of eyes" to evaluate for;
- Unedited templates
  - Inconsistent with the visit – disallowed under audit
- Copy and Paste
  - Fails to note new information from visit to visit – disallowed under audit
- Outside of scribing, allows others to document critical areas for the physician, undetected on the surface
  - Example – HPI, physician responsibility. Other person = disallowed

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Need for Coders?

Health Management Technology, January 29, 2010 (article)

"Computer Assisted Coding (CAC) does not eliminate the need for medical-coding professionals to be involved in the coding process, but it can make them more productive and accurate.

Technology has finally arrived that is radically changing the process of medical coding in health-information management. Computer-assisted coding (CAC) automatically generates medical codes directly from clinical documentation. With CAC technology, healthcare organizations can streamline their revenue-cycle processes while becoming more compliant with the increasingly complex payer and quality reporting requirements."

Physician Coder II

- **Position Summary/Career Interest**

The primary functions of this position are to provide staff support for coding of charges with CPT, ICD-10 and HCPCS and to be a resource for the physicians and other health care providers in regard to coding and to review medical documentation to insure appropriate physician billing

Coder II Position

- **POSITION SUMMARY:**
  As a Coder II, you will manage and execute coding clinical notes supporting a minimum of one specialty. The Coder also functions as an amazing partner to provide feedback and documentation advice to our physicians, practice management team, denials team, and their fellow coders.

Coder vs. Auditor

Coder

Assigns codes being somewhat trusting of information placed in front of him/her

Auditor

Scrutinizes the quality and content of the record, trouble shoots, and explains deficiencies.

Creates written explanations for findings and recommendations

But they're both communicators and educators-
a VALUABLE ASSET to any organization!

Need for Reviewers

- No longer can we work without oversight in our organizations
- We must have strong compliance programs with a plan for self-monitoring (internal or outsourced)
- The reviewer/auditor must consider themselves a resource and educator, not just the "bad guy"

Compliance Auditor II

- Develops audit programs, determines scope, objectives, and approach.
- Routine audits provider charges and medical charts to review coding procedures, compliance with government regulations and company policies.
- Prepares clear, concise audit workpapers.
- Provides constructive recommendations to management and providers.
- Drafts formal, written reports stating the audit conclusions in a clear, concise manner.
- Conducts meetings with physicians to review findings and recommendations.
- Provides coding training sessions for providers and staff and researches coding questions.
- Presents audit reports to the Hospital's Internal Audit & Compliance Committee.
- Serves as a resource in addressing compliance queries from CMS, other third parties, internal legal counsel, Hospital Executive office or other staff/ interested party.
- Researches, leads and directs activities related to payor audit queries.

Appeal Writer / Denials Manager

- Given the increased payor scrutiny;
- Denials management positions are opening up
  - Tracking and trending / educating
- Appeal Writers are in demand
  - An appeal is not just attaching records "See attached".
  - Looks at every aspect, documentation, coding, regulatory, payor specific rules.
  - Very savvy in developing strong arguments.

Audit background extremely helpful for these positions

Advancing

So, what does it take to transition from a coder to an auditor, or an appeal writer, educator, or to a consultant?

- Initiative
- Making yourself heard – let your desires be known
- Self motivation to learn
  - New specialties
  - Report writing skills
  - Teaching techniques
  - Research / reading
- Willingness to be vulnerable – have perseverance to try and try again.
- Up your level of professionalism .

Advancing

What it takes

- Welcoming advice from others.
- The ability to say “I don’t know”, and feel ok about it.
- Understanding there will be trying times, provider/admin meetings, conflicts.
- Understanding and embracing the goals of the organization and the project.
- Time management.
- Be a good listener – empathy towards those under review.
- Being able to take criticism.

- *And speaking of criticism ….*

Communication Skills

- Auditors require either excellent writing skills, or have assistance with report writing.
- The quality of the report determines the believability of the information and credibility of the author.
- Reports impact the internal audit department’s reputation and/or directly effect a client’s decision to rehire or refer an audit firm’s services.
- Reports should go through a “technical review” process prior to releasing to the provider.

- *Consider attending writing workshops.*
- *Network with others.*
- *Ask for sample (redacted) reports from others.*

Communication Skills

- Findings/errors must have clear and concise explanations.
- The content must be educational.
- Codes in the reports should have descriptions, or be described by the writer.
- The reader must have "nuggets" of information to take away from the report, that are useful and that can be applied to their work flow or operations.
- The writer cannot assume the reader is familiar with coding language (NCCI edits, recite differences in 95 vs 97).
- Mastering the skill of written explanations takes time, and lots of practice, and lots of feedback (*constructive criticism).*

Fine tuning the writing

- In the documentation we could not find x-rays results documented. Documentation shows it was ordered, but only documented as a 2-view with 3 views coded.

❖The Reviewer was unable to locate x-ray results. An order was present, however, it was written as 2-views, not three, as coded.

- Documentation supports a lower level of service, since the history only supports expanded problem focused, when a detailed history is needed to support the code. Based on the history, only a 99202 is supported.

❖Documentation supports a lower level of service. The history was less than detailed with a limited HPI and only one ROS. For the new patient, where all three key components are required, this brings the code down to 99202.

- Not signed can't bill.

❖The progress note was not signed at the time of the review. Though it may have been billable, under a Medicare audit a signature attestation will have to accompany the records release. Medicare expects documentation to be completed and signed "as soon as practicable".

Fine tuning the writing

- Detailed history. Detailed exam. MDM is moderate. Rx given.

❖The history and exam were both detailed. Medical decision making is moderate for the new problem (cellulitis), that requires Rx's for PO antibiotics, IM steroids, and Rx topical cream. Lab drawn. Skin markings (measurements) were made and the patient is to watch carefully for further extension. RTC 5 days to reevaluate. Code as 99214.

- Add modifier 25.

❖The separate and identifiable E/M service is supported by the extended work in diagnosing and managing the infection; prescriptions written, labs and x-ray ordered, and consideration for referral. Append modifier -25 to convey this to the payor.

- Also code the smoking.

❖According to ICD-10 guidelines for hypertensive diseases, report the patient's nicotine use when applicable. Since the patient has hypertension and continues to smoke, we suggest adding the patient's use of cigarettes *(dependence)* to the assessment, and report accordingly. Consider codes from the F17.21_ category.

Fine tuning the writing

- 99222 to 99221. Medical record documentation supports a code lower than the reported code. The examination is insufficient. Medical record documentation supports adding R41.82 Alerted mental status as this was addressed in the assessment and plan.
- 99213 to 99214. Medical record documentation supports a code higher than the reported code. Patient presented with a new problem requiring a comprehensive history and additional work up. *And what about risks?*
- Medical record documentation supports reporting 45380 –Colonoscopy with biopsies instead of 45378 – Colposcopy with specimen collection by brushing/washing.
- Code 32096 not supported. Code 32096 (lung biopsy), is bundled into the payment for 32480, single lobe pneumonectomy, meaning it cannot be billed during the same operative session unless the qualifiers for modifier -59 have been met (such as separate location/incision). Consider using the "X" modifiers in lieu of -59 as they prompt the coder to select the reason for unbundling.

Consultants

- An auditor is more focused on coding accuracy. A consultant brings years of experience. They've seen 500 hundred reports for the procedure, they know quality/complete documentation when they see it.
- They might be familiar with several EMR systems
- Typically a broader level of experience in health care
- Not unusual to work nationwide
- They are more apt to look at bigger pictures, such as risks to organization, short/long term. Bringing a stronger compliance feel to the project
- Often work with attorneys
- Create innovative solutions (restructuring templates or workflow, updating systems, evaluate staffing, etc.)

Setting Ourselves Apart

- Create a powerful resume – one that speaks to the specific job description. *May need to tweak for different positions/applications. Hi-lite different skills (PATH, RHC etc.)*
- PROOF READ!!! Have another person proof/edit before sending
- Include not only references to what you've accomplished, but also to what you can bring to the organization!
  - Market yourself!!!!
- Training and research experience are a huge bonus
- Articles written, presentation experience

Setting Ourselves Apart

- Offer samples of your reports if available
- Be prepared to discuss the "wins" that you've had in previous positions
  - *Appeals*
  - *Rejections/denials*
  - *Days in A/R*
- If experience is limited, emphasize your willingness to learn, seek out training opportunities. Including additional specialty credentials
- Make it known that you have strong connections, you have resources and support, you are connected with the people at the AAPC of KC!!!

Finding the Right Candidate for Auditing

- Start be defining the goals of the position. Provider audits? Education? Formal reports to the compliance committee? *WHAT DO YOU WANT TO GLEAN FROM REPORTS?*
- How often will audits be done? Is there room for crossover work in A/R for working appeals or denial management?
- Envision the position /person's role within the organization.
- Don't rule out the "right" person for the position due to lack of experience. Invest in the right person. *Audit skills can be taught, where personality, work ethic, and initiative cannot.*
- If not a coder, ask a coder/auditor to be a part of the interview process.

Finding the Right Candidate for Auditing

- If the position requires interacting with providers, include a provider in the interview process
- Request sample work (reports)
- As them to discuss common hot topics during the interview
- Ask them what they found effective in past experiences when it comes to documentation, coding education *(whether they delivered it or received it)*
- Advertise through the AAPC

In conclusion

- Start reading job descriptions now. This helps you to anticipate what skills and experience are needed for the type of job you desire
- Make your wishes known to supervisors "I want to advance!"
- Be willing yourself to seek out education and training
- Look at specialty credentials to further demonstrate your expertise
- Stay connected with the AAPC!

Thank you for attending

Linda Duckworth, CHC, CPC
Senior Managing Consultant & Compliance Officer
The SCBI
Grain Valley, MO
lduckworth@thescbi.com

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