Policies and Procedures: WVU Physicians of Charleston
Internal Audit Processes

Section: **Compliance**
Chapter: **Billing**
Policy: **Internal Audit Processes**

I. Purpose

The purpose of this policy is to set forth the processes to be utilized by WVUPC for annual organizational audits of departmental billing.

II. Scope

This policy is intended to set forth the processes applicable to internal audits which are to be performed by a WVUPC employed certified professional coder (CPC) on an annual basis, and at such other frequency as may be directed by the WVUPC Board of Directors, with advice and assistance of the WVUPC Compliance Officer and Corporate Compliance Committee. The audit processes summarized within this policy are intended to supplement the performance of routine periodic self-audits of departmental billings by each WVUPC clinical department, and any annual Independent Review Organization (IRO) audits required by governmental authorities.

III. Statement of Policy/Procedure

The Office of Inspector General (OIG) has issued compliance guidance for health care providers which emphasizes the importance of self-audits to ensure that medical records and bills comply with applicable coding, billing and documentation requirements. Such audits, the OIG has noted, are an effective way for physician practices to ascertain what, if any, problem areas or areas of risk may exist for the practice, and to develop and implement appropriate corrective responses. This policy is intended to ensure that the self-audit guidelines identified by the OIG are implemented within the WVUPC organization, and that a reasonable and workable process for the performance of such audits, which takes into account the unique nature of our organizational practice, is implemented.

A. Frequency of Internal Audits by the Organization

WVUPC shall implement a process by which annual internal audits of coding, billing and documentation of claims submitted by or on behalf of each WVUPC provider who has been issued a PIN number by the federal health care programs are performed. Additionally, annual internal audits of those WVUPC billing/coding staff members who have been identified by the Compliance Officer for internal peer review shall also be

performed, in cooperation and collaboration with the several clinical departments. Internal audits may also be performed on a more frequent than annual basis if so directed by the Compliance Officer on the basis of the results of any such annual audit of individual providers and/or billing personnel.

The internal audits covered by this policy are intended to supplement the periodic performance of self-audits by each clinical department of WVUPC of their own billing and documentation practices and procedures. The audit processes outlined herein are intended to serve as an additional set of "checks and balances" for the WVUPC organization to ensure that intra-departmental errors or other areas of risk in billing, coding and documentation, if any, are timely identified and properly addressed.

B. Oversight of Internal Audits

The internal audits to be performed pursuant to this policy shall be delegated to an individual assigned by the Chief Operating Officer of the WVUPC corporation, with the advice and input of the WVUPC Compliance Officer. The individual assigned the duty of performing such annual audits shall be a certified professional coder (CPC) or shall have such other comparable skill, training and/or certification as is satisfactory to the Compliance Officer and COO. Oversight of the annual internal audit process and of the involved CPC reviewer shall be delegated to the WVUPC Compliance Officer. The audits shall follow the provisions of this policy in terms of selection and size of audit samples, development and implementation of audit guidelines and forms, and processes relating to post-audit reporting.

1. **Sample Structure and Process**

The individual assigned the responsibility of each annual audit will, with the assistance of the WVUPC Information Systems Administrator, facilitate a random sampling of claims, retrospective to claim submission, for the provider member under review. The review sample so selected shall take into account the specific type of patient encounters relevant to the individuals under review, and shall insure that the sample selected is reasonably representative of all such types of encounters.

The random sample selected for review shall be comprised of a minimum of 10 encounters, to include both Evaluation and Management services and any minor office procedures performed during the encounter. For surgical departments, at least 2 of the 10 encounters shall be for a major surgical service.

Once all paid claims associated with the encounter included in the probe sample have been reviewed, the audit can be terminated if no charge variances are identified. As a threshold standard for the auditing protocol, any provider who fails to acquire an 80% accuracy rate in the 10 chart review must undergo retraining provided by the Compliance Department. Providers will be notified of the results of their audit findings by the CPC

assigned to the review, assisted as necessary by the Compliance Officer. Any overpayments identified by the audit will be promptly refunded, and remedial steps will be taken to correct the problem within 30 days of identification of the compliance variances.

Issues with **provider** documentation, code assignment or other related concerns which are identified on audit shall be communicated to the department via the practice administrator and senior departmental biller, with the goal being to provide remedial education to the provider and to determine a training plan. Re-training at this level shall be provided by or at the direction of the Compliance Department and shall be specific to the identified problem areas. Upon completion of supplemental training to the provider, a verification review shall be performed by the Department of Compliance. Following completion of the verification review, if problems or inaccuracies are still found, the provider's clinical department shall be responsible for additional training of the provider and any necessary additional monitoring of the provider's claims in order to ensure that valid code selection and adequate documentation has occurred, pre-claim submission. The Compliance Department shall resume auditing for the provider and department in question on the next regularly scheduled audit.

WVUPC **abstraction/coding personnel** will also be audited annually on either a prospective and/or retrospective basis of 10 encounters from a minimum of 5 charts, according to their specialty area designations. Fewer encounters may be reviewed for those coding personnel whose job description includes only minimal CPT coding assignment. A judgmental random sample may, in the discretion of the compliance auditor, include evaluation and management services, minor procedures, or major procedures depending upon the abstractor/coder job description within the relevant department. The judgmental random sample will be pulled by or at the direction of the Department of Compliance from the abstractor/coder work volume on an unscheduled basis. Training will occur for all abstractors not achieving a 90% accuracy rate. For any previously billed services in which an overpayment has been identified, prompt refunds will be made and remedial steps taken to correct the problem within 30 days of identification of the compliance variances.

For abstraction/billing personnel, re-evaluation for audit results under 90% accuracy will occur within the same quarter. Failure of such personnel to achieve the 90% accuracy standard upon re-evaluation will be communicated to both the individual, to their immediate supervisor and to the Practice Administrator for the department in question. At that point, the abstractor/coder's billing responsibilities shall be assigned to or supervised by other abstractors in the department, or to abstraction personnel as otherwise approved by the COO until further training is completed. Once re-training is completed, the abstractor/coder may be re-assigned to his/her normal duties, subject to a second, pre-claim submission verification review to be performed by the Compliance Department within 30 days of the re-assignment. Failure of an abstractor/coder to achieve a 90% accuracy rate after a second verification review may result in demotion or termination of employment.

2. Audit Review Content

a. The review of the selected charts for each provider being audited shall be focused upon the particular date of service identified by the random and/or judgmental sampling process.

b. The internal reviewer will utilize a focused audit report tool designed by the Compliance Department to facilitate the analysis and reporting of each of the following:

- **Documentation of the record:** Whether appropriate documentation was in the chart for the services coded and billed;
- **Accuracy** in code selection and modifier assignment;
- **Indication of Teaching Physician presence:** Whether the teaching physician adequately documented presence for the services coded and billed according to Medicare's teaching physician guidelines;
- **Service up-coding:** Whether the code and/or level billed were higher than the supporting documentation;
- **Service down-coding**: Whether the code and/or level billed were lower than the supporting documentation;
- **Un-captured charges:** Whether the record reflects the rendition of a service for which un-captured charges exist;

3. Processes for Post-Audit Reporting

a.. Once the audit of the selected records has been completed for all of the providers within a particular department, a departmental audit report shall be prepared by the internal reviewer which summarizes the major findings for each provider whose charts have been reviewed, and any relevant recommendations for correction and/or improvement.

b. Each provider whose documentation has been the focus of the internal review shall also receive individualized feedback from the internal reviewer within fifteen (15) days of the completion of the relevant department's review, or within such other timeframe as specified by the Compliance Officer.

c. The internal reviewer's written report of audit findings for each department shall be provided within twenty-four (24) working hours of its completion to the to the Compliance Officer. The Compliance Officer shall distribute such report to the Practice Administrator, the departmental Chair, and to the COO of the WVUPC organization. Except as required by law, neither the audit report nor the results thereof shall be

communicated to other third parties without the express approval of both the COO and the Compliance Officer of the WVUPC organization.

d. Following receipt of the internal reviewer's departmental report, the Compliance Officer and the Compliance Auditor shall meet with the Practice Administrator and billing supervisor of the department under review in order to examine and analyze the findings of the audit team and to formulate an appropriate plan for addressing any identified deficiencies with the individual physicians and/or billing staff involved.

e. The Compliance Officer of the WVUPC organization shall provide a quarterly report to the WVUPC Compliance Committee regarding the results of all cross-departmental internal audits and any subsequent remedial measures, including supplemental education, found to be necessary under the circumstances.

f. Billing errors identified by the audit process which require refund shall be forwarded to the appropriate WVUPC billing staff for processing.

g. Remedial instruction and supplemental audit review shall be mandatory for audit results falling under the rate of accuracy specified within this policy.

IV. References

- 65 Fed. Reg. 194, pp. 59434-59452 (Oct. 5, 2000)
- www.complianceinfo.com ("Managing Successful Coding and Billing Audits")
- WVUPC Corporate Integrity Agreement, January 27, 2006.