Video Transcript: Chart Auditing to Improve Fiscal Practices

Caitlin Hungate: [00:00:00]
Thank you everyone for joining. My name is Caitlin Hungate. I'm with the Reproductive Health National Training Center, or RHNTC, and I'm delighted to welcome you to our virtual workshop on internal chart auditing to improve Title X projects and sustainability. Before we begin, I have a few announcements. As you joined our Zoom meeting today, everyone was muted, given the large number of participants, but you will be able to unmute your audio at any point.

So before we get to the conversation, I wanted to provide an overview of what our 90 minutes today will look like. So we'll first start with a presentation by my dear friend and colleague, Ann Finn, and then we'll have plenty of time for your questions. We'll go through a few case scenarios around auditing some claims or some charts and kind of unpacking potential errors and issues. And then we will have again more time for conversation. You can ask questions throughout the conversation throughout our time together this morning. Using the chat at any time during the workshop. And we received a lot of great questions and just insights as many of you are new to your role or new to agency. So we hope to get through as many of those questions or issues in our time together.

A couple notes about the recording. So today we will record the presentation with Ann, but when we get to the question and answer interactivity, we're going to pause that and stop the recording at that point. So what is available, what will be available on RHNTC will be the presentation only. And so you'll see a presentation, the recording, and a transcript on rhntc.org in a few days. Closed captioning has been enabled for this workshop. If you need closed captioning, please click on the CC icon at the bottom of your screen.

And we're gonna chat out the evaluation for today's session at the beginning. Thanks, Nancy, so much. Your feedback is really important. We've used, and this has enabled the RHNTC and the team to make improvements in our trainings for the field. And so feel free to open up the evaluation link and follow along in our conversation. To complete the evaluation in real time. In order to receive a certificate of attendance, a certificate for completion, excuse me, for attending this workshop, you do need to be logged into RHNTC.org when completing the evaluation.

And last but not least, the presentation was supported by the Office of Population Affairs, or OPA. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA, OWH, or HHS. So as I mentioned, my name is Caitlin Hungate. I am a Title X grantee liaison and TTA provider as well as a fiscal lead and have been facilitating this fiscal workshop series. So this is number three of five. So keep an eye out for additional events later in June and July to address some common challenges around the fiscal components of the Title X program. I'm joined by Ann Finn, who's a healthcare reimbursement consultant. And many of you probably know Ann or have worked with Ann. We've partnered with Ann over the years on all things billing and coding and are so grateful for the continued partnership and expertise.

So on the next slide, we have our objectives that we hope by the end of the workshop, that we hope that you'll be able to describe how chart auditing supports project sustainability and compliance. That you'll be able to name one strategy described by a peer to support the implementation of chart auditing. And lastly, to identify one RHNTC resource that can support conducting chart audits. So as I mentioned, we'll have a first presentation from Ann, which I'll pass over to Ann in a minute. Then we'll stop the recording and be in conversation with you.

So based on the registration, we know a lot of you are new to your role or new to conducting chart audits. So we hope that the content that Ann is sharing kind of helps ground your understanding in chart audits, how to use them, and so forth. We'll close out with sharing a few resources. And again, as I said, when you joined, you were muted and we invite you to participate as you're able today. So if that means staying off camera, great. If it means joining on camera, also great. When we get to the interactivity, please feel free to unmute your line and join the conversation or use the chat as you are able to do so. At this point, I'm gonna turn it to Ann to take over.

Ann Finn: [00:04:46]

I'm okay, thanks. Great, thanks Caitlin and good afternoon, good morning to everybody that's on the call. I'm looking forward to this session and really I encourage your participation like Caitlin said and sharing because part of what I hope from this session is that it's where we really share what's worked for you and what are your challenges. There has been a lot of turnover and a lot of new people and we welcome everyone that's new and don't ask questions because the best people learn from and to use as a resource is each other and to reach out to after. So I really encourage any types of questions and feedback and you know if you have something that's worked it would help someone else and if you have a struggle someone else probably has the same. So you know it's interesting for this session. I hope we're talking chart audits, but you know, we've really kind of looked at this through what are all different ways to kind of look at the documentation and coding and what are some different volumes, not just strictly opening up a chart and looking at the documentations. So we'll have some other suggestions for you. So even those of you that are doing chart audits at this point, I think you'll pick up some new ideas and we look forward to hearing from you if there's something that you're doing. So welcome.

So just to start, you know, with grounding about kind of, you know I want to spend a few minutes thinking about like why do we take the time to do some internal audits, right? And why is it important? And the first and most important thing is that we are all a business at this point. You know, it is good to have a mission but we can't have a mission if our doors aren't open. Right? So we really need to operate as efficiently and bill everything that we are, you know, entitled to and be paid appropriately for our services.

And so if we look at the Title X guidelines, there's an expectation right in the guidelines that gives you funding that says you will bill all of the different payers, whether it's Medicaid or other commercial plans that are legally obligated to pay for services. So, you know, right, there is an expectation that you're going to do that. And then from that, right, where reimbursement will flow. And we'll help your clinic and agency to provide, you know, the wonderful care that you all do. So it's really important in moving away, and I think all of us have gotten there, but really moving away from that, like it's okay to let revenue leak. It's okay, you know, like I don't have time, it's, you're being more focused on the mission. We do have to operate like a business today and collect all the money that we can and keep all the money that we can.

Okay. So, you know, building on that, why bother, right? It's a lot of work. Everybody's busy. Everybody's on hamster wheels, right. So one is just like, as I said, it increases your reimbursement consistency. You know, the worst thing is having you're getting paid and then you have a payer audit and you've got to give back money and you got to pay fines. That's painful. It's, a lot time, et cetera. So the more, the better quality and consistent coding that we do. And capture and you know provide on our claims the more consistent our reimbursement is going to be and we're going to find opportunities right we're gonna get billed we're we're gonna get paid for services that a payer is willing to pay us for but if we don't code it we're not going to get paid Coding reviews and internal reviews are also can be part of your compliance plan.

Internal compliance is a very big important part of your agencies and should really be part of the language that is being talked about in your agency because it's easy to not focus on it and then it's easier to have some problems. And sometimes. You know, it's difficult when I see agencies that are really not focused on the compliance and this is slipping and that's slipping and this isn't right. And, you know, again, being a business, being as tight as you can, worrying about protecting that patient health information, um, making sure that we're billing appropriately to every payer. And we don't, you don't I haven't run across much fraud, but there are, you know sometimes there's these situations, right? So we want to have a tool in place that we as an agency and management are looking. And keeping an eye on things. Mostly, you know, I know because of the wonderful group this is, mostly it's there's mistakes made because it's just complicated and that's okay and we'll talk more about that.

We also want to have denial prevention. You know, denials cost a lot of money. We think about how much work it is to get a claim in and then it gets denied and then we got to track the denial. We got to figure it out. We've got to resubmit it. Revenue is delayed. So the less denials, the better. 5% or less denial rate is a great best practice and something to work towards. Like I said, we don't want outside audits, take backs, fines. If a payer finds a problem, it usually costs you more than if you self-disclose a problem because they'll add on some fines, that kind of thing. So we want to have clean, consistent coding across all services and then the payers will pay for the services for your contractual obligations.

So part of that, too, then, is if we are really clear and we are doing a good job with our coding and we're getting everything in, we're going to have a more reliable accounts receivable. What we're billing, we are entitled to and we should be paid for. I think it also creates a positive environment and staff performance, you know, when people are all. The ship is rising and everybody's doing a good job. It is a better place to work. It's a better attitudes with every woman. There's lots of problems and inconsistencies and that it just creates negativity. So, and then the last thing is that this helps the patients to have a great, better experience with your agency and clinic, right? We want, we don't wanna have a lot of problems. We don't want them to be charged for things they shouldn't be. We just wanna make sure that the patient experience is as good as it can be. So those are kind of what I think is a great, you know, starting point of like, this is important for a lot of different reasons.

OK, so let's think about charting again. You know, we're going to think today about a lot of different ways, how can we look and how can we slice and dice our data to find opportunities? But what do you want to achieve and why? Right. So I think the first thing when you're thinking

about doing an internal review is, you know, what is it that I'm worried about? Is it just a big overall? I want to do a chart review and look at documentation in the charts. Am I worried about, like, are we capturing all these certain services? You know, what is it that I want focus on? Sometimes it's just some low-hanging fruit and I want to do quick review and sometimes it's more in depth. We have to think about the timing and the priorities. You know sometimes these things get started by management when the clinic's in the middle of another, you know, big payer review or something that's going on.

I used to work for a gentleman whose wife was a coder in our agency. And he would always, he would always do this coding review Christmas weeks. And it was just, you know, stress that wasn't needed. That was not a good time of the year to do this, you know, coding review that we would take on each year. What is your internal capacity? Do you have people that can do it? Do you know who can work on it? You know, do you have the right people to work on the review and kind of know what you're looking for so that you can kind of figure out how to move it forward? And then what are you going to do with the results? Right. So we'll talk a little more about that. And sometimes just reviews can take on lots of different ways, like it can be short and focused, it can be longer and detailed, it can be announced, planned, everybody knows it's going to happen, it could be an unannounced, you know, maybe a little team of people is going to do something and find out the results and then discuss it with staff later. So things to think about as you're planning for reviews.

A few of the steps are that I think are really, you know, what we need to kind of look at before we get started is one, identifying your targets, like we said, and really clearly identifying the objectives that you want to look at. You know, you don't want to have these reviews that go on and on and that we want to have here's what we're going to do and here's the end line. And this is what I'm going to, what I want to do to get there. We want to be clear about who the staff is that's involved and expectations. We need checklists. We need to have a good way to transcribe our results so that it's consistent, especially if we have a couple of people working on it. How big is the sample size? Do we want to look at 10 claims? Do we wanna look at 100? What is it that you need to see what's happening in your organization? And then gathering all the pertinent documentation and performing the audit, right? So we're gonna get going here.

Then we've got... Really important that we maintain HIPAA confidentiality, that everyone on your team is, you're always talking compliance in your organization. But that is what leads conversations, right? Is that everybody has, you know, compliance in mind and being careful about patient information, et cetera. We wanna have a way to analyze and verify the results. We wanna have a way that's consistent. You know, like you want to be able to, that people can track. And document the same results in the same fashion so that you can roll it up easily and it's consistent, right? And then what is your, how are you gonna report your findings? You know, what are you going to do? You're gonna need a little report. We might not need 20 pages. Maybe it can be short. What is it that you're going to provide as findings? Those are just things in the planning.

And the biggest thing is then, and I think like most of us work in a team environment. And you want to share the results you know sometimes these things happen and then it doesn't get shared with the people that are involved and I worked with so many of these of all of you where we figure out something with billing and that you get the clinicians and the billers together and the clinicians will say well I never heard that from the biller that that was a problem the billers

say I never hear that from a clinician that that was a problem so the more that you can have really have like team communication then they'll start to work together. And finally like what are you going to do to correct the problem right you don't want to just identify it you want to have a corrective action plan and then you got to figure out how you're going to measure success I always I've shared the story a few times so some of you heard this but we worked with one of the sub recipients a few years back and they really had a problem with their fees they just were not happy you know it was very low and they they did a whole little review and they that you know we did the steps and then they monitored progress and it didn't get better. Right? We were like, why isn't this improving? And it turned out that they found an unexpected, you know, finding that, well, the patients were just leaving and not going to front desks.

But anyhow, once they tweaked, but that was only through monitoring, you know really tracking the fees each month and then saying, why, isn't, this improving. So they had a goal to meet and then they were able to resolve a little bit of a snafu in between. And then they improve their revenue. The last thing I want to say on these steps is, you know, celebrate the successes together. You're not going to go from zero to 90 in one month, but if you have a big problem with denials and you can just start taking them off and solving them, that's a really good thing to celebrate with your teams. We all are multitasking and working hard and. Really, it's great to have a positive reinforcement about the progress that you make. So that's all my mantra, and we'll talk more about how there's some ideas.

Audit focuses. So like we said, we call this chart auditing, but what are some ways to slice and dice the, you know, the coding, the documentation, the ways to look at our data to help us find revenue opportunities. Our last, when we did a coding and review, we always talk about revenue leakage and really making sure we plug up the pale. So this is ways that you can think about what are our different services and where do you see opportunity. But documentation is really important. First of all, are the clinicians documenting the services appropriately in the medical record, which is a legal document with their signature on it. And that's always a good reminder to clinicians that this matters because you're putting your potential on it. And it needs to support the codes, right? So if we're doing services, it needs be clear why you're doing it, why you are doing it. Are you getting all of the right codes? Do you have the CPT codes for all the services, diagnosis codes, modifiers? Sometimes, and I see this, even recently I saw this where I see in the chart. The codes that you know are there and then I see on the bill different codes and sometimes the billers are changing codes and fixing things and it's not getting fixed on the chart. So that's something sometimes to look at. Are your charge capture processes and forms are those all up to date? That's a really good area to audit, to say, you know, our. Is everything on our super builds or whatever the forms are that you're using all recent codes? And not out of date codes are all the new services that we're providing on those forms and within our processes.

Templates are a big area too that I find you know If you do some reviews of the templates that can really help clinicians document their service as well You know when we have same-day larks and counseling or medical visits really making your template so that it's easy for the clinician to say, yes, this is a separate and distinct medical visit from the procedure the patient is also getting. Remittance reviews. This is a big area where billers really need to be trained on how to look at the remittance, look at these, the codes that come from the payer. What are the denials? Where are the denial is coming from? Is it front desk? Is it billing? Right. And then targeting it on it. Timely billing of services. I hate that denial. Like that's just throwing money

down the garbage. You know, this. You should not be having timely billing rejection or denials that say you're too late submitting a claim. So that's something to look forward to and then accounts receivable, right? Who's paying? Is there a payer? That's a problem. A service? That's the problem. So all of these different ways to look at it can lead you to find, you know, really kind of enhancing your coding and documentation and resolving problems.

So then even further drilling down, we can look at all these, but just thinking about ideas, the type of service, right? Is this a preventive visit? Is it a contraceptive visit, is it a LARC procedure? Maybe we wanna look by type of services and kind of focus on that. Maybe we want to do some E&M, evaluation and management coding, those are the medical visit codes, and we'll look at the levels. We'll have an example of that later. LARCs insertions to pay devices. Should be a one-to-one match. Sometimes it's not and you're missing the device getting paid, the insertion doesn't get coded, the clinician forgot the removal of a, you know, device, you didn't code it, right? So we want to make sure that everything kind of matches up with LARC procedures.

Procedure injections with E&M, right, we want make sure if we're giving a depo injection or, you, know, we have a same-day procedure that we're coding it appropriately with a lot of fires and are they getting paid? Point-of-care tests, ultrasound lab billing, et cetera. Some of these extra services that we can get paid for, depression screening, after hours, interpreter. And the last one is like, some agencies have a real problem with this, the clinician's charts being open, right? And that's just something to monitor with, you know, and... You can track that and we really need to work with the clinicians that are the frequent flyers of this problem because they are just delaying revenue and so we need to be on top of that. 24 to 48 hours is the best practice for charts to be closed and then they go to billing. Otherwise they sit open and they can't be billed.

Okay, so our coding checklist, and we're going to talk about each one of these, so I'm going to jump into the first, instead of reading these all, the first bullet being compliance with coding guidelines, right?

We're going into one, you know, there are ICD coding guidelines. I mean, for the many of you for family planning, we're very dependent on the Z30 contraceptive management codes. But there are other codes that we need to be using when we're doing well visits, when we are doing sick visits, when we having a problem, when were having multiple services going on. So we want to make sure that we are looking at, you know, are we coding it in a way that is consistent with the guidelines and not causing denials with payers that say that's not the appropriate code, there isn't a code to support the service, etc.

A proper CPT assignment to all services provided. So if you do during a review to say, what all happened during this medical visit and encounter? And then does everything relate to a CPT code? Even if it's a few of the services go to the same CPT Code, right? You should be able to kind of look at everything and say, yes, I see this. The one, a common one I see is, I don't know why, LARC removals getting missed. Where the clinician says, oh, I forgot. I was so busy doing it. I forgot to code it. And that gets missed. So everything should go to a CPD code.

Reviewing code and unit accuracy with contraceptives and medications dispensed. So that's a big one, you know, where you just see one, or you see one milligram of depot instead of 150,

right? And then you get, you now, a very low payment, like I see 30 cent payments. Because it was only one unit or one unit of pills dispensed when really three were dispensed.

So that's a good review and then modifiers which we'll talk a little more about but You know modifiers go on CPT codes on the claim and they can impact payment They can make a payment more they can make it payment less. They can trigger something to pay So they're really important that your billers understand modifiers and understand how should the how should that impact payment? Because one area I see revenue loss is where a claim is paid, but it wasn't paid appropriately. So it just gets posted as paid, but if you look at it, there's unpaid services on it or underpaid services or overpaid services. So really making sure that not only was it paid, but it was appropriately paid. Again, think compliance.

So, the second bullet was documentation review, right, does a medical record documentation adequately support all assigned codes? And you know, an example of this comes to mind with working with Dr. Polakar, who's been on lots of webinars with us and I will present with him and he'll say, you know you just can't do all kinds of lab tests just because the clinician wants to, there has to be medical necessity, right? You can't just order a batch of all kinds of STD testing when there's not medical necessity for it. So I always hear him in my ear about medical necessity and documentation to say, why did I do this code? If someone is not sexually active and it's all documented and then you're doing like pregnancy tests and that kind of thing, then a payer might say, Why are you doing these tests? So we want to document why we're each of the tests and services that we're doing. So if something is not documenting then then we want to identify it and we really want to work with the clinician.

Again that's that feedback loop to say our documentation is not clear. You know when I look at records for people and I'm not an official auditor or anything like that but I'll look at them and that you have to it tells a story. The documentation tells a story and sometimes a clinician knows what's going on especially when it's a follow-up It just says follow up, which is. Really not good documentation. It should tell the story to a reviewer without them having to refer to other records. It should be clear why the patient was there. The reason for visit is not always a chief complaint. Once that patient gets in the room, it changes, right? We know that with, especially with teens and that kind of thing, we know there can be. So really making sure that that gets updated by the provider and all of the services that happen once they're in the rooms are documented.

So we want to also look at code accuracy, right? Because let's say for our E&M codes, our 992 codes, medical visit codes, we wanna make sure that one, that they're the right level, that we're getting paid to the highest level of service that you're providing. That sequencing, we wanna to make sure that things get, you know. Put on the claim accurately and associated with the right CPT codes and they go so that something all pays right you want all services to pay on that claim so it's really looking at code selection what's the level what's, the sequencing are we under coding are we using the wrong code and then we can identify some areas to fix there.

Like I said chart to claim for consistency I see that sometimes, especially when there's papers, super bills, or there's something, and then somebody else is transcribing it and putting it into, and they, you know, I just see a lot of different changes. And if you're changing things, your billers should not, they are not certified coders, and they should not be entering things because

they know that that's what's gonna get paid, and I know that this is right. Right, if there's Something to change, they should be going back to the clinician. And you should be updating the record and doing an addendum to the record. And so that right is showing that you reopen the record, let's say that there's some, you know, there was some changes that are made, but I, you know be careful about billers just changing things and billing and it not reflecting in the medical record because under review, that can be an issue.

Sorry, medical necessity. We talked about this. Really important that the documentation supports all services and why they were done.

NCCI edits, these are edits that Medicare, Medicaid, and a lot of payers use are kind of like scrubbers, right, that they say help us to reduce payment errors. And so there's a set of edits that are out there. For example, If you give an injection code 96372, the CPT code, and you have a medical visit E&M code in 993 or 992, there is an edit on this that says don't pay the medical visit unless there's a modifier 25 on it to say it's separate and distinct. So I have seen people that have billed an injection with a medical visits and the injection paid. Which is usually a low amount and the medical visit didn't get paid and the claim gets marked and posted as paid But you missed, you know, the main service getting paid So we want to be careful to be, you, know, aware of these edits. Builders should be aware of these and then what is the expected Modifiers and what is the expected payments? You know the good thing with family planning is there's not that many different services So you really can have your batch of like this is typical services and what we expect for reimbursement.

Okay, so this is a big one that I have seen through the years, like oops, we got overpaid, we made a mistake. I mean, it happens. That's okay, right? We all make mistakes. And, but it's what you do. It's how you correct it. One, if you see, I worked with a lot of different agencies where I point out things that are overpaid and then nothing happens. And that's not right. If you are overpaying, you need to resubmit that. You need to correct it with your payer in a timely manner. You have an obligation when you have a contract with payers to correct mistakes. If it's overpayment and you have an obligation to say you underpaid me for things. Sometimes if it's small, you can just resubmit the claims.

If it's a larger issue, I know a lot of people will contact the payer, they'll self-disclose it, they'll work on a list of claims and that is a best practice. And typically the rent defines then and if a payer finds a problem. But let's say you do that, you still gotta fix the root causes, right? You still gotta get off the hamster wheel and you gotta fix a problem so it doesn't keep happening. And you wanna track it for compliance issues to say, we resolved this. And then another thing that's really important, especially when you're having problems, is do perspective. I mean, looking forward before you bill, do reviews of your charts and the billing before it gets submitted and say, okay, now we think we've resolved this problem, let's submit the claims and then kind of move forward. And then your compliance, your internal compliance plan, you wanna make sure that that's an integral part of your agency and that that getting reviewed annually.

We want provider education again, closing that feedback loop and if you don't go back and you don't train staff, it'll never change, right? And most people just don't know. So we want to provide tools, which we have great tools on the RHNTC. I love the medical decision-making tool. It's my favorite tool for coding that we worked on and it just gives a lot of family planning

examples of what would this be considered for a problem? What would this be considered for data, which we'll look at. So that's a great tool, but there's a lot of good tools on the RHNTC.

And we want to have some internal controls, right? How are you going to monitor? What is a key performance indicator? What is the way to track your success? It can be you're having problems with a denial from coding. Maybe we're going to track the number of denials. Maybe we want look at E&M coding, and we're gonna track that by provider for the next six months and see that there's an improvement. We um you know maybe it's gonna be LARC devices and insertion procedures. So we just need to figure out how you're going to monitor.

We want to always, I've kind of made this point, but you know, you want to have an environment. I just want to say that it really, it's important that there's an environment where it is expected that you will do quality coding and positive communication. And if somebody sees something that's not right, there is a place to go and someone to talk to about it. You know, the worst thing is when somebody doesn't feel safe to say something or. You know, because most of the time it's not intentional. So we just want to be able to reach out and then correct the problems. And, you know we want to protect the people to come forward. We don't want it to be at the staff lunch that we're all talking about how, you now Mary, Mary told us that there's a problem and okay, we want really take this seriously and have, you know practices and expectations in place.

Caitlin: [00:33:23]

Thank you all for your participation today, for your questions, for your comments, for sharing strategies and resources, especially for those of you that are new in your role or struggling with an issue. It's really nice to hear from each other. This does conclude our event. Nancy did chat out the evaluation. Please do complete the evaluation as it really helps inform future events. Thank you to Ann for your continued partnership and expertise. And Thank you all for your active participation. As a reminder, the event, the slides, and the transcript will be recorded and posted on RHNTC in a few days. Thank you again for your time and have a wonderful rest of your day.