Medical Billing Audits for Local Health Departments

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Illinois Public Health Association

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Executive Summary

Local health departments (LHDs) operate in a dynamic regulatory and economic environment, as the healthcare industry has undergone significant changes over the past few years. While the primary objective of physician practices, hospitals, LHDs and other providers remains providing reliable and accurate healthcare outcomes for clients and patients, the manner in which organizations are providing these outcomes has changed. With respect to LHDs, the effects of the Great Recession continue to linger with funding cutbacks at the federal, state, and local levels. In addition, the Patient Protection and Affordable Care Act (ACA) provided a significant shift in the regulatory environment, which required LHDs to react accordingly. The changing environment places a significant strain on a LHD's ability to provide essential services to its community.

In addition to providing positive health outcomes, a concurrent objective for providers is to offer healthcare services in a manner which generates enough revenue to sustain the organization and enable them to continue meeting the needs of their patients. At the intersection of these two objectives is the clinical documentation in medical records that serves as the primary basis for not only patient interaction and care (e.g., diagnosis, treatment, counseling, etc.), but also for revenue generation (e.g., medical billing through the patient, private insurance or public insurance).

Given the importance of accurate and complete clinical documentation, there are many benefits of evaluating medical billing records to identify areas requiring attention or improvement. This evaluation process is commonly known as a medical billing audit.

For a LHD, a medical billing audit can serve a number of different purposes, including:

- Protecting against false claims and billing activity;
- Identifying potential coding errors and problem areas before government payers challenge claims and request an audit;
- Ensuring compliance with regulatory statutes concerning reimbursement;
- Identifying areas where the LHD could increase revenue through appropriate reimbursement;
- Serving as a data analysis tool to provide information on staff efficiency (e.g., patterns in RN visits per day, coding of these visits, etc.); and
- Providing critical strategic planning inputs to optimize LHD operations.

While there are numerous benefits to a medical billing audit, it can also be a significant undertaking. A medical billing audit requires dedication of staff resources to ensure that the audit provides the desired outcomes to identify and address problem areas. The particular level of depth for an audit is up to the LHD, but while more detailed audits can

provide greater benefits, they also take longer and require more resources. In this respect, an external audit using a third party can often alleviate some resource constraints, but at an additional cost. Nevertheless, the benefits of a medical billing audit tend to outweigh the costs, whether the desired result is to minimize Medicare or Medicaid audit risk, improve internal practice policies and efficiency, generate additional revenue, or a combination.

This paper reviews a basic four-step framework for conducting a medical billing audit, with a particular focus on LHDs. Each step includes a description, and where appropriate, introduces hypothetical examples to illustrate the benefits and risks of a medical billing audit.

What is a Medical Billing Audit?

Accurate and reliable clinical documentation is a cornerstone of a successful health care practice. This best practice applies to physician practices, hospitals, local health departments (LHDs) and other providers of health care services. Clinical documentation not only serves as the foundation of the health care outcome, but also represents a critical link between the patient, provider and the party responsible for payment for services rendered. In many cases, this represents a third-party payer such as private insurance or Medicare/Medicaid. In order to evaluate the effectiveness and reliability of clinical documentation, many organizations can benefit from conducting periodic medical billing audits to assess whether the clinical documentation accurately captures the activities and outcomes that pertain to quality health care outcomes.

A medical billing audit involves a review of clinical documentation to focus on the accuracy, completeness and also trends that exist with respect to coding, policies, and procedures. As noted by one trade group:

> *The goals of an audit are to provide efficient and better delivery of care and to improve the financial health of [the] medical provider. Medical record audits specifically target and evaluate procedural and diagnosis code selection as determined by [provider] documentation. Once areas of weakness are revealed through an audit, you can present the audit findings and identify opportunities for training in your health care organization.*[1]

There are a number of different goals of a medical billing audit, often tied to the strategic objectives of the healthcare organization. For a small physician practice, the medical billing audit might focus on improving revenue generation by identifying areas of denied claims or incorrect coding. For a larger hospital, a medical billing audit might serve to mitigate the risk of a Medicare or Medicaid audit with respect to public insurance claims. For a LHD, a medical billing audit can serve a number of different purposes, including:

- Protecting against false claims and billing activity;
- Identifying potential coding errors and problem areas before government payers challenge claims and request an audit;
- Ensuring compliance with regulatory statutes concerning reimbursement;
- Identifying areas where the LHD could increase revenue through appropriate reimbursement;

[1] "What is medical auditing?" American Academy of Professional Coders (AAPC), available at: https://www.aapc.com/medical-auditing/medical-auditing.aspx. While AAPC applies the definition primarily to private practices, it has applicability for LHDs, including those that do not have a physician on staff.

- Serving as a data analysis tool to provide information on staff efficiency (e.g., patterns in RN visits per day, coding of these visits, etc.); and

- Providing critical strategic planning inputs to optimize LHD operations.

This list is not comprehensive and the particular reasons for conducting a medical billing audit may vary from organization to organization. In addition, there are different types of audits, including both prospective and retrospective audits. The American Medical Association (AMA) and American Academy of Neurology (AAN) distinguish these two audit types as:[2]

- In a prospective billing audit, a designated practice staff person or internal compliance officer reviews the claims before they are submitted to the payer to ensure the appropriateness of the coding, documentation and adherence to health plan medical payment policies.

- In a retrospective audit, a designated person reviews claims for appropriateness after they are paid. All overpayments and billing errors identified during a retrospective audit should be handled according to the payer's repayment guidelines.

The AMA and AAN definitions explicitly discuss a "practice staff person" or "designated person" in explaining a prospective and retrospective audit. This raises a key question of who should perform the medical billing audit. In some cases, an internal audit (e.g., one conducted by a provider staff member) is sufficient to provide critical information and identify potential deficiencies, particularly with respect to prospective external audits. However, external audits, namely those conducted by a third-party consultancy or individual, can also provide benefits above and beyond an internal audit. For example, the third party can bring in specialized technical expertise, operate more efficiently than a staff member (while also freeing up the staff member to continue normal job functions), and provide an unbiased view of the medical billing process and outcomes. The last point is critical when conducting a medical billing audit as part of an overall strategic planning process. However, even if an LHD or other provider uses an external party, the LHD or provider should remain an active participant in the audit process for best results.

Importance of a Medical Billing Audit to Local Health Departments

Local health departments (LHDs) operate in a dynamic regulatory and economic environment, as the healthcare industry has undergone significant changes over the past few years. The effects of the Great Recession continue to linger for LHDs, resulting in funding cutbacks at the federal, state, and local levels. Lower or inadequate funds place a significant strain on a LHD's ability to provide essential services to its community. In

[2] "How to perform a physician practice internal billing audit," American Medical Association and American Academy of Neurology, Updated August 2010, available at: https://www.aan.com/uploadedFiles/Website_Library_Assets/Documents/3.Practice_Management/1.Reimbursement/1.Billing_and_Coding/7.Audits_RAC/internal.pdf.

addition, the Patient Protection and Affordable Care Act (ACA) provided a significant shift in the regulatory environment, which required LHDs to react accordingly.

The National Association of County and City Health Officials (NACCHO) identified several critical issues facing LHDs in light of a changing public health landscape. These include:

- Budget cuts and staff reductions;
- Change in mix, scope and scale of services;
- New billing opportunities and trends; and
- Collaboration with other providers.

Each of these issues has an impact on LHD practice management, including the provision of quality healthcare, revenue generation, and operational efficiency. Yet, challenges exist as to how LHDs can effectively monitor staff operations to proactively address practice management issues. A medical billing audit is one solution to help LHDs monitor operations and address key strategic issues such as reductions in budget, changing services, and new billing opportunities. In addition to the aforementioned purposes of a medical billing audit, additional benefits for LHDs include:

- Improving health outcomes by identifying errors or areas where LHDs are acting inefficiently. For example, a medical billing audit might uncover instances where LHDs are using incorrect or outdated codes for procedures. Given the change from ICD-9 to ICD-10 in October 2015, this can lead to inefficiency and delays in appropriate treatment, diagnosis, and payment. In addition, the Centers for Medicare and Medicaid Services also recently ended ICD-10 flexibilities effective October 1, 2016, which means that providers need to be much more specific when coding. As a result, providers can no longer have flexibility in billing a "family of codes" or not fully specifying codes.[3]

- Increasing efficiency through a benchmark analysis on productivity. A primary example includes evaluating the number of registered nurse (RN) visits per day, analyzing the revenue generated by these visits, and focusing on ways to increase the number of visits while maintaining a high standard of quality care.

- Identifying revenue opportunities by evaluating service and payer mix. LHDs that fail to understand the mix of services and payers run the risk of not maximizing revenue and being unresponsive to market demands. A medical billing audit can provide LHDs with a clearer picture of where, how, and when clients are using particular services and the extent to which the LHD is generating revenue through reimbursements.

[3] Additional detail is available at https://www.cms.gov/Medicare/Coding/ICD10/Frequently-Asked-Questions.html and http://www.icd10watch.com/blog/cms-clarifies-what-end-icd-10-flexibilities-means.

While there are numerous benefits to a medical billing audit, it can also be a significant undertaking. A medical billing audit requires dedication of staff resources to ensure that the audit provides the desired outcomes to identify and address problem areas. The particular level of depth for an audit is up to the LHD, but while more detailed audits can provide greater benefits, they also take longer and require more resources. In this respect, an external audit using a third party can often alleviate some resource constraints, but at an additional cost. Nevertheless, the benefits of a medical billing audit tend to outweigh the costs, whether the desired result is to minimize Medicare or Medicaid audit risk, improve internal practice policies and efficiency, generate additional revenue, or a combination.

A Typical LHD Billing Process

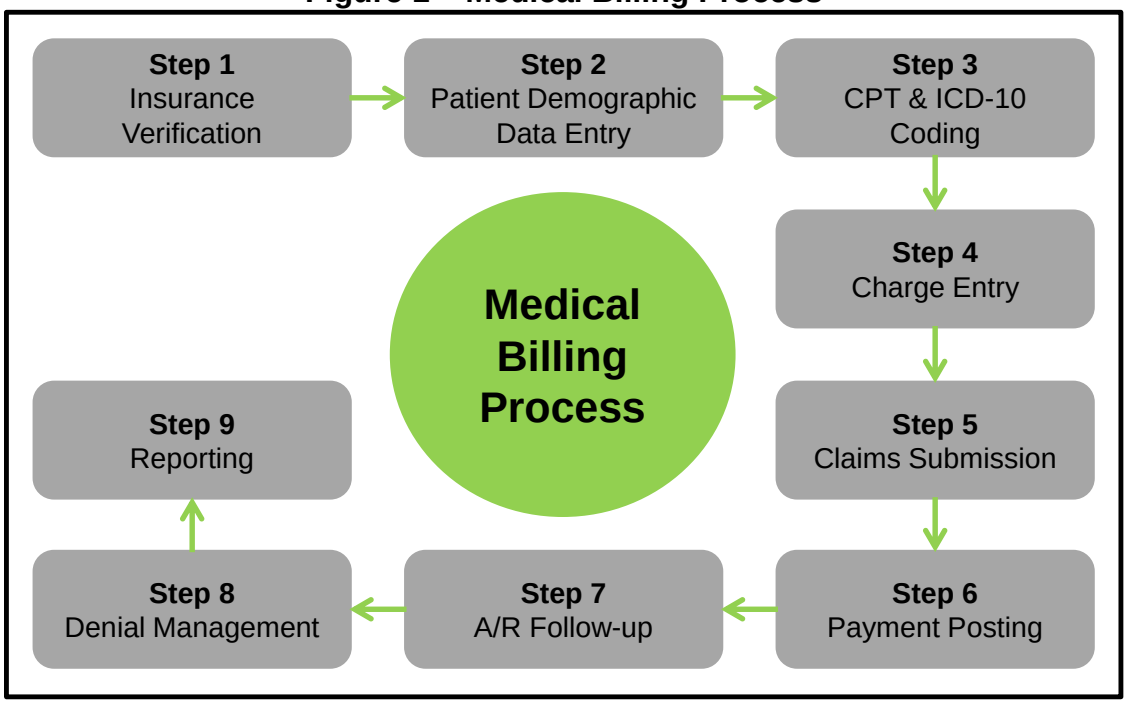
The previous section discussed the need to dedicate resources, either financial or human (or both), to conducting a quality medical billing audit. Yet, the structure and scope of the medical billing audit also depends on the organizational make-up of the entity being audited. LHDs typically have unique organizational configurations based on the populations served and services provided. For example, a typical LHD might not have a physician on staff, relying solely on a RN or other staff to provide clinical services such as immunizations, STD/HIV testing or maternal and child health services.

An additional consideration is that many LHDs do not have an electronic health records (EHR) system, which means that a medical billing audit requires a manual review of paper copies. For example, as of 2013, only 22 percent of LHDs surveyed by the National Association of County and City Health Officials (NACCHO) had implemented an EHR system, and only 22 percent more had plans to implement an EHR system.[4] Adoption of Health Information Exchanges (HIE) was even lower, where only 13 percent of LHDs had adopted HIEs, with an additional 19 percent planning to implement HIEs.[5]

Despite the slower technology adoption rate compared to some physician practices, the overall billing process for LHDs is similar. Figure 1 illustrates the general medical billing process.

[4] NACCHO, 2013 National Profile of Local Health Departments, p. 62.
[5] Ibid. HIE is defined as the exchange of healthcare information electronically across organizations within a region or community.

Figure 1 – Medical Billing Process



Patient interaction occurs prior to Step 1, where the LHD encounters scheduled patients or walk-ins. In the first step, the LHD verifies the patient's or client's insurance, followed by capturing patient demographic data. During the diagnosis and treatment phase, physicians or clinical staff capture visit details and enter them into the medical record.

For billing purposes, the individual(s) responsible for billing third-party payers matches the particular services provided with appropriate diagnostic and procedural codes. Third-party payers currently rely on the existing Current Procedural Terminology (CPT) coding system developed by the American Medical Association (AMA) and the Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare and Medicaid Services (CMS). As noted by the AMA, the purpose of the CPT is "to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians and other health care providers, patients and third parties."[6] The HCPCS includes all CPT codes (which are numeric), but also includes alphanumeric codes to capture primarily non-physician services such as ambulance services and prosthetic devices.

Claims submission is either via electronic systems or using paper claims. After submission, the third-party payer reviews the claim and if it finds errors or issues, may deny the claim. In these cases, it is incumbent upon the LHD to review the submission, fix any errors, and resubmit the claim.

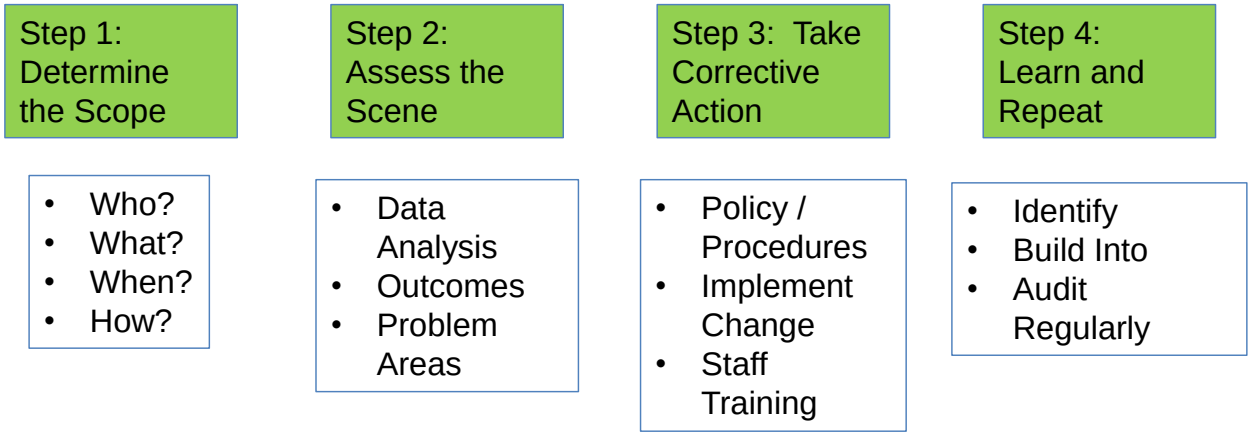
[6] American Medical Association, "CPT Process: How a Code Becomes a Code." Available at https://www.ama-assn.org/practice-management/cpt%C2%AE-process-how-code-becomes-code.

The medical billing process is a component of the overall revenue cycle management process for LHDs. As a result, a well-conducted medical billing audit will provide information vital to improving not only data collection but also revenue cycle management.

How to Perform a Medical Billing Audit

The particular scope and structure of a medical billing audit typically depends on the objective, depth, amount of resources, and intensity of review. As a result, there is no "one size fits all" checklist for auditing billing and coding, but there are some general steps that every LHD should take and key considerations along the way. Figure 2 presents an overview of the four general steps in the auditing process.

Figure 2 – Medical Billing Audit Process



Step 1: Determine the Scope

The first step in the audit process is to determine the scope of the audit and the resources needed to complete the audit in a timely and efficient manner. Key factors that influence the scope include the number of providers in the LHD, the number of clinical staff, the mix of different payers the LHD works with, and the specific staff composition of billers and coders. These factors can vary greatly based on the size of the LHD. For example, Table 1 provides a summary of the median number of employees and full time equivalents (FTEs) for LHDs based on the size of the population served. Not surprisingly, LHDs serving smaller populations have fewer employees.

Table 1 – Median Employees and FTEs for LHDs (2013)

	Median Number of Employees	Median Number of FTEs
All LHDs	20	17
Size of Population Served:		
< 10,000	6	4
10,000 - 24,999	12	9
25,000 - 49,999	19	15
50,000 - 99,999	35	28
100,000 - 249,999	77	64
250,000 - 499,999	155	130
500,000 - 999,999	323	251
1,000,000 +	470	453

Source: NACCHO, 2013 National Profile of Local Health Departments, Figure 4.2, p. 22

The data in Table 1 also indicate differences in staff composition. Table 2 presents a more detailed look at the staff composition of LHDs based on population served. As shown in the table, most of the smaller LHDs do not have a physician on staff, while the largest have a median of 3 physicians. Most county health departments in Illinois fall within the 25,000 to 999,000 person range, as shown by the boxed entries in Table 2.

Table 2 – Median FTEs by Occupation for Select LHDs (2013)

	Size of Population Served								
Staff Position	All LHDs	< 10,000	10,000-24,999	25,000-49,999	50,000 - 99,999	100,000-249,999	250,000-499,999	500,000-999,999	1,000,000+
Administrative or Clerical	4	1	2.5	4	6.79	14	28.25	48.5	101.5
Reigstered Nurse	4	1	2.75	4	6	12	19	34.5	44.45
Environmental Health Worker	2	0.1	1	1.8	3	7	14	25	34
Public Health Manager	1	0.7	1	1	2	2	4	14	17
Emergency Preparedness Staff	0.74	0	0.2	0.5	1	1	2	4	5
Health Educator	0.9	0	0	0.55	1	1.71	3	5	9.9
Nutritionist	0.5	0	0	0.6	1	3	5	8.5	20.9
Public Health Physician	0	0	0	0	0	0.25	1	1.7	3
Community Health Worker	0	0	0	0	0	0.5	2	6	20
Epidemiologist	0	0	0	0	0	0	1	2	6
Information Systems Specialist	0	0	0	0	0	0	1	2	4.5
Laboratory Worker	0	0	0	0	0	0	0	2	10
Licensed Practical or Vocational Nurse	0	0	0	0	0	0	0	2	3
Public Information Specialist	0	0	0	0	0	0	0	1	1
Behavorial Health Professional	0	0	0	0	0	0	0	1	0
Oral Health Care Professional	0	0	0	0	0	0	0	0	1

Source: NACCHO, 2013 National Profile of Local Health Departments, Figure 4.4, p. 24

Given the vastly different staffing models used by LHDs based on the size of the population served, a medical billing audit for the largest LHD will be considerably different from that completed for a smaller LHD.

A best practice for conducting a medical audit is to assign or designate a team member as the audit coordinator or leader. For internal audits, this is likely the individual conducting the audit, while for external audits, this is the individual serving as a liaison between the LHD and the third-party auditor. Yet, as Table 2 illustrates, finding that person in a smaller LHD might be difficult, particularly if the LHD is seeking to do an internal audit. Nevertheless, designating an audit coordinator is an important part of mapping out the audit process.

In the event that a LHD seeks a third-party consultant, the audit coordinator should also be involved in finding the right firm. Like any procurement opportunity or new hire, the LHD should consider not only the experience of the firm, but also whether the firm has reasonable rates compared to other firms.

The next general step in mapping out the audit process is to develop the audit tactics. This includes determining the right approach to identifying the particular records a LHD seeks to audit. Principal issues include determining the size and scope of a particular sample of records to review. One standard approach is to randomly select a certain number of charts or records for a provider (e.g., physician or RN) and payer (e.g., Medicaid) and review documentation versus what was filled out and submitted to the third-party payer. This will allow the LHD to assess whether encounters were coded correctly (e.g., possibly undercoded or overcoded) and whether claims were processed appropriately.

A separate approach entails auditing particular billing areas for a LHD. For example, a full-blown audit across all departments and services may not be as valuable as a targeted audit focusing on key service areas, such as immunization billing. To limit the scope while still achieving desirable results, a LHD can conduct an audit that focuses solely on selecting random records related to immunization visits to ensure that documentation is filled out correctly and reimbursements (when applicable) are being requested and received. In this case, a chief task for the audit coordinator is developing a representative sample of immunization billing records that will satisfy a threshold of accuracy and reliability. While the old adage of “more is better” might seem appealing, it only holds true up to the point that the marginal cost of reviewing additional records exceeds the benefit of increasing accuracy or reliability.

Another consideration with respect to the medical billing audit is determining the appropriate time period. For example, should a LHD conduct a review of records over multiple years or a more recent and shorter time period? The answer to this question will depend on the purpose of the audit and the resources available.

The last issue related to determining the scope of the audit is creating a formal audit plan. This document will include the specific nature of the audit, while also assigning

responsibility and accountability for completing the audit. Larger LHDs will likely require buy-in from multiple stakeholders before commencing the audit and a formal audit plan will serve as a clear and transparent roadmap in defining audit tasks, responsibilities and timelines.

Step 2 – Assess the Scene

The second general step in a medical billing audit is to conduct the audit and assess the scene. Key areas of consideration include:

- Check the LHD billing reports for troubling trends or risk areas. This can include checking the reports against past performance month-over-month or year-over-year.

- Review the frequency of provider services (e.g., physician or clinical staff) over a set period and compare it with that of peers using the latest industry data. For example, a LHD can analyze an Evaluation and Management (E/M) frequency report and compare it to the most recent Medicare E/M frequency data. Alternatively, a LHD can analyze the frequency of visits and services provided and compare to national or state data provided by advocacy organizations (e.g., NACCHO) or state health departments.

- Analyze CPT code usage by providers and billing staff. This includes evaluating whether clinical staff and others are appropriately coding client encounters. One example is making sure that registered nurses and billing staff are following appropriate procedures with respect to coding and billing of immunizations, particularly given any rules that apply to the Vaccines For Children (VFC) or other programs that might have different insurance billing requirements.

Assessing the Scene Hypothetical #1 – A Mid-Sized LHD with multiple RNs[7]

As an illustrative example of assessing the scene through a medical billing audit, the first hypothetical example entails a medical billing audit of a mid-size LHD that has multiple registered nurses on staff. The primary reason for the audit is two-fold. First, the LHD is interested in how its RNs are coding patient encounters and second, whether there are any discernable differences in coding patterns between each RN and a general industry average drawn from other LHDs. The medical billing audit accomplishes these tasks using a benchmarking process.

Benchmarking is one of the oldest and most useful data analysis tools available to providers to compare coding behavior to either an industry standard or select peer group.

[7] The hypothetical scenarios presented in this section are intended for educational and illustrative purposes only with respect to a medical billing audit. Specific medical billing codes and procedures for a LHD may depend on a number of different policies and regulations related to the nature of a specific client interaction. This includes whether the encounter is subject to a private versus public payer, as well as whether there are other federal or state policies that influence specific coding and reimbursement.

In fact, many Medicare and Medicaid audits arise out of data analysis consisting of benchmarking provider coding behavior compared to industry norms. As a result, providers who actively track and interpret coding behavior compared to other providers will be able to manage compliance risk by identifying potential Medicare audit triggers and correcting or substantiating their claims. Benchmarking not only facilitates identification of potential audit issues, but also has the benefit of assisting in resource allocation, increasing transparency within the practice (particularly if it is a multi-physician practice), and providing quantitative measures to assist in identifying risks and opportunities.

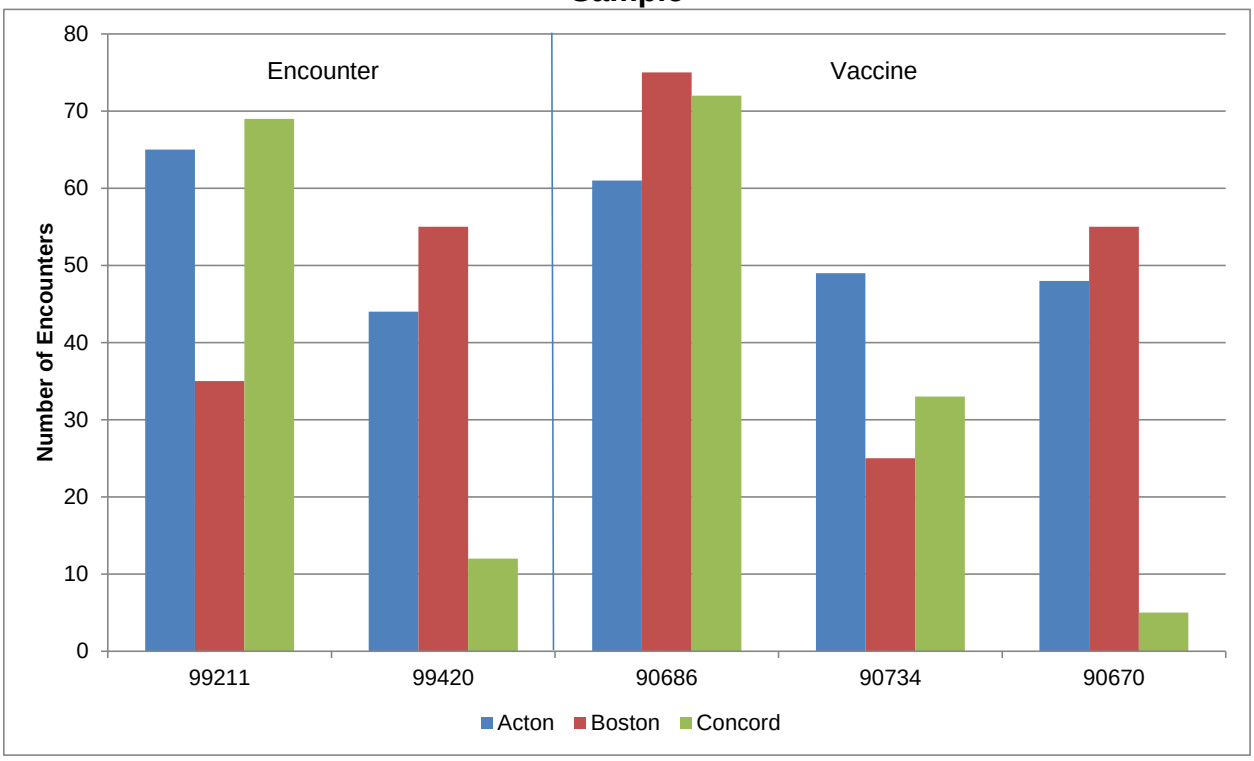
To illustrate benchmarking, consider the coding behavior of three full-time RNs at the mid-sized LHD. The auditor first identifies the most common codes used by nurses and billing staff at the LHD, which includes:[8]

- 99211: Level 1 Established Office Visit
- 99420: Administration and Assessment of Health Risk Assessment Instrument
- 90686: Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
- 90734: Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
- 90670: Pneumococcal conjugate vaccine, 13 valent, for intramuscular use

Next, the auditor selects a representative sample of clinical documentation and compiles information on the frequency of coding usage by each nurse with respect to the aforementioned common codes. Figure 3 presents a discrete distribution of coding behavior for Nurse Acton, Nurse Boston, and Nurse Concord. The figure captures the patient encounters and vaccinations (absent the administration codes) based on the particular interactions observed in the documentation sample.

[8] Most frequent LHD coding encounters provided by the Illinois Public Health Administration (IPHA). These may vary based on the particular services offered at different LHDs. Immunization CPT codes and explanations available at: https://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cpt.

Figure 3 – Coding Count of Patient Encounters and Vaccines for a Select Record Sample



A review of Figure 3 immediately reveals interesting coding behaviors and patterns. Potential areas for investigation are whether (a) the nurses are accurately coding the encounters and (b) whether there are any concerns with the different coding patterns for visits and the most commonly recorded immunizations.

With respect to patient encounters, Nurse Acton tends to code slightly more office visits than health risk assessment encounters, while the converse is true for Nurse Boston. As for Nurse Concord, she tends to have very few health risk assessment encounters compared to her fellow RNs. The vaccination coding patterns are also illuminating, given some of the observed differences between nurses. For example, all three nurses tend to have a similar number of flu vaccine encounters.

For CPT 90734 coding behavior, Figure 3 shows that Nurse Acton coded twice as many encounters as Nurse Boston. Again, while this may be accurate, it is worth exploring to ensure that each nurse is coding appropriately and if so, what might explain the difference in frequency of vaccinations for one nurse versus another. Lastly, CPT 90670 shows an interesting difference in behavior of Nurse Concord compared to her fellow nurses. Specifically, she administers a significantly lower number of pneumonia immunizations than her fellow nurses.

Key questions that arise from these data include:

- Is Nurse Boston accurately coding health risk assessment encounters compared to office visits? Specifically, is he potentially miscoding on 99420, given that in general the LHD would expect to see more office visits than health risk assessments?

- What explains the significant difference in office visits (99211) and health risk assessments (99420) for Nurse Concord? Is there a reason she is seeing or coding so few health risk assessments compared to office visits?

- What explains the differences in immunization billing patterns for each nurse? Specifically, what factors contribute to the differences observed for Nurse Concord versus Nurse Acton and Nurse Boston?

- Are there any issues with the coding patterns of office visits and immunizations? Namely, is the LHD missing a revenue opportunity by not including a 99211 code when one is appropriate?

The answers to these questions may be sufficient to assure the LHD that patient encounters and billing practices are in order, or alternatively, that the LHD needs to address certain issues. These could include improving billing processes and procedures, as well as additional staff training and better revenue cycle management.

Assessing the Scene Hypothetical #2 – A Rural LHD with one RN

A second hypothetical involves a smaller LHD that has only one RN and focuses largely on immunizations. In this case, the LHD conducts a medical billing audit to investigate whether immunization encounters are being correctly coded, such that the LHD is both optimizing revenue and also adhering to the Medicaid billing parameters. In this case, the LHD hires a third-party consultant to conduct a targeted medical billing audit of immunization encounters recorded by Nurse Longfellow. As part of this medical billing audit, the consultant compiles data on all 4-month-old patient immunization visits coded by Nurse Longfellow during a specific time period. Table 3 summarizes the results of the visits.

Table 3 – Summary of RN Coding on Four Month Old Immunization Visits

	Service Count	CPT
Total Encounters	100	n/a
Coded Events:		
Nurse visit	43	99211
E/M Visit (Est. Patient)	2	99212
Rotavirus	100	90681
DTaP-HiB-IPV	96	90698
DTaP-Hep B-IPV	4	90723
Pneumococcal	100	90670
Vaccine Administration	4	90460
+ Vaccine Admin Add-On	9	90461
Vaccine Administration (percutaneous, intradermal, subcutaneous or intramuscular injection)	88	90471
+ Vaccine Admin Add-On	100	90472
Vaccine Administration (intranasal or oral)	4	90473
+ Vaccine Admin Add-On	6	90474

In this simplified hypothetical, Nurse Longfellow has 100 immunization encounters for 4-month–old patient visits during the period of interest. A review of the summary statistics raises some immediate audit issues that require attention. These include:

- The validity of the 43 "Nurse Visits" as shown with CPT 99211. An area of initial concern is whether the nurse visit code is applicable depending on the nature of the immunization visit and type of third-party payer. The key question is when a patient sees Nurse Longfellow only for immunizations, should a 99211 be reported in addition to the vaccine administration codes? Furthermore, if the third-party payer is Illinois Medicaid, is the nurse visit allowed but not the administration codes (or vice-versa)? What about when it is a Vaccines for Children (VFC)-eligible visit?[9]

- The two codes for E/M CPT 99212 appear to be erroneous. The LHD does not have a physician on staff and only the lowest level of office visit (99211) is allowable by Nurse Longfellow. In this case, any claim with the 99212 would likely be rejected by the third-party payer, resulting in revenue and operational inefficiencies.

[9] The reporting of 99211 encounters with respect to vaccines can have very strict rules and guidance. For example, the only encounter where the 99211 code should be reported when vaccines are given is for the Illinois Department of Public Health. No other payers allow it unless there is a specific reason, which without a physician should not be addressed.

- Another area of concern is whether the 4 CPT 90723 codes really should have been CPT 90698. The Hepatitis B vaccine is typically not given at four months old, but is in the allowable range of catch-up immunizations. However, the HIB is a four-month immunization, so it would not explain why in exactly four cases there was a Hepatitis B (in combination with DTaP and IPV) but not HIB. This is likely a coding error requiring attention.

- The coding includes several entries for 90460 and +90461. These appear to be clear errors in coding, given that these codes pertain to physician or other qualified health care professional encounters and not encounters with RNs, such as Nurse Longfellow. These codes should never be billed. For example:

    - 90460 is IA through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered [emphasis added]

- The medical billing audit should delve deeper into the exact nature of the coding of vaccine administrations for CPT 90471 and 90472. Specifically, the LHD should recognize instances where encounters are not coded appropriately. Examples include when inclusion of vaccine administration codes are prohibited by a particular payer or program or instances where it amounts to double counting in conjunction with an office visit. An example is that the Illinois Department of Public Health does not allow billing of 90471-90474 codes. Clearly, this creates tracking and statistical challenges when a Medicaid plan has rules that differ from other payers.

In this simple case, the billing audit would have uncovered several different areas of concern, many of which can be addressed through better staff training or instituting enhanced billing procedures and policies.

Step 3 – Take Corrective or Strategic Action

The results of the medical billing audit serve multiple uses, tailored to the original intent of the audit. For a LHD, the results often provide critical strategic information that can improve revenue cycle management, leading to improved health outcomes. For example, specific actions that providers, including LHDs, can take after conducting a medical billing audit include:

- Set concrete, achievable targets for improvement such as a percentage decrease in the denied claims rate or increasing revenue per patient visit. For a LHD, this can include analysis of the revenue per RN visit.

- Make a concerted effort to pressure payers to pay their contracted rates in a timely and accurate manner. Follow up as much as necessary to achieve billing and payment objectives. This is particularly important as LHDs see an increase in

private insurance billing, which may increase even further in the future pending possible modifications to the ACA.

- Address any internal problems and train staff and providers on how to improve in problem areas identified via the audit. For example, staff cannot code what is not documented, so ensuring that providers (including RNs and clinical staff) note all details necessary for accurate codes to be used is essential.

Returning to the first hypothetical discussed above, there are concrete steps that a mid-size LHD can take to address potential areas of concern. First, the medical billing audit needs to identify the source of Nurse Concord's penchant for seeing a significantly higher number of office visits compared to health risk assessments. It could be that she tends to see very few health risk assessments compared to Nurse Acton and Nurse Boston. As a result, corrective action might not relate to billing issues, but rather a focus on whether the assignment of clients or patients is optimal or equitable among staff. Alternatively, perhaps there is a coding issue with respect to either office visits or health risk assessments that the LHD should address. Undercoding, overcoding or miscoding can have a significant impact on revenue and reimbursements and if Nurse Concord is incorrectly coding certain patient encounters, then the LHD needs to address this issue.

A second potential area of corrective action involves Nurse Acton's patient encounters and billing behaviors compared to her fellow nurses. Specifically, the random sampling of records identified 109 total encounters for both office visits and health risk assessments for Nurse Action, but only 90 and 81 for Nurse Boston and Nurse Concord, respectively. From a revenue cycle management perspective, the LHD may seek to explore the extent to which Nurse Boston and Nurse Concord could see more patients and record more encounters, if indeed the differences arise due to patient volume. While this is slightly more difficult for LHDs than private practices, it nevertheless presents an opportunity for revenue cycle management improvements identified through a medical billing audit.

The second hypothetical dealt with a small LHD with a single nurse. This hypothetical raised a number of points with respect to corrective action. Clearly the LHD needs to correct the errors in coding behavior, particularly as it relates to blatant miscoding of encounters. Not only are these claims likely to be denied (requiring a fix and resubmittal), but it also raises the chance of a Medicare or Medicaid audit. These "unexpected and unwanted" audits can be far more costly to a LHD than a medical billing audit. In addition, the LHD can use the results to evaluate practice management. Perhaps industry standards show that a typical LHD has 120 clinical encounters for the four-month-old immunizations over the same period of investigation as Nurse Longfellow's 100 visits. While this may simply be a function of the clientele, it is worth exploring at a larger scope to see if there are areas of improvement in either efficiency or increasing the number of patient visits.

In many cases, a key outcome of a medical billing audit is the development of improved staff policies with respect to not only medical billing, but also revenue cycle management. Training is a key component in developing a competent, reliable medical billing operation

for a LHD. In order to achieve success, the LHD can invest in staff training and resources by focusing on particular areas identified in the medical billing audit. One possible outcome is the LHD committing to training all administrative and clinical professionals in the billing cycle, including policies and procedures.[10] The New York State Department of Health Bureau of Immunization and Office of Public Health Practice identified several steps to help institute procedural change with respect to billing operations. These include:[11]

- *Develop a mechanism to capture the existing attitudes at the LHD.*
- *Identify benefits of changes as well as any potential roadblocks.*
- *Develop an effective communication process which addresses key concerns of staff including:*
    - *What is the reason for the change?*
    - *What are the desired benefits to be achieved by the LHD from the change?*
    - *When would the transition over to new processes occur?*
    - *Who will be involved in the change?*
    - *What steps will be taken to ensure that an effective change over occurs including training, tools, technology?*
- *Create a comprehensive training and education program to ensure that all affected staff members have the resources to fulfill their roles and responsibilities.*
- *Consider process roadblocks and realistic solutions.*
- *Allow for personnel to raise concerns about the change with a means to address these concerns to minimize the fear of change.*
- *Monitor and adjust the implementation plan as required.*

By following these steps, a LHD can focus on improving its medical billing operations, and ideally, its overall healthcare operation.

Step 4 – Learn and Repeat

In all likelihood, an initial audit will raise a number of different issues for a provider to consider and potentially address. For LHDs, these issues may depend on the size and scope of operation, or alternatively, on the particular services being provided and clients served. In order to maximize the benefits of a medical billing audit, the last step is "repeat." Specifically, LHDs can make medical billing auditing a regular occurrence. Best practices indicate conducting internal audits at least once per year, although larger organizations may conduct them as often as once per quarter.

In addition to repeating audits, LHDs can also build processes into the medical billing operation to make auditing easier and more automatic. Adoption of medical billing

[10] Another possible outcome is the development of better policies and procedures, particularly if there is a lack of policies or procedures in place at the time of the medical billing audit.

[11] "Elements for Successful Immunization Billing Practice at New York State's Local Health Departments." New York State Department of Health Bureau of Immunization and Office of Public health Practice, June 2012, p. 19, available at: http://www.health.ny.gov/prevention/immunization/providers/docs/immunization_billing_practice.pdf.

platforms with built-in diagnostics can help the LHD run frequent reports, monitor coding behaviors and track net collections. These are all parts of a learning process that can help the LHD improve health outcomes and simultaneously increase revenue.