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Is your organization prepared for the coming audit storm?

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Regulators had already intensified and expanded the scope of their auditing road map before COVID-19 entered the US. In late 2019, U.S. Department of Health & Human Services' Office of the Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) direct its contractors to recover $54.4 million in improper payments to acute care hospitals due to incorrectly coded claims.[1]

Further intensifying its ongoing efforts, the OIG added auditing of COVID-19 incentive payments to its Work Plan in August 2020[2] while simultaneously increasing compliance risk by requiring a positive test result for the higher inpatient payment.[3] While the latter was unpredictable, there is no reason the industry should be surprised by the incentive payment audits—an increased layer of oversight that is expected to continue to evolve and present significant revenue integrity challenges in 2021.

The stakes at play within the current audit climate are not lost on today's C-suite. A recent survey of healthcare chief financial officers and revenue cycle leaders revealed considerable confusion and concern over coding and claim requirements.[4] Increased workloads related to COVID-19 claims—a factor that will continue to pose challenges—was also named a top issue, second only to erratic and unpredictable claim volumes.

Heightened regulatory scrutiny naturally leads to the need for optimal approaches to revenue integrity, a growing best practice that maximizes revenue capture while ensuring the highest level of compliance. Healthcare executives are wise to consider key areas of risk and shore up compliance and billing strategies.

Top risk areas: A closer look

A mid-2020 study from the American Medical Association found that providers, on average, saw a 32% revenue decrease amid the pandemic, and many entered 2021 operating within razor-thin margins.[5] Minimizing compliance risk to ensure no money is left on the table is now paramount to sustainability. Before auditors come knocking, providers should prioritize three categories of scrutiny: telemedicine, bundling, and coding denials.

Telemedicine

Telehealth will be remembered as one of the greatest shifts in care models precipitated by the pandemic. Notably, FAIR Health found that telehealth claims lines increased nearly 3,000% from September 2019 to September 2020.[6] COVID-19 opened the door to mainstream use of this modality; now, the industry can expect continued advancement in remote care to support greater access, lower costs, and better outcomes.

Yet along with the positives of telehealth also come the growing pains. The healthcare industry is, by and large,

still learning what payers expect in terms of parameters that support a compliant, clean telehealth claim. In truth, providers are finding that multiple issues—ranging from missing documentation to use of the wrong communications tools and varying state requirements—are creating new complexities for clean claim submission.

Not surprisingly, telehealth has caught the OIG's eye, as one look at the regulator's civil enforcement page reveals that telehealth compliance is a priority.[7] Consequently, healthcare organizations need to elevate monitoring of telehealth claims and be able to answer key questions: Were claims paid at the correct rate? If denied, was the reason related to regulations prior to CMS enacting a more simplified approach, or was the claim denied due to improper coding or modifiers?

Revenue integrity teams should also proactively monitor telehealth claim adjudication. If a payment or claim rejection is delayed beyond 30 days, outreach should be undertaken to determine what's causing the holdup, as time is not traditionally on the provider's side. The older a claim gets, the less likely it will be paid. The reality is that issues occur on both sides of the spectrum, and healthcare organizations need to ensure that payer mistakes don't affect the bottom line.

Bundling

Bunding, or the process of linking medical services together under one code, is a common practice in today's billing departments. While this practice can create efficiencies and improve patient care, it is also fraught with potential for error.

For example, providers should make sure that clinical documentation supports separate identifiable procedures when using modifiers "25" or "59." They should also keep an eye on missed opportunities to unbundle cases of clinical documentation. Missed opportunities and potential revenue loss are equally important to unsubstantiated unbundling that will increase risk of an external audit.

Coding denials

Understanding the causes of coding denials is always an important function of revenue integrity, but 2021 will present unique issues. As stated previously, telehealth presents a new compliance challenge via the introduction of new codes, and history often repeats itself in that changes like these lead to an increase in denials.

In addition to telehealth coding errors, healthcare organizations must also gear up for potential errors related to evaluation and management coding changes that went into effect this year.[8] While the extensive revisions aim to minimize administrative burden for physicians, documentation readiness must reflect a holistic view of patient care rather than a checklist of conditions for reimbursement.

The financial impact of overcoding/undercoding in either of these converging risk areas cannot be overstated. Evaluation and management codes 99211–99205 represent 40% of total revenue on average,[9] and telehealth claims continue to soar. Thus, proactive auditing and denial monitoring will be critical to quickly determining root cause and ensuring complete, accurate revenue capture. Providers should ask key questions: Was the denial due to improper codes and modifiers? Did documentation not align with reimbursement requirements?