Automate Probe Auditing: Proactive Billing Process Improvement

By Ken Micciche

Executive Summary

The 2005 Deficit Reduction Act, which went into effect in January 2007, has increased the ante for healthcare providers by bringing Medicaid compliance concerns center stage with Medicare. Federal funding is now available to states as financial incentives to curb payment for incorrect claims. This means closer scrutiny of claims. Among areas affected are clinical laboratories.

The OIG has recommended quarterly probe billing audits as a means for providers to demonstrate their good-faith efforts at preventing waste, fraud and abuse. These audits of a minimum of 30 randomly selected claims will turn up billing problems not normally found without such audits. You may find missing charges, overcharges and undercharges at a minimum. Vendor software is available to help automate and speed this laborious task. Automated software use provides the capability to increase sample sizes to high confidence levels as well as documenting the existence of a comprehensive compliance program that heads off errors.

Background

Is your organization actively auditing billing capabilities in order to reduce systemic errors and to identify missed and/or erroneous Medicare and Medicaid billing? If yes or no, is your institution ready for government auditors? It should be, because government auditors have been enforcing new regulations since January 2007.

To understand this issue you need some familiarity with the Deficit Reduction Act of 2005, (DRA, or the Act). The Act, which took effect January 2007, includes a provision which takes federal oversight of Medicare and the states' Medicaid programs to a new level.

The problem addressed by the Act was that Medicare and Medicaid expenditures were growing and will continue to grow very quickly. In some states, Medicaid expenditures account for a third of the state's budget, and in five years, Medicaid is expected to be the top expenditure in state budgets across the country.

In past years, federal oversight of state Medicaid programs had been lax, due mainly to insufficient funding and staffing. Now, as a result of the Act, there is a new chain of accountability and standards for Medicare and Medicaid cost control, and the net effect is that, among other areas, medical laboratories are facing more scrutiny than ever.

> *The best way to prepare for that closer scrutiny is to conduct proactive probe billing audits on your own.*

The Key Elements of DRA

These key elements of the law will lead to increased audits of provider billings:

- The federal government is providing financial incentives to states that enact false claims statutes mirroring the federal False Claims Act. As states adopt these statutes, Medicaid billing audits will become more common and more uniform.
- All healthcare organizations receiving annual Medicaid payments of at least $5 million must establish written policies, applicable to all employees and contractors, which provide detailed information about Medicaid fraud. Ignorance of state and federal regulations will not be an acceptable excuse for violations uncovered by audits.
- Even organizations that do not achieve $5 million in Medicaid business will be affected by the new provisions of the Deficit Reduction Act, which requires the federal Centers for Medicare and Medicaid Services (CMS) to actively curtail fraud, waste and abuse at all levels through investigations and audits.

Congress has placed the authority on states to take action in order to prevent and punish Medicaid fraud, waste and abuse. These changes will impose substantial legal risks to healthcare providers. Investigators will use the latest data mining techniques to uncover billing errors and questionable billing practices by healthcare organizations of all sizes.

In addition, the penalties for Medicaid billing errors, especially systemic errors, will be significant. Under newly enacted regulations, even one or two consistent billing errors could lead to huge fines of up to $10,000 per transaction.

Exhibit 1 – Sample Report

Patient Name	Medical RecNum	Encounter	Encounter Date	Physician	Patient Status	Phys Diagnosis	Phys Ordered	Lab Tests Resulted	Collec-tion Date	Billed CPT	Venip	Fee Sched Amount	Net Paid
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	BASIC METABOLIC CHEM PANEL	True CPBAS	3/2/2004	80048		ATP08	
PICKARD, JOHN SAMUEL	1000004	3064119427					Reg Order Record Not Found			81001		4.43	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	PHOSPHORUS	True PHOS	3/2/2004	84100		ATP01	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	CBC	True CBC	3/2/2004	85027		9.04	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	PROTIME	True PT	3/2/2004	85610		5.49	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	TYPE AND SCREEN	True TAS	3/2/2004	86850		No data	
PICKARD, JOHN SAMUEL	1000004	3064119427					Reg Order Record Not Found			86900		4.17	
PICKARD, JOHN SAMUEL	1000004	3064119427					Reg Order Record Not Found			86901		4.17	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	Magnesium	True MG	3/2/2004	Test not billed on Claim		No data	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	Partial Thrombo-plastin	True PTT	3/2/2004	Test not billed on Claim		No data	
PICKARD, JOHN SAMUEL	1000004	3064119427	3/2/2004	Edwards	OP	722	Urinalysis	True UASCR	3/2/2004	Test not billed on Claim	Venip Charge Not Found	No data	68.64
PICKARD, JOHN SAMUEL	1000004	3064119427					False, these unordered tests were found in Test Results file.	UMIC					

Medical laboratories, whether within a hospital or independent, now face new pressure to demonstrate compliance with federal and state regulations. And while labs generally do not tend to have large numbers of billing errors, the errors that do occur in labs are fairly easy to detect. So, institutions need to be prepared to substantiate their billing processes and have the ability to document and provide an audit trail.

Be assured that CMS is serious about its new responsibility. As part of the bill, Congress provided funding for at least 100 new employees whose duties consist solely of protecting the integrity of the Medicaid program, and CMS must make an annual report to Congress that includes data showing the return on investment (ROI) of its fraud and abuse prevention and recovery efforts.

This demand for a ROI means that enforcement at both the federal and state levels will have to be increased and that means closer scrutiny of claims. The best way to prepare for that closer scrutiny is to conduct proactive probe billing audits on your own.

Some Recent Findings

In a July 12, 2008 Wall Street Journal article authored by Theo Francis, a three-year study in Florida, New York, and California yielded overpayments by Medicare of $992.7 million. Of this, $60 million was successfully challenged by medical providers. The audit also identified $38 million that providers should have received but did not.

The Likely Targets

Some likely targets will include an audience that has not experienced prior Medicaid compliance issues. These targets will likely include: hospitals, long-term care facilities, managed care programs, and large providers.

Healthcare providers should be closely monitoring certain issues within their own organizations, including:

- Excessive services and charges
- False claims and quality failures
- Unacceptable record keeping

Exhibit 2 – 500-bed Hospital

Description	Frequency based on 120 claims	Error Rate	Annual Financial Impact	Comment
Test billed / not resulted	3	0.6%	$15,241	Overpayment
Wrong code billed	1	0.2%	23,636	Overpayment
Venipuncture not billed	5	1.1%	8,670	Underpayment
Tests resulted/ not billed	22	4.6%	151,700	Underpayment
Code not in charge file	1	0.2%	10,800	Underpayment
Claims underpaid by payer	0	0.0%	-----	
Lost Revenue*		5.9%	$171,170	
Overpayment		0.8%	$38,877	
Total Codes Review	475	6.7%		
TOTAL LIABILITY		6.7%	$210,047	

Exhibit 3 – Independent Clinical Testing Lab

Description	Frequency Based on 372 Claims	Error Rate	Annual Financial Impact	Comment
Test billed / not resulted	9	0.6%	$11,555	Overpayment
Wrong code billed	3	0.2%	947	Overpayment
Venipuncture not billed	9	0.6%	3,240	Underpayment
Tests not billed	4	0.3%	8,371	Underpayment
Code not in charge file	9	0.6%	33,269	Underpayment
Claims underpaid by payer	6	0.4%	818	Underpayment
Lost Revenue*		1.9%	$45,729	
Overpayment		0.8%	$11,502	
Total Codes Reviewed	1569	2.7%		
TOTAL LIABILITY		2.8%	$57,231	

* Lost revenue based on Medicare Clinical Laboratory Fee Schedule Payment Rates

- Worthless services and errors as a basis for criminal indictment

The Value of Laboratory Probe Audits

Probe billing audits, conducted at least quarterly per OIG recommendation, are an important component in any lab's compliance program. First, they demonstrate a good-faith effort at preventing waste, fraud and abuse. And second, they often identify and report errors that can help lab managers recover lost revenue.

A probe audit provides the means of verifying that physician order requests are captured on paper or through scans, performed, and billed according to Medicare Clinical Laboratory Fee Schedule Payment Rates. It is surprising how often a probe audit of just 30 randomly selected claims—the sample size recommended by the Office of the Inspector General—will turn up billing problems.

Exhibit 1 depicts the results of a recently conducted a probe audit of a laboratory at a 450-bed hospital using automated vendor software designed for this purpose. Of the 30 claims examined, 13, (43 percent) had at least one billing error. For six claims, tests were ordered and performed but not billed. Additionally, eight claims did not have the Venipuncture billed. And in three claims the wrong test was billed. So at this lab, which is not atypical, the probe audit immediately uncovered a significant opportunity for lost revenue recovery.

In another scenario, (Exhibit 2), a 500-bed hospital identified a billing error rate of nearly 6% and lost revenue of $172,000.

Probe audits can also be used by independent testing labs (Exhibit 3). In an audit conducted at an independent testing lab, the audit program was able to demonstrate a lost revenue error rate of roughly 2% and lost revenue of $45,729.

Conducting probe billing audits like this does not need to be onerous. In addition, to independent consultants who can conduct audits, the process can now be automated with new software that analyzes laboratory billing through the use of an automated probe audit tool that cuts audit time and effort significantly.

Automating Your Capabilities

Due to software automation capabilities users are able to expand the probe audit from a minimum of 30 quarterly claims to a maximum that reveals a 95% confidence interval. The best way to prepare for that closer scrutiny is to conduct proactive probe billing audits on your own.

In an environment where states are continually developing programs and compliance requirements, healthcare providers will be well advised to take proactive advantage of the availability of automated audit capabilities to limit their exposure and culpability.

Summary

Regardless of whether you choose to use manual or automated probe billing audits, the important thing is that they are conducted to document the organization's self-assessment and provide evidence of a robust compliance program, reduce culpability and recover revenue. Then, when the federal and state auditors arrive at your door, you'll be able to demonstrate a reliable, comprehensive compliance program that allows your institution to make confident informed decisions when it comes to laboratory billing. **NP**

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