UC Riverside, School of Medicine Policies and Procedures
Policy Title: Coding and Documentation Audits
Policy Number: 950-02-021

Responsible Officer:	Chief Compliance and Privacy Officer
Responsible Office:	Compliance Advisory Services
Origination Date:	3/2021
Date of Revision:	
Scope:	UCR Health Clinical Enterprise

I. Policy Summary

The Compliance department shall monitor the billing for goods and services that are provided to UCR Health patients. Compliance staff shall review services provided by UCR Health physicians and qualified healthcare professionals for billing accuracy, coding accuracy, and compliance with federal, state and third-party payors' rules and regulations as well as any UCR Health policy.. Coding and documentation reviews will be performed for all UCR Health providers to identify and address any noncompliance with professional billing practices.

II. Policy Text

A. Type of Audits: Evaluation and Management outpatient and inpatient visits, office and hospital procedures and other diagnostic services provided by UCR Heath providers will be reviewed under the appropriate type of audit as requested by the School of Medicine's Chief Compliance Officer and/or the Compliance Committee. (Refer to Attachment 1)

1. New Provider Audits
2. Routine Review
3. Routine Follow Up 1: Providers who did not pass the routine review audit.
4. Routine Follow Up 2: Providers who did not pass routine follow up 1 review audit.
5. Special or High Risk Based Review: Review conducted due to a potential compliance risk based on defined criteria.

B. Frequency of Audits: Audits of retrospective claims will be conducted to ensure compliance with coding and billing federal and state regulations. Periodic monitoring including monthly, quarterly and annual reviews where applicable, of previously audited areas and/or providers will be conducted to ensure continued compliance with applicable internal policies, procedures and external regulations.

C. Overpayments: Any audit findings that identify overpayments based on insufficient documentation will result in a refund request form submission to revenue cycle management. Insurance refunds are to be processed within 60 days of the completed audit.

D. New Providers: The Compliance department should be notified of any physician or qualified healthcare professional new to UCR Health to ensure that the billing, coding and documentation guidelines are communicated. New providers to UCR Health will have their services reviewed within the first quarter of their start date.

E. Education: Regular and periodic education, training and support to providers on documentation, billing and coding are conducted to remain compliant and updated on the regulations and guidelines of Medicare, Medi-Cal, Tricare and any other government related entities. All individuals involved in the billing process, including the clinic staff and revenue cycle staff are also educated to comply with the professional fee billing rules and regulations.

III. Responsibilities

Compliance Advisory Services

IV. Procedures

A. Goals

1. Examination of retrospective billing data to determine if the documentation for a particular claim is correctly coded and if all charges have been a captured on the day of the encounter.
2. Review of the patient's medical record to gather information to identify any risk areas.
3. Review and monitor coding practices and the adequacy of the documentation and code selections.

B. Audit Sampling Methodology

1. Scope: Audit samples will be randomly selected from all payors.
2. Population of bills: Audits will be retrospective from the prior quarter service dates.
3. Sample Size: A baseline audit will be used to measure the coding compliance of each provider. The baseline audit will include 10 transactions/cases per practitioner of their most billed codes.
4. Types of Audits: New Provider, Routine review, Routine follow up, Special review or High risk-based audits.
5. Identified Risk: New Physicians and physicians previously employed by HMO's or their related foundations (i.e. Kaiser).

C. Audit Score Methodology

1. Passing Audit Score: An accuracy audit score of 90% is passing.
2. Error Rate Calculation: Documentation discrepancies and coding errors are weighted. Assigned points are based on the findings of the documentation review. (Refer to Attachment 3)
   Accuracy Formula: *1 – (total points for px codes/px lines reviewed)*.
   The accuracy score sums the points for all cases based upon the finding(s). The score for any individual Px code per case is capped at "1." The lower the score the better, so a total of "0" is perfect.

D. Frequency of Audit

1. Providers with a passing score of 90% or above will be reviewed once annually.
2. Providers with a score of 89% or less will be audited again within 6 months from the last failed audit.
3. New Provider compliance reviews will be conducted within the first quarter after their hire date.

E. Audit Reporting

1. Findings and recommendations will be documented by the compliance coding auditor and will be reviewed with the provider prior to the final audit results.
2. The compliance coding auditor will meet with the provider (in person, via Zoom or by phone) to discuss the audit outcome and any coding compliance or UCR Health policy violations.
3. Following discussion with the provider, the final audit results will be communicated to the department chair and FAO, Chief Compliance and Privacy Officer, Compliance manager, physician and the Compliance Committee.

F. Refund Process

1. The compliance coding auditor will complete an Estimated Refund and Rebill Report which will include the provider information, service date, patient information, original billed codes and the recommended CPT, HCPCS, ICD-10-CM, units and modifier information.
2. The Estimated Refund and Rebill Report will be submitted to Revenue Cycle Management.
3. The difference between the billed CPT reimbursement amount and the recommended CPT reimbursement amount will need to be verified by Revenue Cycle Management.
4. If the claim is still within the billing period, a corrected insurance claim will be submitted.
5. Once completed, Revenue Cycle Management will provide the completed refund request form to the Director of Clinical Compliance for review/approval/signature.

V. Forms

Attachment 1 - Types of Provider Audits
Attachment 2 - Estimated Refund and Rebill Report
Attachment 3 - Audit Score Methodology

VI. Revision History

Approvals:

COMPLIANCE COMMITTEE (04/28/2021)

Paul Hackman Digitally signed by Paul Hackman Date: 2021.05.14 14:46:09 -07'00' 05/14/2021

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