New payment review strategies

What to do if you receive an outlier coding notice

In an August 2017 notification to providers and suppliers, the Centers for the Medicare & Medicaid Services (CMS) communicated changes to its medical review and education strategy. CMS will now concentrate its efforts using a program called "Targeted Probe and Educate" (TPE).

Medicare Administrative Contractors (MACs) will identify and selectively audit **individual providers** with outlier service billing patterns, rather than audit all providers billing the identified service.

If you are identified as having billing practices that vary significantly from your peers, your MAC may conduct a probe sampling of 20 to 40 claims per service item. If, after such review, an unacceptable error note is determined, individual training will be provided for each reviewed item.

If a provider sufficiently improves after any one of the reviews, that item will not be reviewed again for 12 months. However, if no improvement is made after three rounds, the provider will be referred to CMS for further action (e.g., 100% prepay review, extrapolations, referral to a recovery auditor or other actions).

While the impact of the TPE program is unknown, some of our clients have encountered commercial payers already using similar strategies. As these inquiries do not always include a documentation review, providers should be aware of these varying notices and prepare to respond accordingly.

For example, when commercial payers conduct data analyses to compare providers' evaluation and management (E/M) coding levels to that of their peers, they may find a few providers who fall outside the norm. Some physician practices have reported receiving letters identify-

Internal vs. external reviews

Review type	Frequency	Cons	Pros
INTERNAL	**Periodic and ongoing**	▪ Staff limitations (knowledge and/or lack of time) ▪ Possible provider resistance to feedback ▪ Internal conflict of interest ▪ Skewed perspective (too "close to" the data to identify issues)	▪ Less costly than external review
EXTERNAL	**Annual and targeted**	▪ Greater expense and time involved than one would expect in simply performing and internal review	▪ Less expensive than hiring a full-time coding professional, assuming only limited time is needed for annual or targeted reviews ▪ Credentialed coding professionals with broad coding and healthcare industry compliance knowledge and access to pertinent benchmark data ▪ No conflicts of interest ▪ Perception as more authoritative, so providers more open to feedback

ing them as outliers due to billing pattern data that show they are billing higher levels of E/M—office or hospital visit—codes than their peers.

Interestingly, these payer letters often are sent to create awareness and not to request documentation for conducting an audit. Payers are using this "soft approach" to educate, and subsequently monitor, practices before resorting to time-consuming, expensive documentation audits.

Contacting outside help

A practice may or may not have the internal capacity to perform E/M coding reviews. Even when a practice employs a coding professional, it may request an external review for various reasons. The table outlines a few of the pros and cons of conducting internal versus external reviews.

Cost is often the greatest factor when making this decision, but it is important to weigh the cost of an audit, which may be far greater than the cost of an external review. Typically, a practice can achieve optimal risk and cost management by combining internal and external review efforts (i.e., performing internal reviews, then periodically validating them through external reviews).

The best defense

Now that payers are using data analysis to identify outliers, providers should be prepared to explain why their data differs from the norm, because differing coding patterns do not always equate to improper coding.

Ultimately, proper medical record documentation is the best defense in a medical review. Therefore, providers should confirm the accuracy of coding and documentation and determine the factors influencing their billing patterns, if it differs from that of their peers.

Patient population, location of practice and sub-specialty focus are all potential contributing factors and credible influencers. Providers should not artificially alter billing patterns as a means of avoiding a potential audit.

If a practice receives a letter, we do not recommend responding directly to the payer unless the letter states that an actual response is required. Check with your attorney regarding an appropriate response plan. ◘

Valerie Rock, CPC, is senior manager of the compliance advisory services team at PYA, specializing in coding, reimbursement and compliance. Send coding questions to medec@ubm.com.

Q: What should I do when I receive a notice that I am an outlier?

Receiving a notice letter doesn't necessarily mean that you are billing improperly. However, it is essential to evaluate your organization's coding accuracy, as such notifications are likely a precursor to an audit. The following strategies can help you feel prepared and confident when, and if, this time comes.

1. Be proactive

Create a response plan now, so you will know how to respond in the future. Treat these notifications seriously—too often they get "misplaced." The assumption is, "The payer isn't asking for anything (right now), so I don't need to worry about it." Ensure each payer has your correct mailing address and contact information. Assign someone the responsibility of confirming this information annually—include your top five major payers in this review. If payer letters are misrouted, they are less likely to be addressed timely and appropriately.

2. Follow a routine

If you are not already conducting routine coding reviews (of both code utilization and clinical documentation), start now. Perform reviews annually, at minimum. Create each provider's coding baseline by conducting an initial coding review to determine code utilization patterns that can be used to self-identify areas for focused education. Routine reviews are essential to mitigating potential coding and/or compliance issues, and the results will guide corrective actions to further self-monitor and manage risk.

3. Conduct a review

If you have not been conducting routine coding reviews, or you have not conducted a review during the period indicated in the letter, you should do so after receiving the letter. Your review should include a data analysis, by payer, of E/M code utilization, or other code set as indicated in the notification letter, to validate the payer's claim.

If your self-review confirms the payer's findings, the next step is to confirm that the provider's documentation supports the code level billed for a sample of claims. A review of 10 to 25 encounters per provider is sufficient. Use the results of the review to educate the provider named in the letter, and determine if education would be beneficial for all providers in the practice. Coding education is recommended every one to two years. Return to routine coding reviews if there are no findings during this review.