CREATING AN AUDIT PLAN FOR PHYSICIAN OFFICES

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Director of Curriculum | AAPC
OIG Compliance Guidance

- Implementing written policies, procedures and standards of conduct.
- Designating a compliance officer and compliance committee.
- Conducting effective training and education.
- Conducting internal monitoring and auditing.
- Developing effective lines of communication.
- Enforcing standards through well-publicized disciplinary guidelines.
- Responding promptly to detected offenses and undertaking corrective action.
Objectives

- List the steps to create a successful audit plan
- Identify ways to tailor the audit plan to your practice
- Discuss tools helpful to include in audit plan
Steps to Create an Audit Plan

1. Identify the purpose of the audit plan.
2. Define the scope and timing of the audit.
3. Specify guidelines and documentation to perform the audit.
4. Designate reporting parameters for the results of the audit.
5. Determine follow-up monitoring and education parameters.
1. Identify the Purpose

- Adherence to clinical protocols
- Adherence to compliance program
- Evaluate effectiveness of an electronic health record
2. Timing and Scope

• How many charts will you audit?

• How often will you audit?

• What services will be a part of the audit?

• How will you determine what services will be a part of the audit?

• What resources will you use?
Retrospective vs. Prospective

- Retrospective – claims have been submitted.
- Prospective – prior to claims submission.
OIG Baseline Audit

- Patient intake through claims resolution (retrospective)

- Claims/services that were submitted and paid during the initial three months after implementation of the education and training program.
OIG Periodic Audits

• Minimum: Annually

• Basic Guide:
  • 5 or more medical records per Federal payor
  • 5-10 medical records per physician
2. Timing and Scope

Sample Language:

• A baseline audit will be performed for each new provider three months after the start date consisting of a 30% random sampling of the provider’s records during the first three months.

• An annual audit will be performed on ten medical records per provider.
2. Timing and Scope

Sample Language:

• A baseline audit will be performed for each new provider three months after the start date consisting of a 30% random sampling of the provider’s records during the first three months.

• An annual audit will be performed on ten medical records per provider. The audits will inquire into compliance with specific rules and policies that are the focus of CMS and OIG as evidenced by benchmarking, current year OIG workplan, CMS CERT, and CMS RAC. Audit should also reflect areas of concern specific to AAPC Physicians identified by analysis of claims denials.
Benchmarking: AAPC
Benchmarking: MGMA

Evaluation and Management Distribution for General Practice

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedures</th>
<th>Percent</th>
<th>Procedures</th>
<th>Percent</th>
<th>Procedures</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>1,518</td>
<td>10.07%</td>
<td>10</td>
<td>4.55%</td>
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<td>99202</td>
<td>16,843</td>
<td>11.85%</td>
<td>50</td>
<td>22.73%</td>
<td>20</td>
<td>18.18%</td>
</tr>
<tr>
<td>99203</td>
<td>63,872</td>
<td>44.93%</td>
<td>100</td>
<td>45.45%</td>
<td>50</td>
<td>45.45%</td>
</tr>
<tr>
<td>99204</td>
<td>48,342</td>
<td>34.00%</td>
<td>50</td>
<td>22.73%</td>
<td>30</td>
<td>27.27%</td>
</tr>
<tr>
<td>99205</td>
<td>11,598</td>
<td>8.16%</td>
<td>10</td>
<td>4.55%</td>
<td>6</td>
<td>5.45%</td>
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<tr>
<td>Total</td>
<td>142,173</td>
<td>100.00%</td>
<td>220</td>
<td>100.00%</td>
<td>110</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

Click here to upload all physicians from your practice.

Export to Excel
Resources: OIG Work Plan

- Monitoring Medicare Payments for Clinical Diagnostic Laboratory Tests
- Medicare Payments for Transitional Care Management
- Medicare Payments for Chronic Care Management
- Ambulatory Surgical Centers – Quality Oversight
- Anesthesia – Noncovered Services
- Anesthesia Services – Payments for Personally Performed Services (AA vs QK)
- Prolonged Services – Reasonableness of Services

Table J1: Improper Payment Rates by Provider Type and Type of Error: Part B

<table>
<thead>
<tr>
<th>Provider Types Billing to Part B</th>
<th>Improper Payment Rate</th>
<th>Claims Reviewed</th>
<th>Type of Error</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No Doc</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>46.0%</td>
<td>434</td>
<td>2.2%</td>
</tr>
<tr>
<td>Clinical Laboratory (Billing Independently)</td>
<td>31.6%</td>
<td>2,374</td>
<td>0.5%</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>30.3%</td>
<td>75</td>
<td>0.0%</td>
</tr>
<tr>
<td>Physical Therapist in Private Practice</td>
<td>25.5%</td>
<td>600</td>
<td>1.5%</td>
</tr>
<tr>
<td>Occupational Therapist in Private Practice</td>
<td>25.5%</td>
<td>45</td>
<td>0.0%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>24.5%</td>
<td>47</td>
<td>24.9%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>24.0%</td>
<td>148</td>
<td>0.6%</td>
</tr>
<tr>
<td>Interventional Pain Management</td>
<td>22.9%</td>
<td>60</td>
<td>0.0%</td>
</tr>
<tr>
<td>Clinical Social Worker</td>
<td>19.8%</td>
<td>91</td>
<td>4.4%</td>
</tr>
<tr>
<td>Unassigned</td>
<td>17.5%</td>
<td>50</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

- Undefined codes
- Chiropractic
- Other - non-Medicare fee schedule
- Lab tests – glucose
- Lab tests – other (non-Medicare fee schedule)
- Home visit
- Echography/ultrasonography – carotid arteries
- Hospital visit – initial
- Other – Medicare fee schedule
- Specialist – psychiatry
- Specialist – other
- Lab tests – urinalysis
- Minor procedures – other (Medicare fee schedule)
- Hospital visit – critical care
- Lab tests – bacterial cultures
- Standard imaging – chest
- Other tests – other
- Endoscopy – cystoscopy
- Lab tests – blood counts
- Minor procedures - musculoskeletal
### Table K4: Impact of 1-Level E&M (Top 20)

<table>
<thead>
<tr>
<th>Final E &amp; M Codes</th>
<th>Improper Payment Rate</th>
<th>Projected Improper Payments</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/outpatient visit est (99214)</td>
<td>1.5%</td>
<td>$115,827,633</td>
<td>0.9% - 2.2%</td>
</tr>
<tr>
<td>Office/outpatient visit est (99213)</td>
<td>1.9%</td>
<td>$102,001,514</td>
<td>0.8% - 2.9%</td>
</tr>
<tr>
<td>Subsequent hospital care (99233)</td>
<td>5.3%</td>
<td>$100,850,771</td>
<td>4.3% - 6.3%</td>
</tr>
<tr>
<td>Emergency dept visit (99285)</td>
<td>6.4%</td>
<td>$94,779,148</td>
<td>4.8% - 7.9%</td>
</tr>
<tr>
<td>Office/outpatient visit new (99204)</td>
<td>4.9%</td>
<td>$60,460,563</td>
<td>3.3% - 6.5%</td>
</tr>
<tr>
<td>Initial hospital care (99223)</td>
<td>3.1%</td>
<td>$56,299,409</td>
<td>2.4% - 3.9%</td>
</tr>
<tr>
<td>Office/outpatient visit est (99215)</td>
<td>4.4%</td>
<td>$46,466,237</td>
<td>3.1% - 5.7%</td>
</tr>
<tr>
<td>Initial hospital care (99222)</td>
<td>3.4%</td>
<td>$25,479,177</td>
<td>2.4% - 4.5%</td>
</tr>
<tr>
<td>Subsequent hospital care (99232)</td>
<td>0.8%</td>
<td>$21,329,899</td>
<td>0.4% - 1.2%</td>
</tr>
<tr>
<td>Office/outpatient visit new (99203)</td>
<td>2.3%</td>
<td>$20,345,706</td>
<td>0.5% - 4.1%</td>
</tr>
</tbody>
</table>
# Table K5: Type of Services with Upcoding Errors: Part B

<table>
<thead>
<tr>
<th>Part B Services (BETOS Codes)</th>
<th>Improper Payment Rate</th>
<th>Projected Improper Payments</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital visit - initial</td>
<td>18.6%</td>
<td>$547,338,242</td>
<td>17.2% - 20.1%</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>2.9%</td>
<td>$425,451,474</td>
<td>2.2% - 3.5%</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>6.8%</td>
<td>$391,375,074</td>
<td>5.9% - 7.6%</td>
</tr>
<tr>
<td>Office visits - new</td>
<td>11.9%</td>
<td>$344,918,848</td>
<td>10.1% - 13.8%</td>
</tr>
<tr>
<td>Emergency room visit</td>
<td>9.5%</td>
<td>$204,514,696</td>
<td>7.8% - 11.1%</td>
</tr>
<tr>
<td>Nursing home visit</td>
<td>7.9%</td>
<td>$158,211,022</td>
<td>6.6% - 9.3%</td>
</tr>
<tr>
<td>Hospital visit - critical care</td>
<td>9.2%</td>
<td>$94,288,072</td>
<td>6.1% - 12.2%</td>
</tr>
<tr>
<td>Home visit</td>
<td>5.1%</td>
<td>$14,298,992</td>
<td>0.1% - 10.0%</td>
</tr>
<tr>
<td>Dialysis services (Medicare fee schedule)</td>
<td>1.7%</td>
<td>$13,798,600</td>
<td>0.7% - 2.8%</td>
</tr>
<tr>
<td>Ambulance</td>
<td>0.3%</td>
<td>$13,178,920</td>
<td>0.1% - 0.5%</td>
</tr>
</tbody>
</table>
### NOT A NEW PATIENT - 0039

<table>
<thead>
<tr>
<th>ISSUE NAME</th>
<th>Not a New Patient - 0039</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER TYPE AFFECTED</td>
<td>Physician; Professional Services</td>
</tr>
<tr>
<td>DATE OF SERVICE</td>
<td>03/23/2017</td>
</tr>
<tr>
<td>STATES AFFECTED</td>
<td>2 – all applicable states</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**

1. Social Security Act, Section 1933, [42 U.S.C. § 1395l] (e); 2. Medicare Claims Processing Manual: CMS Publication 100-04; Chapter 12, §30.6.7(A)

**DESCRIPTION**

Providers are only allowed to bill the CPT codes for New Patient visits if the patient has not received any face-to-face service from the physician or physician group practice (limited to physicians of the same specialty) within the previous 3 years. This query identifies claims for patients who have been seen by the same provider in the last 3 years but for which the provider is billing a new (instead of established) visit code. Findings are limited to line with overpayments only.

### NEW PATIENT VISITS - 0043

<table>
<thead>
<tr>
<th>ISSUE NAME</th>
<th>New Patient Visits - 0043</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER TYPE AFFECTED</td>
<td>Professional Services (Physician/Non-Physician)</td>
</tr>
<tr>
<td>DATE OF SERVICE</td>
<td>03/23/2017</td>
</tr>
<tr>
<td>STATES AFFECTED</td>
<td>2 – all applicable states</td>
</tr>
</tbody>
</table>

**ADDITIONAL INFORMATION**


**DESCRIPTION**

Identification of overpayments made when providers report visits with new-patient Evaluation and Management (E/M) codes for patients who do not meet the definition of a new patient. Claims are recouped when a provider bills a new-patient visit code and the same provider or a provider from the same group practice and with the same specialty has performed any other E/M services within a 3-year period of time.
Resources: RAC

**Issue Name:** Global Surgery - Pre- and Post-operative Visits

**Issue Number:** 0045

**Issue Description:** Identification of overpayments associated with minor and major surgical services. 1) E/M services (as specifically defined in the ICM) billed the day prior to, day of, or during the 90-day global period of a major (90-day) surgical service without modifiers as specifically defined in the IOM; 2) E/M services (as specifically defined in the ICM) billed the day of or during the 10-day global period of a minor (10-day) surgical service without modifiers as specifically defined in the IOM; and 3) E/M services (as specifically defined in the IOM) billed the day of a minor (0-day) surgical service without modifiers as specifically defined in the IOM.

**Type of Review:** Automated

**State(s) Impacted:** Region 1

**Provider Type:** Physician/NPP

**Date Posted:** March 17, 2017

**Date Revised:** March 16, 2017

**Dates of Service:** Claims having a “claim paid date” which is more than 3 years prior to the Demand Letter date will be excluded.

**Issue References:**
- Code of Federal Regulations, Title 42 (Public Health), Part 405 (Federal Health Insurance for the Aged and Disabled), Subpart J, Subpart Section 405.936, Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Sections 49 (Surgeons and Global Surgery) and 49.1 (Definition of a Global Surgical Package) (Effective 10/1/2003); Sections 49.2 (Billing Requirements for Global Surgery) (Effective 10/1/2015), 49.3 (Claims Review for Global surgery) (Effective 10/1/2015), and 40.4 (Adjudication of Claims for Global Surgery) (Effective 10/1/2015).Internet Only Manual, CMS Pub. 100-04, Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.5, Subsections 3.5.1 (Reopening Claims) and Section 3.8.A (General) (Effective 6/28/2011) and Subsection 3.8.2.A (Coding Determinations) (Effective 6/28/2011; Revised 1/1/2012).

**Issue Name:** Annual Wellness Visits (AWV)

**Issue Number:** 0028

**Issue Description:** HCPCS code G0438 (Annual wellness visit; includes a personalized prevention plan of service [PPS], initial visit) is a “one time” allowed Medicare benefit per beneficiary.

**Type of Review:** Automated

**State(s) Impacted:** Region 1

**Provider Type:** Physician/Non-physician Practitioner

**Date Posted:** March 30, 2017

**Date Revised:** March 29, 2017

**Dates of Service:**

**Issue References:**
- Code of Federal Regulations, Title 42 (Public Health), Part 405 (Federal Health Insurance for the Aged and Disabled), Subpart J, Subpart Section 405.936, Internet Only Manual, CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Sections 49 (Surgeons and Global Surgery) and 49.1 (Definition of a Global Surgical Package) (Effective 10/1/2003); Sections 49.2 (Billing Requirements for Global Surgery) (Effective 10/1/2015), 49.3 (Claims Review for Global surgery) (Effective 10/1/2015), and 40.4 (Adjudication of Claims for Global Surgery) (Effective 10/1/2015).Internet Only Manual, CMS Pub. 100-04, Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.5, Subsections 3.5.1 (Reopening Claims) and Section 3.8.A (General) (Effective 6/28/2011) and Subsection 3.8.2.A (Coding Determinations) (Effective 6/28/2011; Revised 1/1/2012).
EMR Risk Areas

Sample Checklists for Conducting Internal Monitoring and Auditing

A well-designed compliance program should include both external and internal auditing. [1] Independent auditors, program integrity contractors, or regulatory agencies conduct external audits, while providers conduct their own internal audits. This job aid will help providers conduct internal monitoring and auditing of electronic health records (EHRs). It may also help managed care plans and other ancillary entities that may conduct or assist in monitoring or auditing EHRs. The initial assistance in this job aid addresses using automated vendor or third-party software to monitor for potential fraud, waste, and abuse of EHRs. Further discussion addresses periodic internal auditing and auditing providers should conduct to follow up on issues identified through monitoring at possible instances of fraud, waste, or abuse. For information on internal monitoring and auditing for program integrity issues in general, refer to the "Conducting a Self-Audit: A Guide for Physicians and Other Health Care Professionals" booklet, which is part of the Audit Toolkit podcast at https://www.cms.gov/Medicare-Medicaid-Coordination-Fraud-Prevention/Medicare-Medicaid-Fraud-Education/audit-toolkit.html on the Centers for Medicare & Medicaid Services (CMS) website.

Internal Monitoring

Monitoring is an ongoing effort to ensure that policies and procedures are in place and are being followed. [2] It takes place on a regular basis during normal operations. [3] There are several reasons for providers to implement an internal monitoring program to detect unauthorized access to or use of patient EHRs. These reasons include:

- As "covered entities" under the Health Insurance Portability and Accountability Act's (HIPAA's) Privacy Rule, [5] providers are required to take appropriate steps to protect EHRs from unauthorized access; [6] failure to take these steps can lead to civil monetary penalties. [7]
- CMS requires certain managed care plans to conduct internal monitoring and auditing for potential fraud, waste, and abuse as one of the seven elements of an effective compliance program. [8] and

- Over documentation, or misuse of auto-fill features (macros, templates)
- Upcoding
- Misuse of copy and paste
- Misuse of copy forward
Denials

Ex 1 Denial Analysis

- Depression (Excluded from Coverage): 6%
- Dr. is Appealing: 2%
- Inclusive service: 2%
- Invalid Procedure Code: 1%
- Not Medically Necessary: 1%
- Too Frequent: 86%
Denials

Not Medically Necessary Analysis

80048/80049 - Basic Metabolic Panel
80053/80054 - Comprehensive Metabolic Panel
81001 - Urinalysis
82270 - Fecal-occult
82948 - Blood Glucose
83735 - Magnesium
84443 - TSH
85024 - CBC
87086 - Urine Culture
93000 - EKG
94760 - Pulse Oximetry
95810 - Sleep Testing
97010 - Hot or Cold Packs
97033 - Electrical Stimulation
97110 - Therapeutic exercises
97124 - Therapeutic Massage
3. Guidelines & Documentation

• Who will be responsible for performing the audit?
  • Internal or external?
  • Qualifications required?
    • Credentials?
    • Education?
3. Guidelines & Documentation

Sample Language:

• All audits will be performed by certified coders with one or more of the following credentials: CPC, CPMA
• Auditors employed by AAPC Physicians will be audited by external resources to monitor their accuracy and performance.
3. Guidelines & Documentation

Sample Language:

• All audits will be performed by certified coders with one or more of the following credentials: CPC, CPMA
• Auditors employed by AAPC Physicians will be audited by external resources to monitor their accuracy and performance.
3. Guidelines & Documentation

• What guidelines will be used to complete the audit?
  • 1995 and/or 1997 guidelines

• Specific audit tools?
  • MAC audit tool
  • Internal audit tool
  • Checklists
3. Guidelines & Documentation

- Gray areas in documentation
  - How does the local MAC interpret the guidelines?
  - How will your organization interpret the guidelines?
3. Guidelines & Documentation

• Example: 1995 Guidelines
  Expanded Problem Focused vs Detailed Exam

• Guidelines state:
  
  • Expanded Problem Focused -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
  
  • Detailed -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s)
What is the 4 x 4 method for determining if an examination is scored as an expanded problem focused or detailed?

Under the 1995 guidelines both the expanded problem focused examination and the detailed examination provide for the examination of up to 7 systems or 7 body areas. This has led to variability in reviews utilizing the 95 guidelines, and requiring an interpretation for proper and consistent implementation of the evaluation and management (E/M) guidelines. By providing a tool we call 4X4 (4 elements examined in 4 body areas or 4 organ systems satisfies a detailed examination; however, less than such can be a detailed exam based on the reviewers clinical judgment) our reviewers and physicians have a clinically derived tool to assist in implementing the E/M guidelines and decreasing one area of ambiguity. This tool is consistent with the way medicine is practiced, as confirmed in Documentation Coding & Billing by Laxmaiah Manchikanti, M.D, and A Guide to Physical Examination by Barbara Bates, M.D. And, it is a tool to reduce reviewer variability.
3. Guidelines & Documentation

1995 Examination

The level of examination for 1995 will be determined as follows:

- 1 body area or 1 body system – Problem Focused
- 2-4 body areas and/or body systems – Expanded Problem Focused
- 5-7 body areas and/or body systems – Detailed
- 8 or more body systems – Comprehensive
Procedure/Surgery Documentation

- Date of surgery
- Patient Name and date of birth
- Surgeon
- Assistant Surgeons/Co-surgeons/Interns
- Anesthesiologist and type of anesthesia used
- Facility where services were performed
- Consents obtained
- Pre op diagnosis/Post op diagnosis

- Indications for the procedure
- IV infusions
- Description and details of procedure
- Findings
- Complications and how they were resolved
- Diagnostic reports/pathology reports
- Intra-operative information
- Post-op condition of patient
- Signatures
Procedure/Surgery Documentation

- Date of surgery
- Patient Name and date of birth
- Surgeon
- Assistant Surgeons/Co-surgeons/Interns
- Anesthesiologist and type of anesthesia used
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- Indications for the procedure
- IV infusions
- Description and details of procedure
- Findings
- Complications and how they were resolved
- Diagnostic reports/pathology reports
- Intraoperative information
- Post-op condition of patient
- Signatures

Description and details of procedure:
- Anatomical location
- How the patient was draped
- Equipment used
- How patient is positioned
- Materials – inserted/removed
- Tissue/organs removed
- Closure information
- Blood loss/replacement
- Wound status
- Drainage
3. Guidelines & Documentation

- Checklist:
  - Does the documentation support the codes reported?
  - Is the documentation is complete?
  - Are the services provided reasonable and necessary?
  - Is there a legible identity of the provider?
3. Guidelines & Documentation

• What happens when an error is identified?
  • Overpayments
  • Corrected Claims
  • Addendum/Corrections to the Medical Records
4. Designate Reporting Parameters

- Who does the report get distributed to?
- What is included in the report?
Report Distribution

- Administration
- Compliance Officer
- Director of Billing
- Managing Partners
- Medical Director
- Individual Providers

Sample Language:
Audit reports will be sent to the compliance officer and the medical director for review.
Audit Report

- Patient name/date of service
- Provider name
- Level billed/level documentation supports
- Diagnosis codes billed/diagnosis documentation supports
- Any coding/billing discrepancies
- Medical necessity
- Recommendations/concerns
- Auditor Name
5. Follow-up Monitoring and Education

<table>
<thead>
<tr>
<th>Error Rate</th>
<th>Schedule for Follow-Up Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>Annual</td>
</tr>
<tr>
<td>20%</td>
<td>Eight Months</td>
</tr>
<tr>
<td>30%</td>
<td>Seven Months</td>
</tr>
<tr>
<td>40%</td>
<td>Six Months</td>
</tr>
<tr>
<td>50%</td>
<td>Five Months</td>
</tr>
<tr>
<td>60-70 %</td>
<td>Four Months</td>
</tr>
<tr>
<td>80%</td>
<td>Three Months</td>
</tr>
<tr>
<td>90%</td>
<td>Two Months</td>
</tr>
<tr>
<td>100%</td>
<td>One Month</td>
</tr>
</tbody>
</table>
## 5. Follow-up Monitoring and Education

<table>
<thead>
<tr>
<th>Error Rate</th>
<th>Schedule for Follow-Up Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤10%</td>
<td>Annual</td>
</tr>
<tr>
<td>11 - 25%</td>
<td>Nine Months</td>
</tr>
<tr>
<td>26 - 50%</td>
<td>Six Months</td>
</tr>
<tr>
<td>51 - 75%</td>
<td>Three Months</td>
</tr>
<tr>
<td>76 - 100%</td>
<td>One Month</td>
</tr>
</tbody>
</table>
5. Follow-up Monitoring and Education

- Non-Compliant Providers
  - Additional education/training
  - Verbal counseling
  - Pre-payment audits
  - Refer to Medical Director
    - Reduction, suspension, or revocation of clinical privileges
    - Suspension or termination of employment
Steps to Create an Audit Plan

1. Identify the purpose of the audit plan.
2. Define the scope and timing of the audit.
3. Specify guidelines and documentation to perform the audit.
4. Designate reporting parameters for the results of the audit.
5. Determine follow-up monitoring and education parameters.
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