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| Conducting a Self-Audit |  |

Self-audits are an important tool for practice owners and managers to reduce the risk of claims denials, ensure appropriate payment for services, and improve coding integrity and clinical documentation. Due to the number of post- and prepayment audits by Medicare and third-party payers, self-audits are essential to avoiding practices that increase your exposure to audits and preparing you in case you do become a target.

Medicare auditors are targeting providers with claims that have particular patterns of billing that fall outside the norm, including:

* Excessive use of the KX modifier (outpatient therapy services exceptions process).
* More units of service billed by one provider than is reasonable.
* Insufficient documentation.

A baseline audit, done internally or with the help of a consultant, can help uncover documentation and billing problems. Experts recommend sampling 20 or more charts per clinician. Additionally, small, targeted audits looking at specific operations within your practice can help uncover deficiencies and may be less time- and resource-intensive.

If your self-audit reveals problems with your coding and billing practices that could be viewed as out of compliance, or if it indicates that you may have been inadvertently overpaid, you should contact a health care attorney for advice. Even if the self-audit reveals only minor problems, it is a good time to review your compliance plan and make changes to your policies as needed.

To help you conduct a self-audit, APTA offers these checklists for an operations audit, chart review audit, and billing audit. Use the links under the Resource column to get more information.

# Operations Audit

**Date:**

**Reviewer:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Resource |
| Is your use of the KX modifier (for exceeding the annual therapy threshold) consistent with national norms? |  |  | APTA: [Medicare Payment Thresholds for Outpatient Therapy Services](https://www.apta.org/your-practice/payment/medicare-payment/coding-billing/therapy-cap)[CMS: Therapy Services](https://www.cms.gov/Medicare/Billing/TherapyServices/index.html) |
| Are all physical therapists in your practice setting individually enrolled in the Medicare program with their own NPI numbers? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)CMS: [NPI: What You Need to Know](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPI-What-You-Need-To-Know.pdf) |
| Do you have enough knowledgeable billing and administrative staff for an efficient and compliant billing operation? |  |  |  |
| Have all staff members been trained in precertification, medical necessity, coding, and local coverage determinations? |  |  | APTA: [Coding and Billing](https://www.apta.org/your-practice/payment/coding-billing)APTA: [Medicare Payment](https://www.apta.org/your-practice/payment/medicare-payment) |
| Do you provide ongoing continuing education opportunities for your coding and billing staff to help them stay current with new payment policies and coverage determinations? |  |  | APTA: [Coding and Billing](https://www.apta.org/your-practice/payment/coding-billing)APTA: [Medicare Payment](https://www.apta.org/your-practice/payment/medicare-payment)APTA: [Local Coverage Determinations](https://www.apta.org/your-practice/payment/medicare-payment/coverage-issues/local-coverage-determinations-lcds) |
| Are you collecting the correct information from patients during scheduling and registration, and is the process HIPAA compliant? |  |  |  |
| Are the workflow processes efficient, with clear delineation of responsibilities? |  |  |  |
| Is there a quality check to ensure that claims are free of errors? |  |  |  |
| Are there steps that can be automated to improve efficiency and reduce errors? |  |  |  |
| Are you billing services in a timely manner? (The Medicare manual states: “such claims must be filed to the appropriate Medicare claims processing contractor no later than 12 months, or one calendar year, after the date the services were furnished.”) |  |  | CMS: [Medicare Claims Processing Manual Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf) |
| Are you receiving payment for services that you are entitled to in a timely manner? |  |  |  |
| Is your process for submitting appeals clearly documented and followed by billing staff? |  |  | APTA: [Medicare Denials, Audits, & Appeals](https://www.apta.org/your-practice/payment/medicare-payment/denials-and-appeals)CMS: [Medicare Parts A and B Appeals Process](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf) |
| Does your front desk staff collect copayments and deductibles at the time of service?  |  |  | APTA: [Payment](https://www.apta.org/your-practice/payment)  |
| Is your staff adequately trained in HIPAA compliance? |  |  | APTA: [HIPAA](https://www.apta.org/your-practice/compliance/hipaa) HHS: [HIPAA For Professionals](https://www.hhs.gov/hipaa/for-professionals/index.html)  |
| Is there a process in place to ensure that essential information is appropriately disseminated in a timely manner with responsible staff? |  |  |  |

Deficiencies:

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# Chart Review Audit

**Date:**

**Reviewer:**

**Patient Identifier (ID Number/ Name):**

**Provider(s):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Resource |
| Is there a plan of care on file? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Is it complete? |   |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Is it signed by the physician? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Is there documentation of each patient visit? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Is all documentation legible? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Are all signatures (PT, PTA, and physician) present and legible? |  |  | CMS: [Medicare Program Integrity Manual Chapter 3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf) CMS: [Complying with Medicare signature requirements](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf)  |
| Are there any stamped signatures? |  |  | CMS: [Medicare Program Integrity Manual Chapter 3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf) CMS: [Complying with Medicare signature requirements](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/signature_requirements_fact_sheet_icn905364.pdf) |
| Are all entries dated? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Does the documentation support the ICD-10 and CPT codes that are billed? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Does each entry include a description for each procedure and modality provided? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Does each entry report total timed code treatment minutes and total treatment time in minutes? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Were there charges for all procedures that were provided and/or in accordance with the Medicare “8-minute” rule? |  |  | CMS: [Medicare Claims Processing Manual Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf) |
| Does the documentation support the use of the 59 modifier or the “X” modifiers? |  |  | APTA: [National Correct Coding Initiative](https://www.apta.org/your-practice/payment/coding-billing/correct-coding-initiative-cci)CMS: [National Correct Coding Initiative Edits](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd) |
| Does the documentation support the medical necessity of the services provided? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Does the documentation provide support that the services are skilled?  |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Are all certifications and recertifications complete and included in the chart? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Does the documentation support the frequency and duration of the services provided? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| If the KX modifier (exception to outpatient therapy threshold) is used, is there documentation that justifies continuation of therapy beyond the annual combined PT and SLP threshold?  |  |  | CMS: [Medicare Claims Processing Manual Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)  |
| Are all billed services provided by either a qualified PT or by a qualified PTA with appropriate supervision by the PT? |  |  | Federal Register: [42 CFR 484.115](https://www.ecfr.gov/cgi-bin/text-idx?SID=85c992f74c421963928b7384ba46ef27&mc=true&node=se42.5.484_1115&rgn=div8)  |
| If students are involved in the provision of services, does the documentation reflect that the PT is the responsible professional within any session?  |  |  | APTA: [Student Supervision](https://www.apta.org/your-practice/payment/medicare-payment/supervision-under-medicare)CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220-230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| If services are not medically necessary or are not a covered service under Medicare, is there an Advanced Beneficiary Notice on file?  |  |  | CMS: [Advanced Beneficiary Notice](https://www.cms.gov/BNI/02_ABN.asp) |

Deficiencies:

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# Billing Audit

**Date:**

**Reviewer:**

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|  | Yes | No | Resource |
| Is the number of units billed by an individual provider in a given day reasonable and consistent with MUEs? |  |  | APTA: [National Correct Coding Initiative](https://www.apta.org/your-practice/payment/coding-billing/correct-coding-initiative-cci)CMS: [National Correct Coding Initiative Edits](https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd)  |
| Is the number of units of service per visit (direct contact) reasonable for each claim? |  |  | APTA: [Coding and Billing](https://www.apta.org/your-practice/payment/coding-billing) |
| Are modifiers applied appropriately, and is their use supported by the clinical documentation? |  |  |  |
| Are all PTs enrolled in the Medicare program and does each have their own NPI number? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Are all billable services provided by a PT or by a PTA under the appropriate supervision of a PT? |  |  | APTA: [Student Supervision](https://www.apta.org/your-practice/payment/medicare-payment/supervision-under-medicare)CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220-230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Are services provided by students provided in accordance with Medicare rules? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 230](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
|  Are all billed services supported by documentation? |  |  | APTA: [Documentation](https://www.apta.org/your-practice/documentation)CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| For outpatient settings, have you avoided billing for cotreatments? |  |  |  |
| Is there an Advanced Beneficiary Notice on file for services that are not medically necessary or for noncovered services under Medicare? Are ABNs used appropriately? |  |  | CMS: [Advanced Beneficiary Notice](https://www.cms.gov/BNI/02_ABN.asp)  |
| Have you avoided any unbundling of codes? According to CMS, unbundling occurs when multiple procedure codes are billed for a group of procedures that are typically covered by a single, comprehensive code.  |  |  | HHS: [OIG Compliance Program for Individual and Small Group Physician Practices](https://oig.hhs.gov/compliance/physician-education/05compliance.asp)See also:[Federal Register Vol. 65 No. 194:59434](https://www.govinfo.gov/content/pkg/FR-2000-10-05/pdf/00-25500.pdf)  |
| Is there any upcoding of billed services? |  |  |  |
| Are skilled maintenance services provided in accordance with Medicare rules? |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf)  |
| Is billing for one-on-one codes supported by documentation? |  |  | CMS: [Medicare Claims Processing Manual Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)  |
| Is the total time recorded both for the timed codes performed and for the treatment session?  |  |  | CMS: [Medicare Benefit Policy Manual Chapter 15 Section 220](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf) |
| Is the billing in compliance with the payer’s billing rules, such as the Medicare “8-minute” rule? |  |  | CMS: [Medicare Claims Processing Manual Chapter 5](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf)  |
| Is there an established procedure for ongoing, at minimum annual, review of commercial payer policies and updates to include dissemination to appropriate staff?  |  |  |  |

Deficiencies:

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**Last Updated:** 06/25/2020

**Contact:** advocacy@apta.org