AMERICAN COLLEGE OF RHEUMATOLOGY
POSITION STATEMENT

SUBJECT: **Payer Audits**

PRESENTED BY: **Committee on Rheumatologic Care**

FOR DISTRIBUTION TO: Members of the American College of Rheumatology
United States Congress
Centers for Medicare and Medicaid Services (CMS)
Medical Societies

POSITION:

The American College of Rheumatology (ACR) supports the following regarding the audit of rheumatologic patient encounters:

1. The ACR strongly opposes contingency fees in audit contracts and believes this is a conflict of interest by the contracting auditors. Auditors should be neutral arbiters without additional financial incentives.
2. Insurers should use the same coding and billing requirements for evaluation and management (E/M) services as the most recently published CMS requirements.
3. Auditing organizations should be staffed with certified coders and have a physician medical director readily accessible to audit health care providers to discuss appeals and claims denials.
4. The look-back period (from claim payment date to date of medical record request) should be no more than 2 years.
5. The auditing organization should limit the number of medical record requests to no more than 20 charts within 45 days.
6. No more than one auditing organization should audit a practice's records at one time in order to reduce administrative burdens.
7. The auditor should reimburse the audited practitioner for direct and indirect costs of an audit, with payment occurring within 45 days from receipt of the medical records unless fraud is proven.

BACKGROUND:

An audit of a rheumatology practice should be conducted within reason following the principles dictated above. Rheumatologists treat an array of complex autoimmune and inflammatory diseases impacting the musculoskeletal system. Diseases treated by a rheumatologist include, but are not limited to, rheumatoid arthritis, ankylosing spondylitis, scleroderma, systemic lupus erythematosus, Beçhet's disease, tendinitis, and myopathies. These conditions are often chronic - a rheumatologist will diagnose and treat conditions that will impact the patient for the duration of their lifetime.

Providers employ methodologies grounded by sound science, peer-reviewed research findings, and all federal and state stature where licensed. These form the guardrails through which a provider will treat a patient with rheumatic disease. A rheumatologist will then consider the individual circumstances of the patient under their care to determine a mutually agreed upon treatment path. Such patient circumstances include the severity of symptoms, disease activity, lifestyle considerations, medical history, age, and gender. These considerations are variable and change throughout the patient's lifetime.

The American College of Rheumatology argues that if an audit is to occur, it should be conducted within reason and acknowledge the nuances of providing rheumatologic care. Auditors from the Centers for Medicare and Medicaid Services should acknowledge that rheumatology professionals strive to make the most clinically appropriate decision in the best interest of each individual patient at the time of the encounter.

PAYER AUDITS:

While the ACR recognizes there is a need for oversight and training to code and bill all medical services accurately, there is a greater desire for rheumatologists to focus on quality patient care for those who are living with rheumatic and musculoskeletal diseases. The ACR supports clinical documentation integrity and the regulatory guidelines but believes the Centers for Medicare and Medicaid Services and private payers should review the current auditing programs. These programs operate with an aggressive watchful eye to seek out discrepancies, while there is currently no program in place to help prevent inappropriate billing.

The ACR believes with multiple auditing programs, there are unintentional consequences for practitioners and their practices, as each auditing program is designed to view and audit different areas of coding and billing. Regardless of size or location, each practice faces different challenges with traditional or targeted audits that cause both financial and administrative burdens.

The ACR continues to work with our membership in being fiscally responsible as it relates to billing and coding but asks payers to do the same by improving their guidelines for auditing programs. Payers should also update their auditing process to reflect the 2021 E/M guidelines to prevent costly payment denials after care has already been delivered. The current coding mechanics are sometimes onerous, and payers should take into consideration the practitioner's intent in providing the most appropriate care to patients on a case-by-case basis. The ACR recognizes there is a margin of error in billing claims and provides ongoing education to members to help prevent payment denials and navigate the Medicare appeals process in the event of adverse payment determination.

REFERENCES:

https://www.jkscience.org/archive/Volume14/Role%20of%20Medical%20audit.pdf

https://oig.hhs.gov/oas/reports/region4/41803085.asp

https://oig.hhs.gov/documents/compliance-guidance/801/physician.pdf

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