



MEDICAL AUDITS: TOP TEN TIPS FOR PHYSICIANS TO ANTICIPATE, RESPOND AND PROTECT THEIR PRACTICES

The pressure on both governmental and private payers to reduce the cost of healthcare and the often mistaken, but real, public perception of rampant Medicare and Medicaid fraud have caused both public and private payers to increase audits of all medical providers, including physicians. In addition, medical audits have succeeded in returning billions of dollars to the Medicare and Medicaid programs and private payers. For example, the U.S. Health and Human Services Office of Inspector General (OIG) has found that \$7 is returned to the Treasury for every \$1 spent on audits. This is in part because the payers have access to providers' claims data and there are software programs that allow payers to easily review claims data and billing patterns to identify potential issues of inappropriate billing and fraud.

Although medical audits can be burdensome to a physician practice and may sometimes result in large demands for repayments, there are things that physicians can do to mitigate the chance of being audited and from adverse outcomes in the event of an audit. The list below is by no means exhaustive, but should serve as a starting point for physicians to consider in preparing for and protecting themselves in the case of an audit.

1. ASSESS THE RISK OF AN AUDIT BEFORE IT OCCURS.

Governmental contractors and private payers use software programs to compare physicians with others in their specialty to identify physicians who may be over-utilizing

certain CPT® codes that have been found to be frequently improperly billed. For example a recent Supplemental Medical Review Contractor (SMRC) audit of Medicare claims found that 61% of the more intensive level Evaluation and Management codes (CPT 99214 and 99215) for claims submitted between July 1, 2011 and December 20, 2012 had been improperly paid. Physicians should use one of the readily available commercial products or information available on CMS' website, such as the Part B Nationalization Summary Data File (BESS), to determine if their billing is out of line with others in their specialty, thereby putting them at risk of an audit. Physicians should also review Medicare's Comprehensive Error Rate Testing (CERT) report to determine if they are billing codes commonly found to have been improperly paid by Medicare and ensure that they are properly using and documenting these codes.

Physicians who do not conduct such an analysis are doing themselves a grave disservice. Not only are such reviews a standard component of an effective fraud and abuse compliance program, but they also serve to show physicians how they are being viewed by payers. The results of a benchmarking analysis can therefore provide physicians with information critical to tailoring a defense to an audit or a repayment demand. Of particular importance, physicians should understand the proper benchmark for their practice – the more sub-specialized the practice, the more aberrant the physician's coding may appear when compared with other physicians, even within his or her specialty. For example, a trauma surgeon's billing and coding will vary dramatically from that of a general surgeon, but a payer's audit software may compare all surgeons regardless of sub-specialty. Proper benchmarking can also have implications for other payer policies impacting physicians' bottom line, such as physician designation programs and tiered networks.

One way to assess whether a practice's coding and documentation is consistent with its clinical cases is peer review by other physicians in the practice. Physicians armed with such knowledge before an audit or demand for repayment are better equipped to effectively respond when faced with an audit.

2. ENSURE THAT CODING AND BILLING PRACTICES COMPLY WITH CODING RULES AND RELEVANT MEDICAL POLICIES BEFORE AN AUDIT OCCURS.

Physicians should regularly conduct random audits of their coding and billing practices to ensure that they comply with CPT and other coding rules and the relevant medical policies of the payers to whom they submit claims. As previously stated, the mere fact that a physician's utilization of a particular code is out-of-line with his or her specialty does not mean that he or she is coding inappropriately. It may simply reflect that particular physician's patient mix or subspecialty.

In addition, physicians often take false comfort in the codes applied by their electronic health record (EHR) systems. It is, however, incumbent on physicians to ensure that their coding and billing practices, including codes and information populated by EHR systems are compliant. To do this, EHR systems should not be set at default levels, physicians should not blindly copy and paste between medical records, and a patient's history and diagnosis codes should relate to conditions addressed on the date of service.

Lastly, payers, including Medicare Administrative Contractors (MACs), are increasingly performing pre-payment audits. Although pre-payment reviews can be burdensome, physicians can use them to engage in dialogue with a payer's medical director to identify why they have been selected for pre-payment review, to ensure that their coding and

billing practices comply with a payer's rules and medical policies, and, where appropriate, to challenge and potentially correct a payer's application of CPT, other coding rules, or medical policies.

3. DETERMINE ON WHOSE BEHALF AN AUDIT IS BEING CONDUCTED AND THE TYPE AND SCOPE OF THE AUDIT BEFORE RESPONDING.

Third party payers frequently contract with outside vendors to review medical records and to conduct audits, sometimes referred to as "proxy" audits. Unfortunately, these companies do not always identify the payer on whose behalf they are working or the type and scope of the audit – critical information which physicians have the right to know. If either the name of the payer or the type and scope of the audit are not readily apparent from a communication requesting medical records or initiating an audit, physicians should ask and should document the answers. Such information is essential not only for physicians to know what type of audit they are facing but also to confirm that the entity seeking access to the records is legally authorized to access them under HIPAA or any more stringent state law.

Depending on the type of the audit, physicians should also carefully consider retaining counsel or other consultants. Retaining counsel is generally recommended when facing audits which could result in findings of fraud, such as Medicare Unified Program Integrity Contractor (UPIC) and Zone Program Integrity Contractor (ZPIC) audits.

4. PAY ATTENTION TO DEADLINES AND PROCEDURES.

Physicians should designate an individual responsible for responding to medical audits and for keeping physician informed of its progress. Among other things, this individual should calendar all deadlines and document and retain all communications between the

practice and the auditors. If a request for medical records or an audit letter includes a deadline for providing the requested information, the practice should either timely respond or immediately seek an extension. In addition, if the request does not specify the deadline, the designated responder should ask. This is critical because failure to understand and meet deadlines can have consequences. For example, failure to respond to requests for records within 45 days in a MAC pre-payment review can result in payment denial for the claim. In addition, failure to appeal a Recovery Audit Contractor (RAC) audit finding within the first 30 days can result in recoupment pending appeal, even if an appeal is subsequently filed within the 120-day appeal window.

This practice's designated individual should also verify how and where records are to be submitted. For example, can they be submitted electronically, or, must paper copies be provided? If the practice elects to retain an attorney or other consultant, the practice's designated individual can also be the point of contact for communications with these outside professionals.

5. ENSURE THAT MEDICAL RECORDS ARE COMPLETE.

Before submitting medical records for review, physicians must verify that the records are complete, including adding any documents or test results that had not yet been added to the medical chart. This is critically important because many payers do not allow physicians to supplement the records after the fact, which can result in overpayment demands based on incomplete information. Physicians should review the records and include any explanation or support for any unusual services or tests. In addition, the individual submitting the records should verify that no information has been cut off or omitted in copying, including verification that both sides of two-sided copies were copied. Finally, the individual designated to oversee the audit should retain copies of all records

submitted to ensure that any requests for repayments or audit findings are accurate based on the records submitted.

6. WHEN AN AUDITOR'S OVERPAYMENT DEMAND IS BASED ON EXTRAPOLATION FROM A CLAIMS SAMPLE, ENSURE THAT THE METHODOLOGY IS FAIR.

Some payers use extrapolation, the calculation of an alleged overpayment amount based on a review of a sample of a physician's records. Recovery Auditors (RACs) may not use extrapolation unless they determine that a provider has a sustained or high error rate OR unless an educational corrective action by the MAC has failed to correct any errors. However, a RAC's determination to use extrapolation cannot be challenged on appeal. Extrapolation is commonly used by commercial payers, using a variety of different formulas.

If an auditor or payer demands repayment based on an extrapolation, physicians should endeavor to determine if the claims sample used was randomly selected and the extrapolation methodology is fair. A complete discussion of extrapolation and testing for fairness is included in PAI's White Paper, *Medical Audits: What Physicians Need to Know*, which is posted at www.physiciansadvocacyinstitute.org. However, there are some things that a physician can easily do to gauge the fairness of an overpayment amount calculated based on extrapolation. For example, physicians should ensure that all outliers were removed from the calculation, that zero paid claims were removed from the calculation, and that underpaid claims, rather than just allegedly overpaid claims, were included in the calculation.

Physicians who believe that underpaid claims were not included in the sample or calculation should consider requesting a 100% claims review. Although this can be

burdensome for both physicians and payers, it can prevent unfair extrapolation from a small, possibly unrepresentative claim sample, and can also help identify underpaid claims, thereby reducing the amount demanded, or, in some cases, eliminating the demand altogether.

7. VERIFY AUDIT FINDINGS.

Audit findings are often erroneous. In fact, a Department of Health and Human Services Office of the Inspector General (OIG) report issued in August 2013 based on a review of 2010 and 2011 claims found that approximately 44% of all appealed RAC contractors' findings of alleged overpayments are overturned at the third level of appeal (the ALJ level). (*Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, p. 11).

Other reports have found even higher success rates for providers on appeal. Therefore, physicians should never assume that an auditor's findings are accurate. Rather, they should verify the substance of any findings - for example whether a particular code was billed correctly, whether a patient's diagnosis supported a particular procedure, or whether a required pre-authorization was obtained. They should also check the auditor's math. When faced with a demand for repayment, physicians often believe that it is easier to just pay the amount demanded. Although that may save time in the short-run, physicians taking that route not only may pay more than is legitimately owed, but also may be subject to continued demands for re-payment for the same reason in the future. Therefore, if a physician disagrees with the auditor's findings after objectively reviewing the audit report, he or she should strongly consider filing an appeal.

8. UNDERSTAND APPELLATE RIGHTS AND PROCEDURES AND APPEAL ALL ERRONEOUS ADVERSE FINDINGS.

Physicians should understand a payer's appeals procedures and should timely file any appeal of an erroneous audit finding. Understanding a payer's appeals procedures is important and can have a significant impact the ultimate result of the audit. For example, the RAC program allows physicians 120 days to file a first level of appeal from a demand for overpayment (the "redetermination" level of appeal). However, unless the first level of appeal is filed within 30 days, the physician will be subject to automatic recoupment of the amount demanded on the 41st day, even if an appeal is subsequently timely filed. Therefore, physicians who believe they have a strong case on appeal should consider filing it within 30 days to avoid recoupment. This is particularly important in light of CMS' moratorium on submitting appeals to the ALJ level until the current backlog is cleared. (possible cite to Ed Gaines article *Significance of the Delays in the Assignment of Administrative Law Judges in Medicare Part B Appeals*). As a further example, the RAC appeals process allows for informal discussions as a supplement to the formal appeals. These informal discussions can be useful in having audit findings overturned without having to complete the formal appeals process. Even when audit findings are not changed as a result of informal discussions, they can be useful in understanding the RAC contractor's reasoning. Physicians should be aware, however, that these informal discussions do *not* alter any of the deadlines for filing appeals.

9. INCLUDE ALL NECESSARY INFORMATION TO REFUTE ERRONEOUS AUDIT FINDINGS ON APPEAL.

An appeal of audit findings should be written as if the individual deciding the appeal knows nothing about the audit or the auditor's findings. Each and every audit finding being appealed should be restated and refuted. If a physician is relying on CPT coding policy or specialty society coding guidance on appeals regarding coding, citations to or copies of these materials should be included in the appeal. Likewise, if a physician is

relying on medical literature to refute a finding of lack of medical necessity, a citation to or a copy of the study or article should be included. A summary of a physician's arguments on appeal should also be included.

10. ADDRESS ANY IDENTIFIED CODING AND BILLING PROBLEMS.

There are times when an audit identifies genuine coding and billing issues. In such cases, physicians should take immediate steps to correct the identified issues and show the payer the remedial measures that have been implemented. For example, a staff member or an electronic medical record system may have applied an incorrect code in certain instances. Or, the correct code may have been applied, but the documentation was not sufficient to support the code. Depending on the payer, the situation of the physician practice, and the circumstances of the demand for repayment, payers may be willing to negotiate reduced payment amounts and/or a plan allowing payment over time. Therefore, if a physician can identify the source of a problem and fix it, a payer may be satisfied that the issue will not recur and as a result be more willing to negotiate a reduced re-payment amount and/or a reasonable payment plan.

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