The Rising Tide of Audits: How To Cope
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In the current environment, it is beginning to seem that there are more auditors than potential subjects of audits in health care. This is particularly true in the public programs of Medicare and Medicaid; but they are not alone and commercial payors as well as managed care companies retain the right to audit in their contracts with almost all providers. All can recoup monies from these audits. Some refer to fraud enforcers, depending on what they find. Audits have different significance today, than fifteen years ago. This article describes who the government auditors are and what they do. It describes the intersection of compliance with audit risk; and it sets forth steps to take upon receipt of an audit request to enhance the chance that you will emerge with minimal financial liability.

Who Is Auditing?

While Medicare has auditors for all of its providers and programs, this article focuses solely on those who pay attention to physicians. Probably the Medicare auditors most physicians are familiar with are the Medicare Administrative Contractors (MACs) formerly known as carriers in Part B. Now they are also the former fiscal intermediaries under Part A. There are thirteen MAC regional zones, some covered by the same contractor (e.g., Noridian, Novitas). They compare physicians in their utilization patterns on an ongoing basis. Most audits are generated by physicians who are outliers by comparison with their peers in the number of specified services they bill for their volume of patients. The data generation is also true for several of the other types of auditors. But audits can be generated by referrals from other agencies, or correspondence to the MAC or complaints, among other sources. In addition to paying claims, MACs conduct prepayment and post-payment review. They engage in provider education and training. They have the authority to request overpayments.

There are other specialized contractors who also audit for Medicare. The first are Fee For Service Recovery Auditors. There are three of them nationally with separate contracts for five regions across the country. These are the only auditors that get paid on a contingency basis, but in a change from the original program, they only receive payment after all appeals are taken. Their role is to identify improper payments, both under and overpayments. They only conduct reviews of records – some automated, some with records requests. Like some of the other contractors discussed here, they send a letter with their findings, but if there is an overpayment, the demand letter for the repayment comes from the Medicare Administrative Contractor (MAC). The physician gets a chance to discuss the findings prior to the formal appeals process for any overpayment.

Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs) are contracted with CMS to identify cases of suspected fraud. This focus makes their attention more problematic than mere utilization review by MACs. Most of the PSCs have become ZPICs. There are 7 zones nationally that they cover. The have the authority to request documentation, conduct interviews and on site visits. They may meet with the

physician to discuss questionable or improper practices, inform of the correct procedures to be followed. They may provide educational materials as well. If they find overpayments, they may notify the physician of their findings. There is an opportunity to request their rereview, but the demand letter comes from the MAC. The ZPICs also identify audit targets based on data. Many more physicians have found themselves interacting with these contractors in recent years.

The Comprehensive Error Rate Testing Review Contractor is contracted to measure improper payments in the Medicare FFS program It is not primarily oriented around individual overpayments, but if they request records for their review and find overpayments, the MAC notifies the physicians and normal appeal rights pertain to that overpayment. The Payment Error Rate Contractor does the same thing for Medicaid, but if an overpayment is found the state agency for the Medicaid program contacts the physician.

Like some of the other contractors noted above the Supplemental Medical Review Contractor is to identify Medicare FFS improper payments through medical review. Again, if they find improper payments they notify the reviewed physician who can ask for a review by them. But the overpayment request, if any, comes from the MAC. There is a Medicare Secondary Payer Recovery Contractor which is responsible for all Medicare Secondary Payer post-payment recoveries; and they have the right to issue demand letters.

Against, this daunting background, state Medicaid agencies conduct audits and reviews and may request overpayments. Commercial insurance companies, Medicare Advantage plans and other managed care entities also have medical review functions and may audit and demand repayments as well. Each of these programs has separate appeal rights. Many of these contractors can extrapolate an overpayment from a sample reviewed. While Medicare has rules regarding what qualifies as appropriate extrapolation and statistical sampling by MACs, PSCs and ZPICs, challenges on that basis are very difficult.

All of this puts an enormous premium on getting the claims submission right in the first place. This is even more important since the publication of the voluntary repayment rules which say that an audit from an outside agency is always credible evidence that requires the Part B recipient to conduct an internal investigation and look back six years to determine if additional overpayments need to be returned.[1]

Preventing Audits in The First Place

The best defense here is a good offense; and that means having a viable, robust compliance program. In today's world, any physician practice that does not have an organized, formal, documented compliance plan which it actually follows, is beyond

[1] See Gosfield & Shay, "Voluntary Repayments and the Obligation of Reasonable Diligence", Dermatology World, July 2016, pp. 26-28

foolhardy.[2] The range of topics to be covered include but are not limited to specific responsibilities for assuring compliance with reimbursement rules like "incident to", diagnostic testing supervision, use of mid-levels and the teaching physician rules if relevant. On-going training of staff and physicians as rules change is key. Testing for documentation adherence, understanding of the rules, and taking action when problems are found are essential to determine if the program is even working.

Assigning explicit responsibility and measurable accountability only happens when plans are written in the active voice. ("The billing manager will review 15 EOBs a month for each physician and compare them with the medical record documentation" as opposed to "EOBs will be reviewed periodically.") Who will make sure training occurs? Who has the responsibility to test to see if the training has worked, how often and when?

Who has the right to interact with payment agencies is a point of particular sensitivity. It is best if only one person interacts with payment agencies for anything other than simple claims inquiries. The plan should identify who that person is and under what circumstances contact should be made proactively as well as in response to inquiries. Calling the MAC to get guidance is a mistake. First, the personnel answering the phones typically are not knowledgeable about the arcane rules; but more seriously, long-standing caselaw from the United States Supreme Court has made it clear that "the need for written records is manifest."[3] This means that unless the guidance is in writing it is not considered legally reliable. Still further, a physician practice ought not seek guidance in writing, since the mere fact of asking the question might trigger an audit, because correspondence is a source to identify audit targets. Attorney-client privilege can be useful in those instances where the MAC's clarification of rules is needed. Let the lawyer ask in writing on a blind basis without identifying the practice.

Staying on top of changes in the rules and conveying those changes to staff and above all physicians, is essential. This means listening to webinars offered by MACs, reading specialty society newsletters, looking at the MAC newsletters. In 2007 after more than 40 years of the Medicare program which had always included 'incident to' billing, and diagnostic testing had almost always been billed in a physician practice as incident to the treating physician, the government suddenly said, diagnostic testing can never be billed incident to. Seven years later, a cardiology group found itself paying the government more than $1.3 millon in settlement of a Stark case where they had attributed the technical component revenues of diagnostic testing to the treating physician in 2007 and 2008.[4] In 2006 they were fine doing what they did. The same is true of the commercial payors who send out newsletters and notices of changes in their policies. Someone in the

[2] For information on how to develop, maintain and measure the effectiveness of a compliance program see http://www.gosfield.com/read/compliance-protocols

[3] Heckler v. Crawford County Community Health Services, 467 S. Ct. 51 (1984)

[4] http://healthlawsidebar.com/wp-content/uploads/2014/08/USDOJ-press-release-for-blog-post-08-19-14.pdf

practice has to be responsible for staying current on these changes and making sure they are implemented in the practice on an ongoing basis.

Another approach to preventing audits by government agencies is to do them within the practice. To begin, a baseline audit of a small sample of typical claims (a probe audit) is worth doing using an outside consultant engaged by your lawyer under attorney-client privilege. If problems are found, you will be able to correct them, but you will also have the obligation under the voluntary repayment rules to quantify the overpayment and look back six years, depending on the fact pattern. For example, if the only problems were created by mid-levels and they were only introduced in the practice three years ago, you would only have to look at three years' of data.

Correcting errors in billing as they happen rather than waiting for a quarterly review, for example, can improve results if an audit does occur. All the MACs have forms on their website by which individual claims can be corrected by repayment if they were billed wrong. Some practices prefer to resubmit a corrected claim. Either way, it is critical to keep a record of the correction in case such a claim is including in the universe for a future audit. Still further, if there is a bigger problem that requires multiple claims to be repaid, under the voluntary repayment rules, the MACs are obligated to accept combined claims around a single problem or more than one problem using one form. Attorney guidance when more than one claim is being repaid for a repetitive problem can be crucial.

Since many Medicare audits are generated by statistical aberrations in a physician practice by comparison with peers, a little known technique is to contact the MAC under the Freedom of Information Act. Ask for the list of the top twenty CPT codes billed by specialists of your type in your region. There is no risk in making such a request. Compare that data with what you are doing. You may have to pay a little bit of money to get the report; and it may take longer than you'd like to get it; but it will tell you normatively where you are. The mere fact that you do not conform to the average data does not necessarily mean you are doing something wrong; but it does provide a good empirical basis on which to look closely at any divergences in your specific practice. You may want to consider making changes. The decision to only bill level 3 E & M visits as an example, would be a bad way to avoid liability, because for sure that is out of whack with the performance of peers to whom the practice will be compared.

<u>When The Audit Inquiry Shows Up</u>

One of the biggest problems we see in responding to an audit request is to send the records without someone reviewing them. If there are problematic matters that can be explained, it is entirely legitimate to write a description that sets the services in context or explains whatever is anomalous. Whoever in the practice is reading the records, should do so with a jaundiced eye, assuming the reviewer will give no benefit of the doubt. If a physician has an idiosyncratic documentation style, that approach should be explained. No subject of an audit should ever change the medical record in response to an audit request, but explanatory material is entirely appropriate.

The second biggest problem we see is not sending the entirety of the records associated with the service dates at issue. Client have not included diagnostic studies located elsewhere in the records. In dermatology practices where the documentation of the size of the lesion and the depth of the incision are critical, if the procedural notes are not contained in the same place as the progress notes or other medical record, it is essential that those records be included. Still further, medical necessity is always at issue in an audit. So if there is a note which documents the medical necessity of the treatment plan but it is outside the service dates for requested records, send it anyway with a cover note of explanation.

Typically when the request comes in it will state the target of the review – specific CPT codes or some specific billing practice. In reviewing the records, before they are sent, pay careful attention to those issues; but understand that even though the auditor may be focused there, most have the authority to request repayments on anything else they find which is improper.

The key to getting a positive result from an audit is to provide sufficient context for what is being submitted to help the reviewer come to the conclusion that what is there was done properly. The audit request may come with an inquiry into the nature of the practice – number of mid-levels, number of locations, facilities where services are rendered. All information should be completed accurately. If the practice has a specific clinical focus which may be the reason it has 'kicked out on the computer' from a data perspective, that should be explained in a cover letter. Typically audits are conducted on individual physicians in the practice, but if overpayments are found, they will be withheld from the entire group, if they are not affirmatively repaid.

Appeals

It is beyond the scope of this article to discuss the complexity of appeals of an unfavorable result. Because of the voluntary repayment rules, though, at least in Medicare, it is absolutely essential to take every level of appeal and to get competent legal advice in doing so. The one principle that should apply to any appeals process – whether a rereview by the same agency, a redetermination after a ZPIC review by the MAC or higher levels of review – is that every single denied service should be rebutted on a service by service basis; not by sending a cover letter which requires the reviewer to interpret anything or apply a principle. Frequently initial reviews are inaccurate. The auditor misses documentation that is there. Each one of those issues should be pointed out with an additional highlighted copy of the documentation attached to the rebuttal. Because some audits are a precursor to extrapolation of the results across a physician's reporting of services over a period of time, getting any negative determinations reversed can have an enormous positive economic impact on the overpayment that is extrapolated.

Conclusion

Auditors are everywhere in heath care. Dealing with them is tedious and sometimes complex. The best approach is to avoid negative results in the first place by having a robust, meaningful compliance program and culture. Then if you get audited, the auditors will find little. That is the ultimate goal.