When Medicare Auditors Decide It’s Time for a Check-up

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Every practice treating Medicare patients is subject to an audit by the Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). In the year 2000 the federal government won or negotiated more than $1.2 billion in judgments, settlements, and administrative impositions in health care fraud cases and proceedings; federal prosecutors filed 457 criminal indictments in health care fraud cases, up 23% from 1999; a total of 467 defendants were convicted of health care fraud-related crimes; there were 1,995 civil matters pending and 233 civil cases filed; and 3,350 individuals and entities were excluded from participating in the Medicare and Medicaid programs.

Medicare audits are one of several things that can trigger a larger civil or criminal investigation by federal law enforcement. Usually, auditors conclude that Medicare has made significant “overpayments” and demand that the audited physician return the money. For the most part, auditors are professional and do their best to conduct fair audits. Nonetheless, the landscape is littered with physicians who fully cooperate with audits only to discover that the auditors have incorrectly determined that a large sum of money is owed to Medicare. Such results can quickly escalate into costly disputes involving suspension of payments to the physician by Medicare, appeals, or even litigation. Although the rules governing appeals are changing in ways that may benefit physicians, the process will remain an expensive and unwanted intrusion.

The Audit Process

In order to understand Medicare audits of physician practices, a few words about the Medicare reimbursement system are in order. The CMS contracts with insurance companies to review claims, to pay claims, and to investigate and respond to allegations of fraud and abuse. These insurance companies are commonly referred to as intermediaries for Part A claims and carriers for Part B claims. In the case of physician practices, audits are usually performed by Part B carriers. One of the more common methods used by Medicare to determine that an audit is appropriate is through the identification of billing patterns. Because claim information is stored electronically, Part B carriers’ analysts, auditors, and investigators can quickly identify physicians whose billing patterns for a particular procedure or procedures exceed the norm set by their peers. Carriers often elect to audit these “aberrant” billing patterns and “outlier” physicians.

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Of course, simply because a physician submits a large number of claims does not mean that there is anything wrong. Indeed, Medicare’s use of the term aberrant is often misplaced. For example, consider ophthalmologists who are audited because they exceed their peers’ reimbursements for cataract surgery. The use of the term aberrant to describe this billing pattern suggests that the billing is surprising or unexpected, and that the physicians deviated from the proper or expected course of treatment. This would be a fair characterization if we were discussing pediatric ophthalmologists. But suppose they are ophthalmologists practicing in retirement communities that are densely populated with Medicare patients. Far from surprising, these physicians’ billing patterns should be anticipated. Given a logical explanation such as this, why should the physician have to endure the time and expense of an audit? It does not seem fair. But at the end of the day, if you’ve been selected for an audit, it matters very little how or why you have been selected. Much like a tax audit by the Internal Revenue Service, complaining about the unfairness of being subjected to an audit is unproductive. Like a tax audit, all that matters is being able to defend and document what you have done.

How will you know when you are being audited, and what does the Part B carrier do during an audit? In many cases, the provider will be notified of an audit by a letter from the carrier requesting copies of a select number of patients’ records. Such a request may identify the particular procedure or procedures under review along with a list of patients and corresponding dates of service. In addition to requesting access to the patient charts, carriers may interview patients; speak with the provider’s employees; speak with any billing consultants used by the provider; and speak with the provider. A post-payment audit involves the review of individual patient charts to determine whether the services claimed were reasonable and necessary for the diagnosis or treatment of an illness or injury, were actually performed, and were documented appropriately in the patient’s chart. The carrier will review the patients’ charts and any other requested records, sometimes employing a physician consultant who has expertise in the procedure(s) that are the subject of the audit.

In some cases, the Part B carrier will conclude that there has been an overpayment. The reasons for overpayments vary. The most common billing errors are: providing insufficient or no documentation, using incorrect codes for medical services and procedures performed, and billing of services that were not medically necessary or that were not covered. For fiscal year 2000, the Office of the Inspector General (oig) reported that Medicare paid approximately $11.9 billion because of such billing errors. Physicians generally find the documentation requirements particularly irksome. Auditors, however, frequently maintain that if a service is not documented in the patient’s medical record in accordance with Medicare billing guidelines, then the claim should be denied. Consequently, even though the services were necessary and actually performed, the Part B carrier may deny claims if the services were not properly documented.

Once carriers determine that there has been an overpayment, they extrapolate. A typical audit is based on a review of a small number of claims covering a brief period. For example, for a single physician, a carrier might elect to look at twenty claims over six months. The result may be an overpayment determination of $1,500. But the carrier doesn’t stop there. Rather, Medicare extrapolates this number to cover a much broader period, frequently the six years preceding the audit. For example, depending on the size of the practice being audited and the total paid for the service(s) audited, through extrapolation, twenty claims can become hundreds or thousands of claims, and a $1,500 overpayment may suddenly mushroom into a projected overpayment of $500,000, or $1 million, or more. The carrier notifies the physician of the projected overpayment and typically offers three options: pay the projected overpayment.
amount and waive rights to appeal; pay the projected overpayment and waive rights to appeal, but continue to submit evidence in an effort to have the amount of the projected overpayment reconsidered; or submit to a full audit, consisting of a statistically valid random sample of claims during the period of the projected overpayment. Although the carrier may take months to conduct an audit, the provider will be afforded only weeks to decide how to respond to it.

Responding to a Medicare Audit

There are no shortcuts or secrets here. The best way to defend yourself is to be honest and forthright. Ideally, you want to demonstrate that everything you did was medically necessary, documented in the patients’ records, and appropriately coded on the claim submitted to the carrier. If there is a problem, then the objective is to present the best case to the carrier and minimize your exposure as best you can. The idea is to persuade the carrier that your office did not knowingly submit false claims to Medicare so that the matter does not need to be referred to the OIG for civil or criminal investigation, and the overpayment, if any, is minimal. How do you go about this? Here are six steps you should consider.

• **First**, respect Medicare’s right to audit your practice. The Medicare program is funded by the federal government, and its carriers have an obligation to make sure that the services it pays for are reasonable and necessary and that beneficiaries actually receive the services. Moreover, as a provider in the Medicare program, you have an obligation to make sure that your claims are accurate. Accordingly, your attitude and actions should demonstrate an eagerness to cooperate fully with the auditors. Anything less is counterproductive.

• **Second**, take control of the situation as best you can. Keep records of all contacts with the carrier. Make sure that you are notified of all requests for information. Designate someone in your practice as contact with the carrier. Keep a written and contemporaneous log of all telephone conversations with the carrier that includes the date, time, and a brief description of the subject of the call. Maintain a file of all written correspondence pertaining to the audit. If you do this, you can be sure to know what is going on and, if there is ever a dispute, you will have the benefit of a written contemporaneous record of what transpired.

• **Third**, gather and copy the records requested by the carrier. Review the entire patient chart for all records that relate to the procedure or service being audited. For example, where relevant, be sure to include referrals from other physicians, diagnostic tests and reports, operative reports, and any entries in the chart that relate to the service or procedure being audited, regardless of the date of service. Think outside your own patient chart; where else are there relevant medical records? Are there hospital records or records from other physicians that might document the medical necessity and performance of the procedure being audited?

Make it easy for the auditor to review the records, and make sure you know what is sent to the carrier. Check for errors in photocopying. For example, medical charts often are written on both sides of the page. Make sure that two-sided copies are made where appropriate and that the copies are accurate, organized, and presentable. Copy and retain a set of the records for yourself, so that you know exactly what you sent to the auditor. Finally, send the records with a cover letter by registered mail, return receipt requested, describing the records that are included in your response.

• **Fourth**, under no circumstances should anyone change, alter, or modify the contents of any records. Even where a change or alteration is perfectly innocent, it is likely to attract the attention of investigators, and may be interpreted as an attempt to document services that were not provided. This can escalate the matter from an audit to a criminal referral. Make sure the copies are accurate.

• **Fifth**, personally review and investigate the claims that are being audited. Among other things,
your investigation should determine whether the chart properly documents the services and whether the services were properly coded on the claim form. Review the claims you submitted as well as the payment history and explanation of benefits for the audited services. If this is to be meaningful, you will also need to decipher the applicable Medicare billing rules and determine whether your claims effectively comply with them. For example, if you are billing for a time-based service, does the chart document your time? If you ordered a diagnostic test, does the chart indicate the reason it was ordered as well as the interpretation of the results? Even where the service was appropriately provided, these kinds of documentation problems can result in significant overpayment determinations. Understand that you are required to return any overpayments about which you know. Therefore, depending on what you learn during the investigation, you may be required to disclose errors or overpayments you find, and to return the money to Medicare. In some cases, your investigation will disclose that everything is in order, in which case you may elect to wait for the carrier to complete the audit. In other cases minor overpayments will be uncovered, in which case you should simply refund the money to the carrier when you produce the requested patient records. But sometimes there are more serious problems.

Why do you want to know about these problems before the carrier discovers them? Because, if you do nothing and simply wait for the carrier to complete the audit, if there is a problem, you are going to have precious little time to decide what to do about it. If you find the problem first, then you can properly prepare. Suppose you find that the charts are poorly documented and, therefore, you are concerned that the carrier may deny the claims. There may be other evidence of the services that you can bring to the carrier’s attention to justify the claims before the audit is completed. Alternatively, the billing errors might be attributable to clerical errors—say, a new employee hired just before the audit period has been using a code incorrectly. In that case, extrapolating the new employee’s errors over a six-year period is grossly unfair. Other options may be available as well. You may elect to discuss these with the carrier before the audit is concluded and before the carrier presents you with an incorrect and grossly inflated overpayment determination. You can only pursue these if you make the effort to learn about potential problems as soon as you learn that an audit will take place.

• Sixth, as soon as you are notified of an audit, and certainly before forwarding your response to it, consult with counsel experienced in these matters. Your attorney may suggest you also retain a qualified consultant with expertise in your particular practice area. A good consultant can be invaluable in conducting a self-assessment. That is, gathering and reviewing the responsive records that document the medical necessity and actual performance of services, negotiating the morass of reimbursement rules, and reviewing the payment history for the services that are being audited. Further, when working under the direction of counsel, the consultant’s work will be privileged and, in most cases, the carrier will learn of the consultant’s work-product and conclusions only if you choose to disclose them. It is imperative that you conduct this type of review immediately upon notification of the audit. If you wait until the carrier has completed its audit, you may find that the overpayment determination is so high (rightly or wrongly) that you have lost control of the situation, either because you don’t have enough time to prepare an adequate response or, worse, because the matter has been referred to the oig for investigation.

“Audit-Proofing” Your Practice

The best way to survive an audit and make yourself “audit-proof” is to conduct your practice as best you can in accordance with all applicable rules and regulations governing reimbursement. Here are a few suggestions.
practice management: medicare audits

- Avoid coding errors. Make sure your procedural codes (CPT) accurately describe the services you provided. Often, there are slightly differing codes that may be applicable, or the codes may require the use of a modifier under certain circumstances. Understand the differences and make sure your are using codes correctly. Similarly, diagnosis codes (ICD-9) justify the services you provided. Make sure that you have indicated a diagnosis consistent with your services.

- Take the time to write things down. Write or dictate notes indicating what you did and why. Be explicit. Indicate the services you provided and demonstrate their medical necessity. Don’t leave it to Medicare auditors to infer why you ordered tests. If you don’t document your charts, the best arguments will be of little help during an audit.

- The development and implementation of a voluntary compliance program that outlines, in writing, policies and procedures that are consistent with “The Office of the Inspector General Compliance Program Guidance for Individual and Small Group Physician Practices” is the best way to reduce billing errors and prevent the submission of erroneous claims. It also demonstrates your good-faith efforts to comply with the rules, something that will be taken into account in the event of an audit. Implementing a compliance plan will require that you perform a baseline risk assessment—internally or with a consultant. Among other things, you should review the codes you are using, review the documentation requirements of these codes, and determine if there are any documentation problems in the charts. Training and periodic self-audits also are required. If you want your practice to survive a Medicare audit healthy and in tact, an effective compliance plan is the best investment you can make. NJM

References
