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Guillermo J. Beades and James. M. Tudor

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Practice Resource

The Dos and Don'ts of Medical Payer Audits: How to Identify and Respond to Them

Guillermo J. Beades and James. M. Tudor

ABSTRACT: Prior to the COVID-19 pandemic, medical providers were routinely audited by public and private payers. Since the pandemic, when many payers were forced to pay for expensive COVID-19 related testing and treatment, payer audits have increased. When a provider receives notice of a pending audit or an overpayment demand, there are specific steps that need to be taken to properly refute the findings, reduce risk, and avoid potential civil or criminal referral. Understanding the nuances in the myriad of payer audits, knowing how to respond to each, and avoiding the common pitfalls can make the difference between successfully defending an audit or having to pay back a significant amount of money.

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Medical Payer Audits

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INTRODUCTION

When a physician treats a patient, be it in an office setting or at a hospital, the service provided will have an associated code that describes the specific health care service performed. The code billed comes from the Current Procedural Terminology (CPT) Manual, which is published by the American Medical Association (AMA) yearly. The CPT code is used when providers bill an insurance plan, which in turn, will pay a pre-determined amount for the code used.

Many times, providers will fall into a false sense of security because they will use the same universe of codes for years without any reimbursement issues or negative feedback from a payer. Making matters worse, payers routinely ask for a few charts every year to "spot check" them but rarely give the provider any feedback. This adds to the false sense of security because physicians will take a payer's silence as a sign that they are billing and documenting everything properly.

What most providers do not understand is that payers are constantly running analytics to determine which providers are outliers in terms of billing a specific code more frequently than their peers or making considerably more money. Being labeled an outlier is the number one factor leading to audits.

When a payer decides to audit a provider, there are many tools at their disposal. The Centers for Medicare and Medicaid Services (CMS), for example, has a myriad of audits at their disposal, including Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC), Targeted Probe and Educate (TPE), Supplemental Medical Review Contractor (SMRC), Zone Program Integrity Contractors (ZPIC), and more. Private payers also have different auditing tactics, each with their own risks involved and requiring a different strategy to navigate. Although audits are numerous and have unique trappings, they generally fall into one of three categories, discussed in greater detail below.

POST PAYMENT AUDIT

The most common audit is the post payment audit, which is a retrospective review of previously paid claims. Post payment audits carry the biggest financial exposure for providers as payers seek to recoup past paid claims, at times going back as far as six to ten years.

The pattern is the same across the country for a post payment audit. The provider will receive a letter from the payer advising that they have been selected for an audit. The provider will then be supplied with a list of patients and dates of services being audited. The records are then reviewed by an auditor, typically a certified professional coder, who will issue findings in an audit trail spreadsheet. The spreadsheet will give a claim-by-claim breakdown of any deficiencies in the documentation. A findings letter enclosing the spreadsheet is sent to the provider noting the overall error rate in the audit and identified overpayment demand. If the records audited constituted a statistically valid random sample, an extrapolated overpayment demand will also be identified, many times seeking repayment of five to six years on average.

Most troubling, many times providers will pay an overpayment demand out of fear of a referral to another government agency, a civil or criminal fraud investigation, or being kicked out of the network. These fears are not unfounded as the overpayment demand letters will usually make references to allegations of fraud, waste, and abuse. In some states, like New Jersey, overpayment demand letters also advise that the Office of the Insurance Fraud Prosecutor (OIFP) or Medicaid Fraud Division (MFD) have been notified of this audit and the findings. This only adds to a provider's apprehension and motivation to resolve the matter quickly. However, a quick resolution does not solve a provider's problems and is only a temporary reprieve. To protect themselves, providers need to engage legal counsel, and through counsel, their own certified professional coder who can perform a reverse audit and fight the results.

Payers make mistakes when they audit on almost every occasion. This is often due to the high degree of subjectivity inherent to coding and billing. It is not uncommon to see wide variances in results within a single audit itself. This is because audits are not normally conducted by a single person; they are done by a 'team' of individuals, all of whom may have varying degrees of understanding relative to the rules they are applying. Inconsistent results are the norm, not the exception. Because of this, it is vitally important to take a close look at the results before determining how to respond. If one acquiesces without having conducted a thorough self-analysis, it may be interpreted as an "admission" of wrongdoing (in a sense). Going forward, acquiescence may also guarantee a spot on the radar for the practice, perhaps for years.

Another frequent mistake is not producing all relevant records that support the code(s) billed. It is imperative to produce all records requested in a timely manner and, even after an overpayment demand is issued, producing supplemental records that may have been inadvertently left out.

PRE–PAYMENT AUDIT

A pre-payment audit does not carry the direct financial exposure of a post payment audit with an extrapolation. However, it can have a significant financial impact on the day-to-day operations of a practice, particularly for small and solo practitioners.

When a practice is selected for a pre-payment audit, it continues to treat patients, but it does not bill for the services in the normal course of business. Normally, a practice will bill for a service after the patient is seen, and payment is made within thirty days on average. During a pre-payment audit, payers freeze payments until they review records for the code(s) selected as part of the pre-payment audit and concur that the proper code was used for the service provided. Sometimes, pre-payment audits can include all the codes that a practice routinely bills, whereas other times, only one or two codes may be targeted. Regardless, this process restricts cash flow to the practice and lasts, at best, ninety days or could continue for years.

What constitutes a "passing grade" is subject to payer policies; it can be a straight error rate based on the code(s) billed, or it can be financially measured (e.g., reimbursement associated with billed codes vs. supported codes). For example, an audit based on pure coding accuracy would include grading of each provider or the practice as a whole. A report card would be submitted to the practice, noting their error rate for the code(s) at issue. If the error rate is higher than 25% (or other pre-determined threshold), the pre-payment audit continues. If an acceptable error rate is sustained for an extended period (e.g., greater than three consecutive months), then the pre-payment audit ends.

Working with a certified professional coder (CPC) to "scrub" claims is vital during this process. Scrubbing essentially means that the corresponding medical documentation is reviewed prior to claim submission by a CPC, and the provisional code choices are validated. If unacceptable, the CPC recommends changes to help ensure the highest accuracy. This is important, because the coder speaks the language of coding and often has a broader understanding of the buzzwords and phraseology, which inspires billing compliance. A well-documented clinical note may also be a poorly documented "coding note," although the provider may not be aware of the nuances which make it so.

PRE–PAYMENT REVIEW

In recent years, payers have developed a new auditing tool—the pre-payment review—that is the best of both worlds for payers and the worst possible outcome for providers. The pre-payment review may sound like a pre-payment audit, but they are considerably different.

The key difference is that a pre-payment audit is meant to also serve as an educational tool for providers. They are handled by a pre-payment audit department, report cards with findings and guidance are shared with providers, and there is an open line of communication between the parties.

A pre-payment review, on the other hand, is handled by the payer's fraud, waste, and abuse investigators – commonly referred to as the Special Investigations Unit (SIU) or Payment Integrity (PI) – and no education is provided during the process. There is also no clear indication as to how long a practice will remain on pre-payment review as most payers do not have criteria for when a practice is removed from pre-payment review.

While on pre-payment review, practices will not be reimbursed if the auditor finds that the documentation does not support the code billed. As there is no educational component, a provider will continue to bill and document consistently, without knowing if they are doing so correctly. Once the investigator has reviewed enough claims – usually anywhere from a month to three months' worth of submissions – they will issue an overpayment demand with an extrapolation. Sometimes they will go back only 18 to 24 months, as per state insurance regulations, or they may allege fraud and go back years.

Once an overpayment demand is issued, the matter must be defended on two fronts, both as a post payment audit and an ongoing pre-payment review. Typically, when the matter is settled, both matters are terminated as part of a global settlement.

When a practice is given notice that it is on pre-payment review, a certified professional coder should review records immediately, as in pre-payment audit matters, and immediately instill a corrective action plan (CAP). A properly designed and executed CAP is viewed favorably by most payers; it tells them that a provider is dedicated to "getting it right." It often reveals great insight into the billing, coding, and documentation habits of providers, what their mindset is toward these matters, and also, the impact the practice's electronic health record (EHR) is having on claims. For example, too much scripted text that is aimed to satisfy coding requirements is rapidly becoming problematic. Payers these days want more in the way of **specific** verbiage that shows what a provider did for each patient. A provider may think he/she has been thorough with the electronic attestations, but in fact, they may be contributing to the problem. An effective CAP that is co-administered by a CPC with experience in the payer audit realm will readily identify the potential hot spots and recommend changes to help avoid sending the wrong message.

AUDIT RESPONSE DOS AND DON'TS

When representing a practice or provider going through an audit, there are certain actions that should be undertaken and others that should be avoided at all costs. Below is a checklist with some recommendations that may be useful in securing the best potential outcome:

- **Remain calm.** Most audits turn out favorably, and it does not help to stress about it excessively. The provider needs to remain levelheaded and rational, which goes a long way toward ensuring that the practice follows all of the required steps and responds pragmatically.
- **All communications should go through legal counsel.** Most audits are handled by investigators, not the payer's general counsel. Therefore, it is imperative to avoid investigators speaking directly with the subject of an investigation as investigators are not seeking statements but admissions from providers. Attorneys can help facilitate access to the upper echelon of decision makers at the insurance company, who may become key players when attempting to land a reasonable settlement or successful appeal (if in fact the audit goes in that direction).

- **Thoroughly review all correspondence received from the insurance company.** Pay close attention to deadlines; for example, if the provider is given 90 days to respond, 91 will not do. An extension may be granted, but only if one is requested. Some payers, like CMS, will not grant extensions and have nuances as to how they calculate due dates and when an appeal is considered "received."
- **Submitting written explanations or attestations along with the production of charts may be counterproductive.** For example, one might *think* that something is wrong when it's not. It can plant ideas in auditors' minds, which may in turn color their perspective throughout the entire audit. As such, a reactive response is often preferred to a pre-emptive explanation.
- **Send *ALL* of the records which connect to the billing.** Often, the progress note does not contain all the information required to support a code. For example, a progress note describing administration of injections/immunizations may tell an auditor what was given and how much, but does it include the lot number, method of administration, who provided it, etc.? Depending on a provider's EHR system, the shot record may supplement the note and round out the full complement of required information.
- **Comply with the records demand.** All payers expect providers to maintain documentation to support the codes used, and failure to produce it is a **zero** in the audit. Implicit to refusal is the notion that there must be something disingenuous about the practice's billing, which helps fuel any pre-conceived notions the payer may have based on their analysis of code distribution or volume. Non-production results in a 100% overpayment demand, sometimes with an extrapolation.
- **Have a CPC with experience dealing with the payers look at a portion of the sample prior to submitting records.** Providers cannot go back and modify old records after the fact, but getting a sense for the likely outcome of the audit in advance and beginning to prepare the strategy/response will benefit the defense of any overpayment demand and reduce future risk.

CONCLUSION

Audits come in many forms and require different strategies for a prompt resolution. COVID-19 has not only impacted many practices, but also payers who have been mandated to pay for COVID testing and treatment. The financial burden payers have suffered because of the pandemic is now being shifted to payers with increased audits and overpayment demands.

Although audits are increasing and more are on the horizon, the key takeaway to keep in mind is that if a practice is proactive and self-audits themselves, they can significantly reduce their chances of being audited. For those practices that are going to be targets of audits, they should be counseled to conduct self-audits to ensure their documentation supports their most frequently billed codes. In the end, proper documentation will always survive scrutiny. A provider should think of their medical records as their armor against audits and should ensure that there are no weaknesses in their armor.

Author Profiles

Guillermo J. Beades is a Partner in Frier Levitt's Healthcare Litigation Department and Co-Chairs the Firm's Insurance Defense Group. Guillermo represents health care professionals in a broad range of administrative, civil, and criminal health care matters. He has extensive litigation experience before state licensing authorities, medical boards, and federal and state health care agencies. He represents practices and health care professionals in matters concerning CMS regulatory violations, licensing board administrative discipline, fraud, waste and abuse investigations, and payer post-payment demands and pre-payment audits. Guillermo has extensive experience representing health care professionals in civil and criminal white collar defense matters, including matters alleging Medicare/Medicaid Fraud and "impossible day" cases. He defends health care providers alleged to have violated the Anti-Kickback Statute, False Claims Act, Codey Law, and Stark. Guillermo is frequently asked to present on regulatory issues and serves as General Counsel to the New Jersey Chapter of the American Academy of Pediatrics. Contact him via email at gbeades@frierlevitt.com.

James. M. Tudor, PCA, CPC is a seasoned veteran in the coding/billing compliance space, having acquired extensive depth in the profession over the span of a 30+ year career. Certified professional coder since 1997 (AAPC), Jim has extensive experience in E/M chart auditing and provider education across all specialties, including acute and post-acute settings. Jim is well versed in HCC coding/risk adjustment and Clinical Documentation Improvement (CDI). He has worked for and with several major institutions at the managerial and directorial levels, overseeing internal audit processes and coding quality. Jim currently directs the HCN Coding Compliance division and is responsible for the oversight and coordination of chart audit initiatives and provider education. He also has extensive experience with payer audits, appeals, and litigation, and has served as a subject matter expert in many cases. Jim is a nationally recognized speaker and has also authored numerous articles about coding compliance and audit defenses. Contact him via email at jtudor@hcompliance.com.

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1099 14th Street, NW, Suite 925 • Washington, DC 20005
(202) 833-1100 • Fax (202) 833-1105 • **www.americanhealthlaw.org**