Surviving a Medicare/ Medicaid or Private Payer Audit

Ed. note: Hoyt Torras has three decades’ experience working with physicians, beginning with Georgia Medicaid and the Medical Association of Georgia. Since 1988 he has been Senior Practice Management Consultant with MAG Mutual Healthcare Solutions, Inc. His current specialty is helping physicians with their coding and reimbursement compliance and responding to payers’ audits. Hoyt also works with experienced attorneys to defend physicians against allegations of fraud & abuse.

It happens all too often: a physician's Medicare carrier sends a “Dear Doctor” letter, requesting office and hospital records on a number of patients. It sends you into a panic attack: thoughts of auditors snooping around your office, determined to find coding and billing errors in your charts, threatening to take you to court, levying outrageous fines, etc. It can be very unsettling.

On the other hand, even a little knowledge about audits and what the payers want from them can help you cope if you get that “Dear Doctor” letter. Better yet, some basic preventive steps and procedures in your office practice can reduce the likelihood that you’ll get such a letter in the first place.

How it works

For decades, Medicare, Medicaid and even private health plans have used post-payment audits to recoup funds from physicians who exhibit greater utilization of certain CPT® codes than their peers. Once a physician practice has been identified as an audit target, records are requested so that auditors can determine if the physician has satisfactorily documented the medical necessity of the billed services and used the proper CPT codes for those services.

Sometimes payers look at only a few patient encounters to determine if the physician is billing the proper code, following coverage guidelines, etc. The hoped-for result is that they find everything in compliance, and leave.

But it doesn’t always happen that way: occasionally auditors will find evidence of improper coding and billing in your office. (They may even go to a hospital or nursing home to audit records without your knowledge). If so, you may receive a “Dear Doctor” letter detailing the records they have reviewed and the codes you submitted on claim forms for the audited dates-of-service. If they find any variance in your billing, they will advise you of the codes they deem should have been paid based on your documentation.

Let’s say auditors identify an “incorrect” overpayment of $3,000 in the sampled patient encounters. Medicare or Medicaid can then request repayment of an extrapolated amount that could be as high as several hundred thousand dollars, based on a period of two, three or possibly six years. It doesn’t matter that auditors can be—and are often—wrong in their initial assessment. What matters is that the physician faces severe monetary penalties. Worse, a post-payment audit could lead to a more intense one, or even a fraud investigation with much more serious implications. (But that’s another story).

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What you should do in the event you are audited:

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What you should do

To avoid these audit scenarios, physicians and their office staff should adopt and follow some common sense precautionary measures. Obviously the best advice is to take actions before an audit to ensure you are in compliance with payer rules. Invest in staff training, take some reasonable compliance steps, encourage your staff to ask questions, have someone periodically audit a sample of claims and supporting documentation, keep up with payer announcements, etc.

1) Take the “Dear Doctor” letter seriously. There may be times when a payer audit is actually what it claims to be, “random.” In every case, however, the request for coding documentation should be very carefully handled. Any time you are requested to send records to a payer, make sure someone with experience is preparing what is submitted on your behalf.

Some of the biggest demands we have worked on involved office staff members who did not realize the seriousness of the records request in the “Dear Doctor” letter:

- they didn’t submit the records which best supported the services billed; or
- they didn’t present the submission in an organized fashion. Auditors may not be experienced in reviewing clinical records in your specialty; your records should help them easily spot the key elements supporting the services you have billed; or
- (worst case) they ignored the “Dear Doctor” letter altogether, even failing to respond to multiple letters and their repeated requests for records information.

2) Don’t assume a payer’s request for records is a “routine” or “random” audit. The language in the “Dear Doctor” letter may sound innocuous, with phrases such as “educational effort,” “random, routine audit,” etc. But it is best to assume there is some reason you are being audited.

3) Determine if there is a common theme to the records the payer is requesting. This could help you prepare your most effective reply.

4) Make sure your submission includes the proper documents that best support the services you billed and the “medical necessity” for such services. And (as we emphasize above) organize your records so that auditors can easily determine that the codes billed and medical necessity for the services were proper.

5) Never alter your records. Recreating, altering or falsifying records can turn a simple overpayment situation into a case with criminal implications. Sometimes it is a good idea to transcribe office notes that are difficult to read so as to assist the auditors in their review. But you should clearly indicate that the transcribed records, submitted with your original and dated, were prepared to avoid confusion.

6) Consult a knowledgeable attorney and billing/coding expert to review your submission. Practice management consultants experienced with audits can review your records and determine if in fact billing errors have occurred, whether the payer is entitled to any repayment, and if so in what amount. If the payer submits a request for repayment, attorneys can help negotiate a settled sum, especially if the payer’s extrapolation imposes an excessive or otherwise unjustifiable amount of money.

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