Preparing for Payer Audits

ACEP Reimbursement Committee

Preparing for Payer Audits Guide 2016

This is an adaptation of the American College of Emergency Physicians (ACEP) 2016 Preparing for Payer Audits Guide. The full document can be found here: https://www.acep.org/globalassets/sites/acep/media/reimbursement/preparing-for-payer-audits.pdf

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Due to differences in regional/state/and jurisdictional precepts, rules and regulations, legal guidance should be sought from a qualified attorney in the relevant locality as early in the payer audit process as possible. Health care providers should comply with the lawful service performance/documentation/and coding policies of a payer with whom they contractually participate. The information provided in this document should be used as a guideline only.

There are different types of structural audits. **Retrospective audits** review cases where the patient services have been provided and the coding and subsequent billing have been performed. **Prospective audits**, on the other hand, are done after patient services have been provided, code choices have been made but prior to claim submission (when the self-audit is performed by the practice/billing company) or prior to payment (when the audit is performed by a payer).

I. Why look at governmental audits?

The incidence of governmental audits, by both Medicare and state Medicaid programs, has significantly increased over the last several years. As a result of growing pressure to improve accountability and reduce costs for federally funded medical care, CMS has increased the frequency of random and focused audits in an attempt to identify potential billing fraud. The enhanced recapture of payments for charts that are either poorly documented by the provider or coded to a higher level than a governmental auditor would agree with will help support federally and state run medical programs. Careful scrutiny of what occurs during governmental audits is paramount in identifying common patterns that characterize the audit process, as well as high-risk documentation habits, controversial codes and reimbursement practices that have historically been questioned by CMS sanctioned auditors.

II. Are we seeing any increase in audit frequency?

Yes. Two areas have contributed to the increased frequency of governmental audits: (i) the success of the past Medicare Recovery Audit Contractor's (RAC) demonstration project; and (ii) an enhanced call for accountability and cost-saving measures within recent federal legislation, including the Affordable Care Act (ACA). These audits are viewed by CMS, HHS, and the OIG as critical to the preservation and sustainability of the Medicare trust fund.

The general perception held by the President, Congress, and regulatory governmental leaders are that billions of dollars in health care expenditures are not only unnecessary, but may be fraudulent as well. Many of the proposed health care reform programs are to be financed with the savings that will be realized by curtailing any perceived fraud and abuse.

Commercial Plan Audits

Because of the success of previous government payer demonstration projects at recouping tax dollars, commercial plans are also beginning to use these techniques in an attempt to recover what the plans consider to be 'overpayments' on previously paid claims.

Commercial audits have become increasingly prevalent and oppressive. A nation payer recently issued a number of letters to emergency physician groups stating that a review of recent medical records revealed up-coding and a refund for overpayments was requested. The "error" rate was apparently based on a small number of purportedly random samples, and the statistical validity of these audits as applied to the underlying medical services has not been definitively demonstrated. The results were extrapolated over several years ostensibly to determine the amount of "overpayment" over that multi-year period. In some cases the calculated amounts were small, but for others they were in the millions of dollars.

The plan advised that if United Healthcare did not receive a response to these audits and recoupment demands, then "[Payer] may consider [the provider] in agreement with these [audit] findings".

III. What types of cases are payers focusing on?

Audits are intended to uncover instances of improper or insufficient chart documentation, suspect billing or coding practices, and/or improper Medicare payments. These audits are frequently triggered by reports that identify providers who are outliers as compared to their peers within a particular contractor state or region

Most audits begin with the standard letter identifying specific cases to be collated and forwarded to the payer.

It is important to note that in any payer audit, anything can come under scrutiny, irrespective of whatever the payer might indicate to be the focus at the outset or request for various charts.

IV. What factors generate a governmental audit?

Medical review audits occur for a variety of reasons including atypical billing and coding patterns, anonymous complaints to CMS, variant E/M code distributions, and unusual volumes of various procedural codes. Medical review audits occur most commonly when a provider's frequency distribution for billed codes appears to be significantly different from the historical norms of peer data for a particular state or region.

Commercial Plan Audits: What Triggers a Commercial Plan Audit?

Audits by commercial plans may be triggered:

a) by reports or internal analyses suggesting that an clinician or organization is an outlier

b) by repeated perceived claims submission errors, or atypical billing and coding patterns

c) by plan contract negotiations or renegotiations, or

d) by internal changes in payer bundling or claims management policies (which payers sometimes attempt to apply retroactively), or

e) by reports from individuals (e.g., patient complaints, employer requests, or whistle blowers).

And sometimes, audits just randomly occur.

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Commercial Plan Audits: Types of Commercial Plan Audits

Claims reviews can be a preliminary step commercial plans use to decide whether to conduct formal audits, but may not be subject to the payer's sampling policies related to formal audits. Reviews of claims can, and generally should, also be challenged. When commercial plans conduct formal audits of contracted claims, they should follow the approach outlined in the provider-payer contract; so one of the first things that providers should do when informed that their contracted claims are or have been audited is to review the contract terms related to audits and recoupments with or without extrapolation, if they exist. Occasionally, plans may offer an 'extrapolated' settlement (often based on informal audits which may involve non-representative sampling) to forestall a full blown audit. Sometimes the contract language references payer policies or procedures that are not explicitly written in the contract itself. Such policies/procedures must also be obtained if an audit is performed.

Some other examples of commercial payer audit strategies include:

- Financial accuracy audits performed to ensure that claims are paid according to contract language and the pre-arranged fee schedule.
- Random audits performed to look for member eligibility and incorrect payments, among other issues.
- Historical claim audits performed to review claims for inappropriate payments for services such as follow-up services provided during a pre-determined global period.

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V. Preparing for the Inevitable: What to do before you are audited

The most important preventative measure is to provide thorough accurate documentation for each patient. Sufficient documentation of history, exam, and medical decision making allows coders to code the most appropriate code for the service provided. Furthermore, careful documentation provides the content needed during the audit process to successfully defend the level of service coded and subsequently billed.

In addition to excellent documentation, creating, and then implementing, a **compliance plan and program with processes to support quality documentation, coding, and billing** will help ensure positive operational processes and successful future audit outcomes. Establishment of a formal compliance plan and program can be time consuming, but there are a number of software products on the market that can be utilized to organize policies, track audits and audit results, and drive compliance tasks that will benefit an organization.

The Office of Inspector General (OIG) has identified the seven components of an effective compliance plan for third-party medical billing companies in the following document: http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

These seven components should be fully integrated into the coding and billing operation as well as the physician group practice. These components – which are basic to ensuring compliant coding and optimizing outcomes in an audit situation – are as follows:

1. Implementing written policies, procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Enforcing standards through well publicized disciplinary guidelines;
6. Conducting internal monitoring and auditing; and
7. Responding promptly to detected offenses and developing corrective action.

To help distinguish between the Compliance Plan and Program, the Compliance Plan is what an organization says it's going to do. The Compliance Procedures are what an organization actually does. The Compliance Plan and Procedures must match. The worst possible circumstance is to have one out of synch with the other, especially if the Plan specifications are deemed to be more appropriate than the actual Procedures.

Routine self-audits will identify problem areas and opportunities for improvement in terms of enhanced revenue and mitigation of risk. Educational efforts should target areas of concern that are identified in these internal audits. General audit results and improvements can be communicated in staff meetings. Ongoing discussions based on various scenarios - even just ten minutes a month - will increase consistency in

documentation and coding quality. Deficient or less than optimum documentation can be identified along with specific data elements that could have been documented to create a chart that can easily be defended in any future audit. The Compliance Plan should also address how any underpayments or overpayments resulting from incorrect coding found during internal audits will be addressed.

re-audits will reveal if educational efforts surrounding problem areas resulted in improvements or if additional training is mandated.

Creating a culture of openness and fostering feedback and frequent two-way communication

Other important aspects of an organization's Compliance Plan and Program can be accessed by reviewing the ACEP document related to Compliance Plans and Programs using the following URL: http://www.acep.org/content.aspx?id=32156&list=1&fid=2290

https://www.acep.org/globalassets/sites/acep/media/reimbursement/preparing-for-payer-audits.pdf

Commercial Plan Audits: Preparing for Commercial Plan Audits

It is not a question of whether an audit will happen, the questions is when. The topic of preparing for audits is well covered in the Section immediately above (Section VII). In addition, when contracts are negotiated with payers; providers should consider the potential impact of audits, and the contract language proposed by the plan related to audits and recoupment demands. Contract payment terms, such as case rates or case-limit rates (where the payment is the lesser charge or the payment limit), may substantially reduce the risk of claims audits related to coding and documentation, but expertise is advisable in assessing such rates. It may also be helpful to identify, in advance, the regulations in your State related to this issue.

Similar to preventing government audits, in order to prevent commercial payer audits, the best strategy is to follow payer rules and to provide substantiating documentation.

Commercial Plan Audits: Responding to Commercial Plan Audits

At least 24 states restrict or otherwise place requirements on a payer's ability to recoup overpayments. For example, a number of states impose specific time limits for payer overpayment recoveries. Also, payers might be required to grant due process rights to practices when these practices wish to dispute alleged overpayments, and States frequently require payers to give the practice advance notice and detailed information prior to recouping funds.

Therefore one of the first questions that should be addressed when you are notified of an audit or repayment demand is: has the plan or its audit contractor exceeded the time frame allowed by regulation in your state, or in your contract with the plan, for seeking repayment. However, most such regulations (and contract terms) often contain a time-limit exception when fraud is suspected, or for self-funded plans.

If the provider is contracted with the commercial payer, the rights and obligations for both parties specified or referenced as payer policy within the contract typically cover the conduct of retrospective audits, and hopefully procedural protections for the provider.

Clinicians should aggressively pursue their rights and understand their limitations under their contracts. If audits are not specifically addressed in the contract, clinicians should look to general provisions addressing offsets or adjustments that allow the payer to deduct payments otherwise due or adjust contract payments.

Provisions of the contract that address medical necessity may also greatly impact the audit results, especially if the contract gives the payer full discretion in determining the medical

necessity of a particular service. Provisions dealing with access to medical records should also be reviewed. These provisions may either protect clinicians from inappropriate health insurer requests for access to records or give health insurers free access to the requested health records.

1. Commercial plan audits typically begin with a time- sensitive request for documentation. There are generally no limitations on the number of records that a private payer may request.

Depending on your state law or your participation contract, there may be limitations on the period of time that may be audited. In addition, you may be requested to sign a document indicating that the records provided constitute the entire medical record, which may restrict your right to provide supplementation of the records on appeal. Given that there can be significant consequences (including substantial financial penalties and/or criminal proceedings) emanating from a records request, ceding rights, and adverse audit outcomes, **it is advisable to obtain legal advice early on in the response process.** Clearly notices from a commercial plan alleging possible criminal misconduct on the part of the provider should always be handled by an attorney.

2. When the practice becomes aware of a records request/audit notice, this should be brought to the immediate attention of your compliance officer or appropriate designee. This individual should quickly decide who will act as the primary intermediary to the payer or its representative. This helps to assure that things do not "fall through the cracks" regarding meeting deadlines, etc. It would be advisable for this individual to contact the plan directly (by certified mail) to clarify the steps for responding to the records request notice and the audit. It could also be helpful to establish a primary contact at the offices of the plan or audit contractor. This person would become the main conduit for all information related to the specific audit in question.

3. Once you learn that a commercial plan is initiating an audit or has an ongoing audit, it could be helpful for the provider group or its attorney to contact the plan for clarification of the purpose, focus, and nature of the audit. Inquiries to the health insurer at this point would mostly likely be procedural, since the retrospective audit is probably still in its initial phase—that is, the health insurer suspects (e.g. through a review) that some billing or payment errors have been made, but the scope of, and reasons for, such occurrences may not have yet been determined.

Analyzing commercial plan audit findings:

Once a commercial plan has received the requested medical records and completed the audit, the plan will typically provide a report of their findings, along with a demand letter for recoupment of any overpayments identified. It is likely that the commercial plan's audit findings will differ significantly from what you or your billing entity believes are the appropriate way to code the documentation of the cases assessed in the audit.

If the plan has identified claims coding errors that your analysis reveals were in fact coded incorrectly, you should submit repayment to the plan and advise the plan of any corrective action plan you intend to make to ensure that these errors will not be repeated. Many emergency medicine groups believe that paying an entire modest recoupment demand amount is the easiest and least time-consuming option, but failing to appeal, without any change in billing patterns, could result in a continual cycle of similar documentation requests, claims denials, and recoupment demands.

VI. Avoiding an Audit

It is no secret that avoiding an audit is far more preferable than responding to one! Here are some suggestions on how to appropriately manage your business and avoid being the target of an audit.

1. **Proper chart documentation**: Proper documentation is a must.

2. **Proper coding and billing:** Appropriate coding and billing is the second most important step in the patient-to-bill process.

3. **Internal audits:** Regular internal self-audits ensure that coding and billing operations comply with existing laws, regulations, and polices.

4. **External audits**: Even the best of coding/billing operations should have their work reviewed by an external self-auditor via regular coding and billing processes reviews by industry experts. External auditing is standard in the healthcare industry and provides the final layer of protection against unknown or overlooked areas of importance.

5. **Easily identifiable documentation errors that should be adjusted include the following:**
    a. **Improved legibility.** Auditors commonly cite illegibility as the reason for rejection of the various key elements of the history, exam, and MDM. Illegibility can also lead to down-coding, and may impact subsequent billing of any procedures that were performed..
    b. **Signing of charts.** All charts must be signed by the clinician who provided the care.

VII. Minimizing the Potential Adverse Effects of an Audit

1. **Compliance Plan and Program:** A well-written Compliance Plan and implemented Program should be based on the OIG Model Compliance Plan (for both agencies and coding/billing companies). It is important for all entities involved in coding and/or billing operations to have such a plan/program, as it is the first step in proving to the auditing authorities that you intend to follow proper coding and billing processes and procedures.

   The OIG Model Compliance Plan can be accessed here: http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

   Actually using the plan for internal audits, though, is the next imperative for internal compliance. A good compliance plan identifies processes and/or procedures that are to be followed in a step-by-step manner. Documentation of use of the plan in oversight and correction is the final step in the use of a compliance plan, and can mitigate penalties that may be levied against a group who is found to be inadvertently coding and billing inappropriately.

2. **Audit Response:** Some specific suggestions that will help to ensure the success of an audit include:
    a. Consult with legal advisors in order to preserve appeal material rights as early in the process as feasible
    b. Promptness: Respond promptly, and in advance of any recommended deadlines.
    c. Politeness: Written and verbal responses should be fashioned in a manner that is polite and non- belligerent.
    d. Thoroughness: Your response should include detailed explanations for the rationale behind your decisions. It is not the auditor's job to "read between the lines." References that support your reasoning should be included in your response.
    e. Be "teachable"- Ensure the auditor that you are using your very best efforts to follow an extremely complex set of rules and policies and, if you have incorrectly interpreted one, that you would appreciate their assistance in explaining the rule to you.
    f. Be the expert: Many auditors may have very little training and/or experience in your area of practice. If you do have particular expertise (especially if you employ certified coders and professional billing services), remind the auditing entity that you have special and that you maintain this expertise via ongoing education and training.
    g. It is imperative that you include the clinician and/or clinical director in any appeals discussions. Having the clinician contribute their knowledge, especially related to medical necessity and severity of the case, is critical to the overall success of the appeals process.
    h. Extend an "Open House" invitation: Extension of a sincere invitation to the auditing entity to visit your operations demonstrates that you want to promote a spirit of teamwork and that you have nothing to hide.

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