No Such Thing as a *Routine* Chart Audit Request from a Medicare or Medicaid Contractor
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Current Audit Activity

- Every practice treating Medicare/Medicaid patients can be subject to an audit
- Government has refined their data analytics for “smarter” investigations and prosecutions
- State Medicaid programs are doing more auditing and monitoring
Current Audit Trends

- Scope of audits has expanded beyond “medical necessity” review
  - inaccurate or improper cost reporting
  - improper claim submission
  - unacceptable practices
  - fraud
  - abuse
  - mistakes
  - DRG validations
  - readmissions
- Compliance with supervision requirements
  - Indirect vs. direct supervision

Who Is Performing These Audits?

- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
  - Medicare RACs & Medicaid RACs
  - DME, Home Health and Hospice RAC
- Zone Program Integrity Contractors (ZPICs)
- Unified Program Integrity Contractors (UPICs)
- Comprehensive Error Rate Testing Contractors (CERT)
- Office of Inspector General (OIG)
- Department of Justice (DOJ)
- Medicaid Managed Care Organizations (MCOs)
Audit Red Flags

- Too many claims for level 4 or 5 Evaluation & Management (E/M) codes
- Multiple claims submitted for the same date of service
- Dollar amount of claims greater than the average for a similar health care provider
- Filing claims for service on the OIG’s annual work plan
- Complaints
- High-dollar procedures
- Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs)

CMS’ New Audit Strategy

- August 2017 – CMS announces new national audit strategy
  - “Targeted Probe and Educate (TPE)”
    - Based on pilot programs with four Medicare Administrative Contractors (MACs)
    - MACs “will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate”
    - “MACs will focus only on provider/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers”
      - Identified by MAC via data analysis
CMS’ New Audit Strategy

- **Audit Process**
  - Review of 20–40 claims followed by one-on-one, provider–specific education to address errors
  - Providers/suppliers with high error rates subject to further probe reviews and education
  - Three rounds of audits before referral back to CMS to consider further action
    - Referral to Recovery Audit Contract (RAC)
    - Pre-pay review

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CMS Target Probe and Educate Flow Chart (08/14/2017) available at
How to Prepare for Your Next Medicare/Medicaid Audit

› No one likes to be audited. However, the government’s perceived increase in Medicare/Medicaid fraud and abuse has caused CMS to consistently audit healthcare providers that receive federal dollars.
› Given the possible consequences of an audit, we have a few suggestions...

Please Take This Matter Seriously

› All correspondence from Medicare and/or Medicaid audit contractors should be taken seriously
› This is not just another medical records request.
› Avoid the temptation to delegate this as a routine matter to an administrative employee
› Contact your attorney
Consider the Source

- Medicare or Medicaid auditor requests records for 1 visit versus 10 visits
- Zone Program Integrity Contractor (ZPIC)
- Subpoena
- FBI, OIG Special Agent, State Attorney General

Read the Letter – Carefully!

- Read the letter carefully and include everything it requests.
- In addition to medical records, auditors often ask for invoices and purchase orders for the drugs and medical supplies dispensed to patients.
Clinical Chart Reviews

- Proper documentation is critical. Overpayments are often based on improper payments associated with the following:
  - **Unsupported Services**: Records submitted by provider are not sufficient to justify diagnosis, admissions, treatments performed or continued care
  - **Medical Unnecessary Services**: Documentation in the medical records indicates that the services or products received were not medically necessary
  - **Incorrect Coding**: Documentation submitted does not support the reimbursement code submitted
  - **Non-covered Costs or Services**: Costs or services are not reimbursable because they do not meet reimbursement policies

Provide the Complete Record

- Include a copy of the complete record, not just those from the dates of service requested.
- Include diagnostic tests and other documents that support the services provided
- Include consent forms, medical history questionnaires, histories, physicals, other physicians’ orders, discharge orders, x-rays or other diagnostic images
- **COMMON ERROR**: not producing all relevant documents
Legible, Accurate Documentation

- Make sure all records are legible
- If not, have it transcribed and include the transcription along with the handwritten or illegible records
- Make sure transcriptions are clearly marked
- Do not submit copies with edges cut off
- Label it accurately
- Do not allow for confusion!

Review the Record

- Review all charts before submission
- Make sure all supporting documentation is included
- Properly label each copy of each medical record provided and page number everything
- Records often get lost, shuffled or damaged
Never Alter the Records

- Never alter the medical records after a notice of an audit.
- If there are consults, orders, test reports, etc. that have not been filled into the chart, fill these into the record, as normal, to complete the chart.
- Altering the medical record can be a basis for a fraud claim including criminal penalties.

Include a Brief Summary

- Include a brief summary of the care provided to the patient with each record.
- Make sure the summary is clearly marked as summaries with the date prepared.
- Include supporting medical literature, clinical practice guidelines, LCDs, medical journal articles, or other documents to support any usual procedures or billings.
- Do not allow for confusion that the summary was part of the original medical record.
Time is of the Essence

- Calendar the date the records need to be to the auditor and have the records there by that date.
- If you can’t meet the deadline ask for an extension.

Follow Up

- Any telephone communications with the auditor should be followed up with a letter confirming the telephone communication.
- Send all written communications to the auditor by certified mail, return receipt requested for proof of delivery.
Keep a copy

- Keep complete, legible copies of all correspondence and every document provided to the auditor
- Always retain the original medical record

Audit Findings and Overpayment Determinations

- Determination of overpayment or violation
  - Warning letter
  - Suspension or termination from participation in Medicare/Medicaid
  - Seek recovery of payment
  - Impose other sanctions
- Provider Response Options
  - Appeal
  - Pay Overpayment
  - “Credible evidence”
Exclusion for Noncompliance

- Conviction relating to obstruction of an investigation or audit (42 U.S.C. § 1320a–7(b)(2); 42 C.F.R. § 1001.301)
  - Length of Exclusion: 3 years
- Failure to supply payment information (42 U.S.C. § 1320a–7(b)(11); 42 C.F.R. § 1001.1201)
  - Length of Exclusion: No minimum period
- Failure to grant immediate access (42 U.S.C. § 1320a–7(b)(12); 42 C.F.R. § 1001.1301)
  - Length of Exclusion: length of time access was not granted and an additional 90 days.

Revocation for Noncompliance

- Revocation of Medicare Enrollment (42 C.F.R. § 424.535(a)(10)) *Failure to document or provide CMS access to documentation.*
  - Revocation period: 1 year for each act of noncompliance
Steps to Level the Playing Field

› Use LCDs and NCDs
  ◦ Analyze the requirements for services you perform
  ◦ Determine what documentation is needed to meet the requirements
  ◦ Determine which physicians or other providers have the source documentation to meet each requirement
    • Obtain the source documentation at time of service delivery

› Negotiate your contracts
  ◦ Medicare Advantage (Part C) and Medicaid managed care
    • Timelines to submit clinical documentation
    • Language specifying the guidelines that will be followed in conducting reviews
      • Correct Coding Guidelines
      • Medicare definitions
      • InterQual or Milliman?
      • Peer-to-peer

Steps to Level the Playing Field

› Use the OIG Work Plan (2017)
  ◦ Hospitals
    • HBO Therapy Services
      • OIG believes patients are receiving treatment for non-covered conditions
    • Incorrect Medical Assistance Days Claimed
      • Addressing risk of overpayments under the Medicare disproportionate share hospital payments
    • IMRT Payments
    • Emergency Preparedness
      • Review of hospital efforts to prepare for public health emergencies resulting from emerging infectious disease threats
Steps to Level the Playing Field

- Use the OIG Work Plan (2017)
  - Hospice
    - Review medical records and billing documentation for compliance with Medicare requirements
  - Home Health Agencies
    - Accurately provide patient information to state agencies
  - Skilled nursing facilities
    - Unreported incidents of abuse and neglect
    - Medical necessity
    - Adverse event screening tool
    - National background checks for long-term care employees
    - Avoidable hospitalizations of Medicare eligible nursing facility residents

- Educate physicians and other providers on the importance of documentation
  - Concise does not help with an audit
  - You need narrative descriptions of the services provided, the complexity of the medical decision-making, the complexity of the patient