Are you ready for audits?

Audits can cost your practice thousands — if not millions — of dollars. Protect yourself with internal audits to ensure compliance.

Coding and billing accuracy has never been more important with a growing number of industry auditors and a commitment from the Centers for Medicare & Medicaid Services (CMS) to recoup billions of dollars in overpayments. With stiff penalties for noncompliance or overpayments, practice managers who conduct self-audits regularly can save time and money spent on investigations that can cause practice interruptions and have cost practices $13,000 to $1.3 million in fines.

The Recovery Audit Contractor (RAC) program was developed by CMS to reduce overpayments, estimated at $10 billion. It was part of the Tax Relief and Health Care Act of 2006, Section 302, which required creation of a permanent, nationwide RAC program by Jan. 1, 2010. Today the program is in full swing.

There are four recovery auditors contracted by CMS, each responsible for a specific region. To protect your practice, ensure that you know which agency is requesting files and watch the mail closely for audit notices and timelines. The CMS lists the companies contracted and which states they cover at cms.gov/Recovery-Audit-Program/Downloads/RACAbbr.pdf.

Coding and documentation errors put practice professionals at the greatest risk for audits from government agencies, according to an assessment of more than 100 physician audits across the nation. That study, conducted by Revenue Xpress, LLC, Austin, Texas, shows that physicians in various specialties are — on average — 62 percent
noncompliant with documentation and coding requirements and 45 percent noncompliant with documented medical necessity. If audited — and errors are found — physicians must repay the carrier for every offense. Here are a few examples of how much these violations cost:

Dr. C billed 210 claims to the CMS for Code 99214, and the agency determined that it overpaid on 156 claims, which totaled $13,476. The cause of overpayment was failure to document medical records to support Level 4. Total payment due to CMS = $13,476.

In 2008, Dr. G submitted the following 686 Medicaid claims, and had to pay $20,956 to CMS:
- 86 – 99215 (zero claims met compliance) = $3,956
- 325 – 99214 (62 percent claims billed in error) = $10,400
- 275 – 99213 (40 percent claims billed in error) = $6,600

CMS audited 30 records at Dr. M’s group practice on two occasions and 75 percent of his records failed to meet documentation compliance. CMS extrapolated 75 percent of his records for a three-year period and found $1.3 million in overpayments. Attorneys were unable to reduce his $1.3 million fee.

Improper payments occur for many reasons, including:
1. Payments are made for services that do not meet Medicare’s medical necessity criteria.
2. Payments are made for services that are incorrectly coded.
3. Providers fail to submit documentation when requested, or fail to submit enough documentation to support the claim.
4. Other reasons: Claim payments based on outdated fee schedules, or the provider is paid twice because duplicate claims were submitted.

How it began

The RAC demonstration program began in 2005 in California, Florida and New York, and expanded to Arizona, South Carolina and Massachusetts in 2007. During the demonstration, contract auditors focused on medical necessity issues.

In addition to Medicare RACs, there is the Medicaid Integrity Program (MIP), an anti-fraud initiative introduced by the Deficit Reduction Act of 2005 to recoup fraudulent or otherwise improper Medicaid payments. While RAC audits are targeting an estimated $10.8 billion in inappropriate Medicare payments, MIP audits have an estimated $32.7 billion goal. And then there’s a separate entity that CMS contracts with to conduct audits of Medicaid providers. The Medicaid Integrity Contractors (MIC) bypasses demand letters and sends contractors directly to your office. Imagine finding space for government auditors in your office among your staff and patients.

Determine exposure

Prepare by establishing a RAC/MIC readiness management program. Create goals, appoint a team and ask them to track the latest compliance issues and regulations. Ideally the team will comprise staff with expertise in processing requests and managing denials. The Office of the Inspector General recommends that groups perform at least one third-party independent audit so they know what to expect. For example:

- The standard number of charts reviewed is based on approximately 5 percent of a physician’s workload in one quarter each year. The audit team will request charts from 2008 through 2009.
- A production report for inpatient and outpatient visits during a 90-day period is required.
- Audit teams select records from that production report, which the provider’s office pulls, scans and sends to the audit team.
- The audit team requires a copy of the government form CMS 1500 billed to CMS or the carrier.
- If the provider received a demand

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letter from CMS or a commercial carrier, a copy of the correspondence will be provided to the audit team.

- Surgical providers need to supply a copy of the Operative and Pathology Reports

Internal reviews of physician documentation, medical necessity and claims coding by a certified, specialty-specific coder can provide guidance on necessary changes to reduce financial risk to the practice.

Here are three criteria to consider when selecting a third-party audit firm:

1. Does the company have certified coders with government auditing experience on staff?
2. Will the company provide a report on areas for improvement?
3. Will the audit team provide a consultation on your compliance to help you determine appropriate steps?

Responding to audits

Determine who is making the request. There are many independent auditors and several are government mandated. Each request must be thoroughly understood before sending information. Have a staff member (or someone from a RAC/MIC readiness management team in a hospital) contact the agency or entity requesting charts to clarify what kind of audit is being performed.

Instruct your staff to carefully read all mail. Audit requests should not be taken lightly. Missing deadlines can waive any rights to an appeal and cause lost revenue. It is helpful to know RACs in your area.

For example, the RAC in Texas is Connolly Healthcare and correspondence from this RAC is clearly identified with the official CMS letterhead for Connolly Healthcare.

Decisions and appeals

If you receive a formal demand letter on an overpayment issue and you believe it is incorrect, you may appeal. It is your responsibility to know and understand key deadlines in the appeals process. After receiving an overpayment letter, call the RAC auditor within 15 days from the date of receipt to discuss overpayment. Send evidence to counter an offset. It is important to note that a call does not constitute a formal appeal.

Appeals may be made on five levels (see sidebar). File an appeal if you believe the allegation of overpayment is unjustified. If an appeal is made

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within 30 days of receipt of the overpayment letter, you will avoid a Medicare recoupment action with current payments or future claims submitted. Interest begins to accrue 31 days from delivery of an overpayment allegation letter even if a letter of appeal is filed. No interest accrues if repayment is made within 30 days.

Avoiding audits

Implement structures and processes that minimize exposure to audits.

Conduct pre-RAC audits with a focus on coding and documentation. A retrospective audit of all Medicare patient charts can also be done by an independent external organization that uses certified professional coders. All reviewable charts should be assessed for accurate coding and documentation to ensure full compliance with Medicare requirements.

Pre-RAC audits have found coding and documentation errors along with under-coding errors. These discoveries often lead to more accurate levels of billing, which can increase provider revenue.

Providers should be ready for increased CMS auditing activity since the RAC program is now permanent. Each provider should make every effort to evaluate their coding, documentation and medical necessity documentation. Should you find yourself subject to a RAC audit, effective strategies are available that can be put into practice to assist in reducing your exposure.

Recent government changes

Over the past year we have seen extensive changes to the business of healthcare. One of the biggest areas of change has been the government’s approach to overpayments. Congress strengthened the False Claims Act with regard to refunds and overpayments with the passage of the Fraud Enforcement and Recovery Act (FERA) in 2009 and the Patient Protection and Affordable Care Act (PPACA) in 2010. The Executive Branch has also stepped up its recovery of overpayments with a presidential memo in March to expand and intensify the use of payment recapture audits.

The administration has clearly stated its intention to fund healthcare reform programs through the increased recovery of overpayments with accompanying fines and penalties. With these actions the government has:

- Made clear that the failure to make a refund is a violation of the False Claims Act;
- Set a deadline of 60 days to report and return overpayments (overpayments retained after 60 days become a violation of the False Claims Act);
- Increased fines for the failure to refund to three times the amount of the unpaid refund PLUS a penalty of between $5,000 and $11,000 per unpaid refund; and
- Increased the activity of and the incentives to RACs to find and recover improper payments.

**Levels of appeal**

**First level: Redetermination**
Conducted by carriers or Medicare Administrative Contractors (MAC) 120 days to file the first appeal

**Second level: Reconsideration**
Conducted by Qualified Independent Contractor (QIC) 180 days from redetermination decision

**Third level: Administrative Law Judge**
Conducted by an Administrative Law Judge (ALJ) 60 days from reconsideration decision

**Fourth level: Medicare Appeals Council**
Conducted by Medicare Appeals Council (MAC) 60 days from ALJ decision

**Fifth level: Federal District Court**
Conducted by a federal district court 60 days from MAC decision

**Types of audits**

**Types of Medicaid Integrity Contractors (MICs)**
Audit
Review
Education

**There are five jurisdictions:**
New York (CMS Regions I & II)
Atlanta (CMS Regions III & IV)
Chicago (CMS Regions V & VII)
Dallas (CMS Regions VI & VIII)
San Francisco (CMS Regions IX & X)

**Audit MICs:**
Booz Allen Hamilton
Fox & Associates
IPRO

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