

# **Avoiding That Medicare Audit**

## **And what to do when it happens anyway.**

By Barry H. Block, D.P.M., J.D.

**The author is a practicing attorney and editor of this magazine.**

---

Sooner or later it will happen. You'll open your mail to find out that your Medicare carrier wants you to send them from one to twenty-five charts. Your hands begin to tremble a bit. Are you in trouble -- or is this a routine audit? Should you merely photocopy the record(s) requested or should you contact an attorney? Since the initiation of Operation Restore Trust by the federal government, this scenario is increasingly being played out in podiatric offices nationwide.

There are many reasons for these audits. High on the list is of course, revenue enhancement. With the prospect of Social Security going bankrupt in the next century, the Inspector General (IG) has been mandated to recoup as much in the way of fraudulent or misbilled payments as possible. Vigorous enforcement also has a chilling effect on doctors who are hesitant to upcode, even when appropriate, for fear of being audited. Unfortunately, no matter what codes you bill for, you're likely to be audited.

The following suggestions should, however, minimize the probability of being audited. If you're audited, these suggestions should minimize the consequences.

### **Be Aware of Overutilization**

One of easiest ways to put up the "red flag" to your carrier is to exceed established utilization guidelines for a specific procedure. Your carrier is mandated to track billing for practitioners in your area. Generally, you will not be audited if you stay within two standard deviations of what the average practitioner bills. In essence this means that if you bill a particular procedure more than 95 percent of other physicians in your area, you will raise suspicions.

You can find out how many procedures or specific codes you billed in a particular year by writing to your carrier and requesting a Comparative Performance Review (CPR). This will give you an idea of where you stand in comparison to other providers. You should be using your computer or billing service to keep these statistics about your billing profile.

Does this mean that you should bill in a different manner? Not necessarily. If you are actually performing and documenting medically necessary procedures, you should have no problem

passing muster when you are audited. The prudent thing of course, is to monitor the types and quantities of codes and procedures you are billing for.

Naturally, if you run a "Bunion Clinic", the number of HAV procedures submitted will be higher than a D.P.M. who specializes in sports medicine or pediatrics. However, each year a number of D.P.M.'s are audited for performing an excessive number of injections, debridements, or x-rays. Even excessive use of a particular modifier can trigger an audit.

### **When the Letter Arrives**

The most important thing to do when you are notified of an audit is Not to panic. You aren't the first D.P.M. to be audited, nor will you be the last. In fact, the surprising thing would be if you aren't audited! New guidelines require your carrier to audit one percent of claims.

Pull all the "suspected" charts from your files and read through them thoroughly. Try to determine the specific code which they have in common. Perhaps it's an E/M upcoding or a specific procedure. Hopefully, your documentation is up to snuff and your notes will pass muster. If so, you need only photocopy the notes and send them back to carrier for review.

If your notes are illegible, you should retype them and submit the typed version. As far as Medicare is concerned, if they can't read what you wrote, you didn't do it! For this reason and others, your notes should be dictated. If you're not doing this yet, perhaps the constant threat of auditing should be enough to motivate you. It's a small price for having peace of mind.

If you're not sure whether your notes will pass muster, it's time to hire a practice management consultant to review your records. These individuals are trained to act as auditors. Many have previous experience working for insurance companies or have served as on Carrier Advisory Committees (CAC's).

### **What Happens Next?**

In the majority of cases, you will never hear from the carrier. This is good news because it means that your note was satisfactory. Many times audits are conducted for informational purposes only. The carrier just wants to see how practitioners are coding specific codes. The other scenario is either a bill or a request for addition records.

If you are asked to pay additional funds, you will have to make a decision. That decision may be affected by the amount of money requested. If it is a relatively small amount of money, it may be easier to pay than to fight. You may also choose to pay if you realize that you actually incorrectly billed and were overpaid.

If the amount requested is substantial, it is likely in your interests to contest the determination. There is some variance among carriers to how to contest findings, but here's the way it works in most cases.

Your first step is to ask for a Fair Hearing. A Fair Hearing is conducted by an independent party who listens to your case as well as the case of the carrier. The carrier usually employs a podiatric consultant to assist them. The fair hearing in some jurisdictions can even be done via telephone or by submitting records.

If you lose at the fair hearing, you can request a hearing before an administrative law judge (ALJ). This is an even more formal hearing at which you testify under oath. You should obtain the services of a qualified attorney if you go before the ALJ. You are allowed to introduce evidence, including articles, etc. to bolster your case. Your chances of prevailing at an ALJ are generally greater than at a fair hearing. Additionally, the ALJ has greater powers than the Fair Hearing officer including the power to order your carrier to pay for a lesser or substituted procedure code. If the carrier loses at the ALJ hearing, they are mandated to repay you with interest.

If you lose at the ALJ, you must proceed in Federal Court. At this point, you must again weight the cost of the legal fees plus your lost time versus the amount sought. If Medicare is seeking large amounts of money, as they might do when retroactively and retrospectively assessing you, or if you are sure that you are correct, proceeding may be your best course of action.

### **The Visit**

Occasionally, Medicare will request a site inspection of your records. This generally represents a serious situation and you are advised to retain the services of a qualified attorney. The key to surviving any inspection is not to volunteer anything. The Supreme Court has held that if you "deny" something, you have made a statement, which could potentially subject you to perjury charges. If you say nothing, you avoid putting yourself in jeopardy. The function of an attorney is to protect you by acting as your mouthpiece.

### **Conclusion**

Audits are now a regular part of the healthcare environment. Expect to be audited and be prepared for it. The end result is that your records will improve. You'll also be better protected should you be sued for malpractice. In addition, your practice will be worth more when you sell it.