Dealing with Audits

Persistence and proper documentation are necessary to win.

BY PAUL KESSELMAN, DPM

Many articles written in this and other medical publications provide valuable objective information on how to respond to an insurance company audit. But the author usually has no "skin in the game". That is, the author is objectively reviewing the audit received by another practitioner, who is often overworked and has little if any knowledge on how to handle documentation requests.

This article shares the author's recent experience with his own audit and will provide the reader with some insights to improve your chances of a successful outcome when you receive a post-payment audit request.

Both pre-payment (prior to claim payment), or post-payment (after the claim has long been settled, paid and services provided), audits are a "test" of your documentation. Audits can be demanded by the carrier that processes your claims or, as in the case with Medicare, from a myriad of other agencies.

Under Medicare, there are several agencies which perform post-payment audits. These include those with the most teeth, Zone Program Integrity Contractor (ZPIC) and the Office of Inspector General (OIG); and those which are usually of a more random nature, Comprehensive Error Rate Testing (CERT) and Recovery Audit Contractor (RAC).

OIG Audit

If you receive a letter from the Office of the Inspector General (OIG), you are definitely being targeted. This may be one of the most difficult audits you ever face. The OIG typically does not investigate individual practices unless they suspect criminal activity. Your first and only response to this type of audit is to immediately contact a healthcare attorney who has experience dealing with the OIG and to contact your professional liability carrier, which provides your practice with Administrative Legal Defense. The OIG may stop by your office unexpectedly, can execute search warrants and interview your patients. Having interacted with several clients who have had the unfortunate pleasure of OIG audits, this is an unforgettable experience and one they often never financially or emotionally recover from, regardless of vindication or the amount of payback.

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ZPIC Audits

Zone Program Integrity Contractor (ZPIC) is an agency most readers also hopefully have never heard of. This contractor handling ZPIC audits will soon be changing. ZPIC, like the OIG, has as its primary goal to identify fraud and abuse. ZPIC audits are not random. Rather, your practice is targeted because of billing behavior patterns outside the normal parameters, or because a patient has filed a complaint regarding your billing practice. This type of audit has no specification regarding the look-back period and has unlimited documentation requests (that is, there is no limit to the number of charts they may request). As with an OIG audit, unfavorable ZPIC audits can be financially and emotionally devastat-

Continued on page 54

Audits (from page 53)

ing. The ZPIC can demand refunds and impose fines for non-payment, withhold future payments, and refer your practice for further investigation by criminal law enforcement agencies (e.g., OIG, FBI, HHS).

The ZPIC is paid by CMS to perform this service and unlike other post-payment auditing agencies, they are not paid on a contingency fee (although the ZPIC is also audited and they can receive performance bonuses). If you receive a demand letter from the ZPIC, your initial response should be to immediately contact your attorney and/or your professional liability carrier. Similar to OIG investigations, they can interview your patients without your knowledge and stop by your office to "chat" with you or your office staff. Certainly, this is not the coffee break you or your staff wish for. Legal and professional advice for handling both a ZPIC and OIG audit is a must!

RAC Audit

This agency is paid on a bounty (contingency basis). That is, the more money they collect from your practice, the more the RAC itself recovers. They are paid on a percentage basis of recovered funds and this type of audit may be random or targeted, but they are most often random. The RAC does not have the authority to determine the scope of services for review. CMS annually determines the specific set of CPT and HCPCS codes which the RAC may audit. DPMs should know that DMEPOS currently under RAC review include AFOs and therapeutic shoes for patients with diabetes.

Years ago, my practice underwent an RAC audit for a bilateral pair of custom fabricated AFOs for a patient who had failed custom foot orthotic therapy from myriad other practitioners. His significant posterior tibial dysfunction over many years had resulted in significant ankle and subtalar arthritis. His gait was very painful, and no doubt his disease state had progressed well beyond the capabilities of shoes and custom foot orthotic correction.

The scope of the audit was basically demanding information on his second pair of custom AFOs within six years (beyond Same and Similar). My practice passed this audit and there was no doubt from the start that the auditor knew little about what was being reviewed. It took several communications from my office to spoon-feed the auditor the requirements of the LCD, eventually resulting in a successful outcome, allowing my practice to retain its earnings.

If you receive a demand letter from the ZPIC, your initial response should be to immediately contact your attorney and/or your professional liability carrier.

CERT Audits

CERT, like RAC audits, are random and usually are for specific types of services, which CMS has targeted for review. Unlike ZPIC and OIG audits, these may be for one or several charts, but do not necessarily indicate your practice is being targeted for an investigation of suspected criminal activity. Both RAC and CERT audits, if for only a single or a few charts, can often be responded to without legal assistance. However, if you receive a CERT or RAC audit on numerous charts for a myriad of codes, then obtaining assistance from a healthcare attorney and your professional liability carrier's administrative defense agency is strongly advised!

The CERT is an interesting agency in that while it is auditing your practice, it is also auditing the payment patterns of the paying contractor (in this case Noridian). A recent nationwide downturn in successful CERT recoupments was greeted as good news by the DME MAC. A lower CERT recoupment indicates the MAC payments (or denials) of claims was appropriate. As with a lower golf score, the lower the CERT recoupment rate, the better for the provider and MAC.

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My practice recently received the unwelcome white and red envelope containing a random post-payment review of a single claim for just under $2,000. The CERT auditor initially requested from my practice all pertinent documentation on a custom fabricated AFO for a significantly overweight patient. This individual patient had failed custom foot orthotics and required orthopedic shoes to accommodate the AFO.

The shoes were not covered by Medicare and thus were not a subject of the audit. CERT provided a laundry list of documents, including but not limited to all pertinent medical documentation, National Supplier Clearinghouse (NSC) requirements including Written Proof of Delivery, proof of providing Supplier Standards, Complaint Protocols, and Warranty information. They also listed photos of the patient and the device (if available) and other physician/supplier documentation such as vendor invoicing, detailed written orders, etc.

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Continued on page 56

Audits (from page 54)

weeks) was provided for a response. All the required documentation was sent, including my laboratory order form (to serve as the Detailed Written Order), leaving sufficient time for their response. Several additional documentation requests (ADR) for detailed written order and written proof of delivery followed.

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Additionally, the lab order was signed, dated, and included my type I NPI number. Despite complying with the ADR, this did not sit well with the auditor. For some reason, they also were not satisfied with the patient's written proof of delivery; however, this was easily resolved as an oversight on their part.

After several written communications with the auditor and several phone calls to the CERT, it was eventually determined that they felt the laboratory order did not meet their requirements for a detailed written order (to this date, I don't know why and I have reached out to a CERT auditor to find out why). In fact, the laboratory order had all the elements of a detailed written order, and because it was signed using my referring NPI (Type I), not my supplier NPI (type II), it should have been sufficient.

Discussion with the auditor led to them accepting and acknowledging that as a physician, who is also the supplier, there is no requirement to have a separate detailed written order, so long as that information is documented in the chart. Eventually the auditor understood that both the laboratory order and my chart notes satisfied their requirements. It took a direct quote from the CMS Program Integrity Manual stipulating these facts to get the auditor to acknowledge my assertions. The auditor eventually informed me that no further information was required and someone from Noridian was to contact me with the results.

Fortunately, the CERT provided me the information for the contact person at Noridian handling this audit. Several days later, the CERT coordinator at Noridian contacted me and in less than a minute, I was informed that I had passed the audit. A half-hour discussion ensued after which she agreed there was much work to be done on educating the auditors on reviewing documentation received from physician suppliers.

This one chart experience left me even more distrustful of those investigators—who after all are supposed to have a better understanding of the rules than the practitioner. In plain English, they often don't.

It is important to know that if you do face an unfavorable outcome of a post-payment audit from any Medicare audit—to quote a famous movie, "the defendants have rights." You can appeal your unfavorable decision, although this may cost you money and interest (as the fine accrues heavy interest penalties during your appeal).

My intent in sharing this experience with you is to make sure you dot your "I's" and cross your "T's". Know the LCD and the requirements of the services you are providing, whether E/M coding, DME, routine foot care, surgery, etc. If you know you are right, don't back down from the auditor or agency. Provide them with excerpts from CMS or LCD policy. This experience is not the first encounter the author has had with an inexperienced auditor. If you are an honest practitioner and you have documented appropriately, being persistent will eventually lead to a successful outcome. **PM**

Dr. Kesselman is in private practice in NY. He is certified by the ABPS and is a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.