How to Survive Your Medicare Audit Involving Wound Care

Documentation provides the best defense.

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Recently, many healthcare providers have received letters from third-party companies that are contracted to audit you on Medicare's behest. The audit is known as a recovery audit, contractors audit, or RAC audit. The government is also criminally going after providers they feel are particularly egregious in their billing of pressure ulcerations and skin-substitute treatments. These audits are by no means limited to podiatrists. Medicare is auditing MDs, DOs, and midlevel practitioners. It has become common to see PAs and NPs being audited for very high sums of money.

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When receiving an audit letter, the wise podiatrist contacts their healthcare law firm—one with years of experience dealing with these matters. Law firms with attorneys that have clinical knowledge are very helpful in defending these audits as they understand the medical as well as legal issues involved.

It is helpful to review your patient records at issue to see if there is any commonality of services involved. For example, if you see that most of the records being audited involve patients being treated for wound care, it is wise to think that something about the way you are billing for wound care is causing suspicion by the RAC auditor. Let's start out listing some of the more commonly-seen reasons for such audits:

1) Billing is under the wrong entity

This may seem obvious. Often, it is not. Have you bought a practice and its professional corporation? As an aside, buying another's professional corporation (PC) is often not advised for liability reasons. Subsequently, you may have opened your own PC, with a different corporate name and number. Were you billing under a defunct entity (professional corporation) prior to your new entity being credentialed? The chronology of your credentialing to bill for Medicare can be crucial.

2) Incorrect or inaccurate coding

Every CPT treatment code you use has its own definition. It is crucial that your medical records incorporate the necessary elements to bill that code. Further details may emerge from an applicable LCD, or a local

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coverage determination provided by CMS. For example, does the debridement code you are using require a certain size of ulcer being debrided? Let's look at the CPT code 11042: Your debridement must include going below the epidermal layers into the subcutaneous tissue, which includes the dermis. Note that the 11043 CPT code would include debriding into the muscle or fascial layers.

Each code includes the first 20 square cm or less. There are both depth and width requirements in your billing. Your records must reflect meeting all these requirements. How the wound or ulcer is healing should be part of your record. Successive photographs can be helpful. Just stating "wound is improving" is generally not sufficient. Just because your treatment note is long, or the length of the visit lasted a certain amount of time, it is insufficient to bill for a "3" level E/M code for an office visit. Most E/M codes are not time-dependent.

3) Fragmentation

Fragmentation of coding may involve billing for a level of office visit in addition to a debridement code. That is allowed only if there is a substantially different diagnosis that needs evaluation and treatment. If a large percentage of your patients have both a debridement code and an office visit code for most visits, that will be a red flag for the auditors.

4) Documentation

Your medical chart must be complete, accurate, signed, and completed as soon after the visit as possible. Unsigned records can be one of those seemingly "insignificant technicalities" that causes the auditor to deny payment.

Your medical record should reveal your rationale for your treatment. Explain why you are prescribing a test. Reveal the relevant results of that test and their impact on your treatment plan. It is not enough that the test results are printed in your patient chart.

Various MACs require a treatment plan when treating decubitus ulcerations. Your plan must be within the standard of care. Ask yourself if there is an adequate physical assessment that is recorded in your patient chart, every visit. Specifically with chronic wounds, is there an odor? What is the color? Is it weeping? Has it been cultured and what are the results of the culture? What is the width, length, and depth of the ulceration being treated? Is it shrinking, expanding, or remaining static? What is the area you are debriding? How do you know the necessary area to debride? You need to demonstrate that your treatment is effective. If you are changing your treatment plan, let's say, to include a human skin substitute, it must be justified. Particularly with human skin substitutes, partially due to the high cost, every requirement as particularized in the LCD and NCD must be satisfied.

On the date of treatment, the location, width, length, and depth of the wound should be documented.

If the results of the audit warrant an appeal, there are four levels of appeal. Success is very difficult without appropriate legal representation. The first two levels of appeal are all based on forms and submissions; there is no "live" hearing. Often, there is limited success in winning or significantly reducing the amount of money Medicare is seeking in return at those levels of appeal. If necessary, the third level involves an administrative law judge. The hearing is usually done on the phone. Without going into the details, experience counts in these appeals. Knowing when to press certain points and not dwell on others comes from years of interacting within this system. Audit defense is a specialized area of the law.

Preparing to defend these audits usually involves a team assembled by a veteran healthcare law firm. Attorneys with clinical knowledge and experience are very helpful as they speak both the medical language, as well as being proficient in the legal terminology and procedure. Coding and auditing specialists are invaluable. They must also be proficient in statistics. The team must know if the auditor used a sufficient sample to project percentage rejection rates over your practice base. Investigation and research into rules and regulations usually comes into play. Being knowledgeable of local coding determinations may be crucial in defending an audit. Being able to work with the healthcare provider in appreciating how the office operates is essential in mounting a defense. There is no short- cut to establishing an effective defense to these audits.

When dealing with wound care, with and without the use of skin substitutes, the provider's records should document previous treatments, by both the current and prior providers. It is important to know the type and length of the prior treatments. Were they appropriately given to the patient? Was there progress? Quantify the prior progress, or lack of progress, if possible. That would involve the exact location, size, and depth of the ulcer/wound. If that data is not available, the record should state that.

Not every state requires it, but ideally, the medical record should include a signed consent for your treatment. All co-morbidities that might affect healing should be documented. For example, if the patient is diabetic, how is it being treated, and is it effectively being treated? Is there neuropathy? Paresthesia? How about appropriate radiological results? In other words, there is more going on that may impede or facilitate healing than just wound debridement. This must be documented.

On the date of treatment, the location, width, length, and depth of the wound should be documented. The amount of skin substitute used and wasted should be documented, along with serial number identification of the skin substitute, if used.

An excellent diagnostic tool in assessing and documenting wound care is the Moleculight i:X® and DX™ Point of Care Imaging System. The

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Moleculight technology accurately determines the size and depth measurements while capturing various high-resolution images of the treatment area. Through its proprietary and FDA validated fluorescence technology, it can identify areas of high bacterial colonization that could lead to infection and delayed wound healing. These images can provide immediate actionable insight into the extent, depth, and quality of debridement. This is crucial in enhancing the effectiveness of your treatment and documenting it. The imaging and measurements integrate with all major EMR systems.

Additionally, the fluorescence captured by such an imaging system will improve your ability to qualify the extent of the bacterial load pre- and post-wound debridement. In turn, that will materially affect the treatment plan. Your medical record should reflect this finding. By taking this imaging on an interval basis, for each treatment, you will objectively be able to demonstrate that your treatment plan is either performing well or needs adjustment. This not only allows for more precise, effective treatment of ulcers/wounds, but through documentation, proves it!

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With the recent revelation of government criminal investigation of over a billion dollars of alleged fraudulent use of skin substitutes, one cannot stress the importance for the legitimate healthcare practitioner to document what they are doing and why. **PM**

Dr. Kobak is Senior Counsel in Frier Levitt's Healthcare Department in New York. Larry has extensive experience representing physicians in connection with licensure issues, as well as successfully defending physicians before Medical Boards, OPMC, OPD investigations, as well as Medicare Fraud, Fraud & Abuse, Hospital Actions, RAC Audits, Medicare Audits, OIG Fraud, Healthcare Fraud, Medical Audits, and Health Plan Billing Audits. As a licensed podiatrist prior to becoming an attorney, he served as the international president of the Academy of Ambulatory Foot and Ankle Surgery.