PHYSICIANS ADVOCACY INSTITUTE

December 5, 2014

Nancy J. Griswold, Esq.
Chief Administrative Law Judge
Office of Medicare Hearings and Appeals
1700 Moore St., Suite 1800
Arlington, VA 22209

RE: OMHA-1401-NC

Dear Ms. Griswold:

The Physicians Advocacy Institute ("PAI") is a 501(c)(6) organization founded in 2006. The PAI's mission is to advance fair and transparent payment polices and contractual practices by payers and others in order to sustain the profession of medicine for the benefit of patients. PAI's Board of Directors is comprised of CEOs from nine state medical associations – California, Connecticut, Georgia, Nebraska, New York, North Carolina, South Carolina, Tennessee, and Texas -- as well as a physician from Kentucky. As part of its core mission, PAI advocates for policies designed to make medical audits and the audit appeals process fairer and more transparent.

PAI appreciates the opportunity to respond to the Office of Medicare Hearings and Appeals' ("OMHA") Request for Information seeking input on how OMHA can best address the substantial growth in the number of provider requests for hearings filed with the OMHA and the backlog of pending cases. We recognize and appreciate that OMHA has already undertaken several measures to address the backlog of appealed provider claims. However, PAI believes that the easiest way to decrease the appellate workload and backlog is to reduce the need for appeals in the first place by implementing additional measures to ensure that provider audits are conducted consistently and accurately. The high percentage of recovery audit contractor (RAC) determinations that are overturned in favor of providers at the OMHA ALJ level demonstrate the critical need to address the inherent problems within the current audit process.[1] PAI looks forward to working with OMHA on the regulatory initiatives outlined below that will improve the transparency and efficiency of the audit and appeals processes:

[1] For example, a recent Office of the Inspector General ("OIG") report found that even though providers appealed only 6% of the RAC audit findings, almost half (44%) were overturned at the third (ALJ) level of appeal. (HHS OIG Rep. OIE-04-11-00680, August 2013, p. 11).

- Require additional clinical and educational qualifications to ensure that auditors have the necessary expertise to evaluate medical necessity and coding issues;
- Ensure that RACs provide detailed advance notification to physicians and other health care providers about the scope of the audit as well as detailed reasoning and support for adverse audit findings;
- Delay contingency payments for RACs until the third level (ALJ level) of appeal is exhausted;
- Increase efforts by CMS and the RACs to educate and provide notice to providers on common coding and billing errors to improve the accuracy of claims submissions;
- Provide physicians with a meaningful opportunity to decide whether to file an appeal by allowing the full 120 days to appeal adverse audit findings without the risk of automatic recoupment;
- Reduce the look-back period for RAC audits to two years;
- Add specific extrapolation standards to the statistical sampling pilot.

We believe that our recommendations will strengthen the audit process and produce more accurate audit determinations that will lead to fewer appeals of adverse audit findings.

I. REQUIRE ADDITIONAL CLINICAL AND EDUCATIONAL QUALIFICATIONS TO ENSURE THAT AUDITORS HAVE NECESSARY EXPERTISE IN DETERMINING MEDICAL NECESSITY AND CODING ISSUES

PAI recognizes and supports CMS' previous efforts to require RACs to improve audit accuracy by employing medical professionals, including certified coders and medical directors in order to improve audit accuracy. Additional measures are needed, however, to better ensure fair determinations on medical necessity and coding issues. With respect to medical necessity reviews, CMS could further improve audit accuracy by requiring RACs to use a physician of the same specialty and subspecialty as the physician under review. These measures would help ensure that RACs have the expertise to assess the medical necessity of clinical tests and procedures without the benefit of examining the patient. In order to improve audit determinations involving coding issues, CMS should require RAC personnel to have specific knowledge and experience in applicable ICD, CPT, and HCPCS codes.

II. MANDATE THAT RACS PROVIDE TIMELY AND DETAILED NOTIFICATION TO PROVIDERS

The lack of transparency and detailed advance notification in the audit process creates confusion and contributes to the general sense among physicians and other health care providers that the RAC audit process is inherently unfair. Requiring RACs to provide timely and detailed notification to providers about the medical audit, as well as audit findings, would make the audit process fairer and more transparent. These measures would also improve physicians' understanding of the audit findings, which would help reduce the number of audit appeals and hearing requests. With respect to pre-audit notification requirements, PAI specifically recommends that CMS require contractors to provide physicians and other healthcare providers with at least 30 business days' notice before a medical audit, the names and contact information for the auditors, the legal authority under which

the audit is conducted, a clear designation of the records to be reviewed, the dates by which records are to be submitted, the address to which the records should be sent, and the manner in which the records should be transmitted.

Detailed post-audit notifications would also improve the transparency of the audit process and potentially allow providers to address and remedy audit findings before having to undergo the appeals process. To achieve this goal, RACs should be required to identify: (1) all errors discovered in the audit; (2) the medical and reimbursement policies used in the audit's findings; (3) all underpayments discovered in the audit; and (4) the methodology for calculating overpayment amounts, including information about the extrapolation process if applicable. These post-notification requirements would also better prepare providers for future audits and reduce the risk of repeated errors.

III. DELAY CONTINGENCY PAYMENTS TO RACS UNTIL THE THIRD LEVEL OF APPEAL IS EXHAUSTED

It is important in every audit process that auditing entities employ a fair, balanced and impartial approach. There is growing consensus that contingency payments to the RACs create a problematic conflict of interest and provide a perverse incentive for auditors to make overpayment findings, thus increasing the likelihood for inaccurate audits. PAI agrees with Members of Congress' statements regarding the inherent unfairness created by these contingency payments. For example, in February 2014, a bipartisan group of members of the House of Representatives sent a letter to then Secretary Sebelius stating that "RACs are incentivized to deny claims, even when claims are correct." Similarly, a July 2014 Senate Special Committee on Aging staff report, *Improving Audits: How We Can Strengthen the Medicare Program for Future Generations*, found that "the RAC program pays its contractors based on the amount of improper payment identified through their audits ... [which] creates an incentive to keep improper payments high, rather than to educate providers about how they can better prevent improper payments in the future."

We commend CMS' recent effort to address the RACs' financial conflict of interest by delaying the RACs' receipt of their contingency fees until after exhaustion of the second level of appeal. However, because the second level of appeal is an *internal* appeal and because nearly half of the Recovery Auditor claims appealed are overturned at the third level of appeal, the recent program change does not go far enough to eliminate RACs' incentive to find overpayments. Delaying the contingency payment until claims are subject to external review would ensure providers are not subject to premature and unfair recoupments, as well as help to reduce the financial incentive for RACs to make excessive overpayment determinations.

IV. REQUIRE CMS AND RACS TO EDUCATE AND PROVIDE NOTICE TO PROVIDERS ON COMMON CODING AND BILLING ERRORS

Physicians are practicing in a rapidly evolving, increasingly complex health care environment. Across the nation, physician practices are struggling to respond to new clinical and administrative challenges brought by implementation of the Affordable Care Act, continual changes in Medicare and other government programs, and constantly shifting policies of private health insurers.

The significant changes in the healthcare industry in recent years require greater collaboration between providers and CMS to ensure providers are appropriately guided on new practice requirements and common coding errors. CMS could therefore enhance program integrity and reduce the number of appeals by improving provider education on commonly identified billing errors. If as a result of better education more providers submit correctly coded claims, fewer claims will be identified as needing audits. Therefore, PAI recommends that CMS invest additional resources in educating providers on correct coding and documentation. Additionally, CMS should contractually require RACs to educate providers on identified coding errors and to notify providers about over-utilized codes. Furthermore, RACs should be required to provide 90 days' advance notice before initiating audits or requests for medical records involving over-utilized codes. These measures will better enhance provider education on common coding errors and allow providers to correct, if necessary, their billing and coding practices prior to submitting claims to the Medicare program or being subject to an audit.

V. GRANT PROVIDERS A MEANINGFUL OPPORTUNITY TO DECIDE WHETHER TO FILE AN APPEAL WITHOUT THE RISK OF AUTMOMATIC RECOUPMENT

Providing physicians and other health care providers with the full statutory 120 day timeframe to appeal overpayment findings without risking automatic recoupment would offer physicians a meaningful opportunity to investigate claims and decide whether to file an appeal. The current program rules compel physicians to file an appeal within 30 days of a receiving notice of an overpayment determination in order to avoid automatic recoupment, well before the time for filing a timely appeal has expired and before receiving a hearing on the overpayment finding. Considering that the current claims backlog and moratorium at the OMHA forces providers to wait years to receive a determination on their appeals, providers are essentially compelled to file an appeal within the first 30 days in order to avoid a premature and potentially erroneous recoupment. The current process penalizes providers for utilizing the full time period provided to make a decision regarding an appeal, depriving providers of their due process rights during the appeals process. Giving providers the full 120 day period to review the overpayment determination would allow them to make informed decisions about claim appeals *separate* from any payment considerations, and could therefore reduce the number of appeals filed with the OMHA.

VI. REDUCE THE LOOK BACK PERIOD FOR RAC AUDITS TO TWO YEARS

The number of hearing requests and claim appeals could be reduced by shortening the look-back period for audits. PAI applauds CMS' previous decision to reduce the RAC look-back period from four years to three years. In order to more robustly address the appeals backlog and reduce the significant administrative burden on providers, PAI recommends that CMS further reduce the period for all audits to two years.

VII. ADD SPECIFIC EXTRAPOLATION STANDARDS IN THE STATISTICAL SAMPLING PILOT

PAI supports OMHA's effort to reduce the backlog of appeals at the ALJ level through the statistical sampling pilot. When performed in a statistically sound manner, sampling can be an effective tool to reduce the number of claims reviewed. Allowing ALJs to make decisions based on a subset of the claims under appeal significantly streamlines the appeals process. However, as currently implemented, the statistical sampling pilot fails to require important standards that would ensure that any sampling be conducted correctly. Requiring standards designed to ensure that sampling is conducted in a statistically sound manner would give providers more confidence in the accuracy of overpayment amounts calculated based on extrapolation.

PAI recommends that OMHA adopt the following three specific standards, which reflect those generally accepted by qualified statisticians, to ensure that claims are fairly adjudicated in the pilot program:

1. OMHA should require that extrapolation be based on a statistically valid, stratified random sample, with all zero paid claims and outliers removed. Unless this is done, the average overpayment in the sample could be higher than in the entire group of claims under appeal, thereby unfairly inflating the overpayment owed.

2. OMHA should require that the median overpayment amount in the sample, rather than the average or mean amount, be used as the central data point for calculating overpayments. This is because in audits of medical claims, the average overpayment amount in a sample frequently overstates the overpayment amount due.

3. OMHA should require that the lower bound of the confidence level (the margin of error) be used to calculate any overpayments due. This would eliminate any sample error that occurs from statistical sampling.

A more detailed description of statistically sound sampling and extrapolation and the need for these standards is provided in PAI's White Paper: ***Medical Audits: What Physicians Need to Know***, a copy of which is attached to these comments.

PAI believes that implementing these three industry standards would provide more certainty for providers, facilitate more accurate calculation of any overpayment amounts due, incentivize greater provider participation in the pilot, and facilitate broadening the pilot to sufficient numbers of appeals to effectively address the existing appeals backlog. In addition, adoption of these standards could eliminate the need and cost for providers to retain statisticians as is currently done in the pilot.

VIII. CONCLUSION

PAI appreciates OMHA's efforts to reduce the appellate workload and backlog and the burden this places on providers. We welcome the opportunity to provide input on behalf of physicians on these and any other questions raised by the OMHA as it works to improve the Medicare audit and appeals processes.

Sincerely,

Robert W. Seligson, MBA, MA
President, Physicians Advocacy Institute, Inc.
Executive Vice President/CEO, North Carolina Medical Association

Attachment: PAI White Paper: ***Medical Audits: What Physicians Need to Know***

PAI

PHYSICIANS ADVOCACY INSTITUTE

MEDICAL AUDITS:

WHAT PHYSICIANS NEED TO KNOW

A PUBLICATION OF THE PHYSICIANS ADVOCACY INSTITUTE, INC.

MEDICAL AUDITS: WHAT PHYSICIANS NEED TO KNOW
A White Paper Presented by the Physicians Advocacy Institute, Inc.

PURPOSE

One of the greatest challenges facing physicians and their staffs today is how to prepare for audits and financial reviews conducted by the Medicare Recovery Audit Contractors (RACs) and private payers and how to appeal adverse audit findings. The Physicians Advocacy Institute, Inc., (PAI) is pleased to present this White Paper as part of an effort to assist physicians and their practice staff in understanding and appealing medical audits by RACs and commercial payers.

With ever increasing pressure on both governmental and private payers to reduce healthcare costs, it is inevitable that payers will continue to use audits to identify alleged overpayments and to demand that physicians repay these amounts. However, auditors err and their findings are not always correct. Moreover, even when auditors correctly identify billing and coding errors, such findings do not necessarily indicate fraud and abuse.

Therefore, physicians need to prepare for and manage external payer audits just as they manage any other part of the business side of their practices to minimize the risk of being audited and to ensure that any audit findings are fair and accurate. This White Paper is designed to provide physicians and their staffs with tools to do just that. Specifically, this White Paper will:

- Provide tips on how to assess the risk of being audited or reviewed;
- Describe the various types of audits;
- Discuss the audit process;
- Discuss how to respond to an audit;
- Provide tips to analyze audit findings; and
- Discuss appealing any adverse audit determinations.

THE AUTHORS

The PAI gratefully acknowledges the significant contributions to this White Paper by primary authors:

Frank Cohen, MPA, MBB
The Frank Cohen Group, LLC

Donna D. Wilson, RHIA, CCS, CCDS
Senior Director
Compliance Concepts, Inc.

J. Paul Spencer, CPC, CPC-H
Compliance Officer
Fi-Med Management, Inc.

ABOUT THE PHYSICIANS ADVOCACY INSTITUTE, INC. (PAI)

The Physicians Advocacy Institute, Inc. (PAI) is a not-for-profit 501(c) (6) advocacy organization established in 2006 with funds from the Multi-District Litigation (MDL) class action settlements against major national for-profit health insurers. The PAI's mission is to advance fair and transparent payment policies and contractual practices by payers and others in order to sustain the profession of medicine for the benefit of patients. Towards this end, the PAI offers this publication, "Medical Audits: What Physicians Need to Know" as a critical tool in physicians' understanding and ability to appeal medical audits by RACs and commercial payers.

The PAI Board of Directors is composed of the following state medical association executives:

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Executive Vice President/CEO
Connecticut State Medical Society

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Executive Director/CEO
Medical Association of Georgia

Philip Schuh, CPA
Executive Vice President
Medical Society of the State of New York

Charles B. Shane, MD
Louisville, Kentucky
Lead Physician Plaintiff

For additional information about PAI: Mary Jo Malone, Executive Vice President/CEO, at maryjomalone@sbcglobal.net or Kelly Kenney, PAI Counsel, at k2strategiesllc@gmail.com

ADDITIONAL RESOURCES

PAI is dedicated to providing informational and educational tools designed to assist physicians in addressing the challenges of practicing medicine in the twenty-first century. This White Paper is one of these tools, intended to provide physicians and their staffs with essential information, analytical tools, and recommendations to prepare for and respond to medical audits. Additional information and tools for physicians are available on PAI's website, www.physiciansadvocacyinstitute.org. For additional information and resources, please contact your state and county medical association. The Centers for Medicare and Medicaid Services (CMS) also provides valuable resources at www.cms.gov.

I. SUMMARY OF RECOMMENDATIONS

1. It is a good idea to assess your practice's risk of being the subject of an audit or review even before an audit begins. To do this, you should analyze your utilization of procedure codes and modifiers in comparison with others in your specialty. You should also review the RACs' and Medicare's Comprehensive Error Rate Testing (CERT) report's findings of improper Medicare payments to verify that you are not billing and coding in a manner found to be improper. Bringing your billing and coding practices into compliance is the best way to mitigate the possibility of an audit.

2. Immediately upon receiving correspondence from an auditor seeking medical records or other documentation, you should place it in the hands of the correct person within your practice for response. This individual should establish a contact at the offices of the requesting entity who can serve as the main conduit for all information related to the audit.

3. If the type of audit is not readily apparent from the face of the letter, the designated individual at your practice should contact the requesting entity to make this determination.

4. If the initial letter identifies the specific codes and billing patterns to be examined in the audit or review, conduct your own assessment of the medical and billing records in conjunction with payment criteria to assess the risk. Depending on the expertise within your practice, it may be necessary to consult with attorneys, coders, or other experts to conduct this independent analysis.

5. Be aware of deadlines and respond promptly or ask for extensions. This is especially important if you need to appeal any audit findings.

6. All correspondence with the auditing entity should be date and page stamped and either copied or scanned prior to submission. You should also send all documents by certified mail or another delivery mechanism that provides tracking and verification of receipt. Be sure to retain receipt verification.

7. After receipt of an audit report, analyze the reasons given by the auditors to determine if you agree or disagree with the factual findings. If you disagree, be sure to consider an appeal.

8. If an audit seeks repayment of alleged overpayments, conduct a quantitative analysis of the methods used to calculate the amount due. Such calculations are often based on extrapolation, which calculates the amount due for the entire audit period from a random sample of claims. If extrapolation was used, you may want to consider requesting a review of 100% of your records for the audit period. Although this is generally time-consuming and burdensome, it may

result in finding underpayments that should be deducted from the amount ultimately due. If you are unwilling to undergo a full audit, analyze the extrapolation formula using the tests described in Section V(D)(3) in this paper to determine whether the formula is fair or whether it overstates the amount owed.

II. WHO WILL BE AUDITED? ASSESSING YOUR RISK

Any and all providers who submit claims to payers may be subject to external audits. Statistical evidence indicates that physicians selected for audit are targeted based on some data that varies from that of their peers, such as a significant variation in utilization of certain codes compared with others of the same specialty, or other evidence, such as information from a whistle blower. Some audits are initiated by a commercial payer focused on a particular code group, such as Evaluation and Management (E/M) codes, or a particular issue, such as medical necessity. Federal government auditors often focus on billing errors identified in prior studies, such as the Comprehensive Error Rate Testing (CERT) study, which will be discussed below.

In short, there is no single trigger which will subject a physician practice to an audit. There are, however, proactive steps which you can take to assess your risk of being subject to an audit or review:

- You should review the CERT findings to determine if you bill any of the codes found to be frequently billed in error. If so, you should analyze your billing of these codes to verify that you are using them correctly and that the medical records contain all the required documentation.

- You should benchmark your use of codes and modifiers compared to others in your specialty. You can do this on-line at the CMS website, www.cms.gov, or through software products offered by third party vendors.

- You should conduct periodic claims and chart reviews to identify any coding errors, duplication of claims, and the adequacy of documentation supporting billed codes. Any issue identified in these periodic reviews should be corrected.

- You and your staff should keep up-to-date on coding rules and payer payment policies.

A. Using the Comprehensive Error Rate Testing (CERT) Study as a Risk Assessment Tool

The CERT study was initiated by CMS to identify improper payments made to physicians by carriers, Durable Medical Equipment Regional Contractors (DMERCs), and Fiscal Intermediaries (FIs). The companion study was the Hospital Payment Monitoring Program (HPMP), which looked at facilities in the same manner that CERT looked at medical practices. In both studies, the goal was to identify patterns of payments that were, after review, determined to have been

inappropriate. Beginning in 2009, error rates from both studies were combined to form one global error rate.

To conduct the 2012 CERT study, the most recent study for which data are available, CMS randomly selected 43,492 claims and requested supporting documentation. Of these, 15,645 were Part B claims. After a review of the documentation, CMS reported that overall 9.3% of Medicare claims were paid in error and that 9.9% of Part B payments were made in error. The projected improper payment amount for claims paid to physicians was $7.71 million. Errors cited in the study included no documentation, insufficient documentation, medically unnecessary services, incorrect coding and payments inconsistent with Medicare guidelines and specifications.

Although the potential error rate by procedure code has not yet been reported for 2012, for the past several years, the summary reports identified CPT® code 99214 as accounting for the highest dollar amount of improperly paid codes. In addition, reports from previous years identified CPT code 99310 as accounting for the highest error rate. This means that if you report a significant number of 99214's or 99310's to Medicare, you have a higher risk of being reviewed or audited.

The 2012 CERT study also reported that approximately 28% of the overall error rate was due to payment on claims where the documentation did not support the medical necessity of a service or procedure and approximately 54% of the error rate was for claims reported as having insufficient documentation to report the service. Incorrect coding accounted for approximately 14% of the error rate. From a risk mitigation perspective, it is important to ensure that coding and documentation support medical necessity and the appropriate level of care.

B. Benchmarking your Use of Codes and Modifiers to Assess Your Risk of an Audit

One method for both risk assessment and risk mitigation is to compare your utilization of procedure codes against peers in your specialty and sub-specialty. You can benchmark your use of codes with your peers by referring to the Part B Summary Data File available online at the CMS website (www.cms.gov) or through software products offered by third party vendors. If your billing differs significantly from that of your peers, you are more likely to be audited.

For example, if CPT® 92920 (percutaneous transluminal angioplasty is the fourth most commonly reported code for your practice, but it is not even in the top 25 most frequently billed codes for your specialty, your risk for audit or review is increased, especially since 92920 is on the watch list. As another example, if your use of 99214 is three times that of your peer group, your risk for audit or review will be increased.

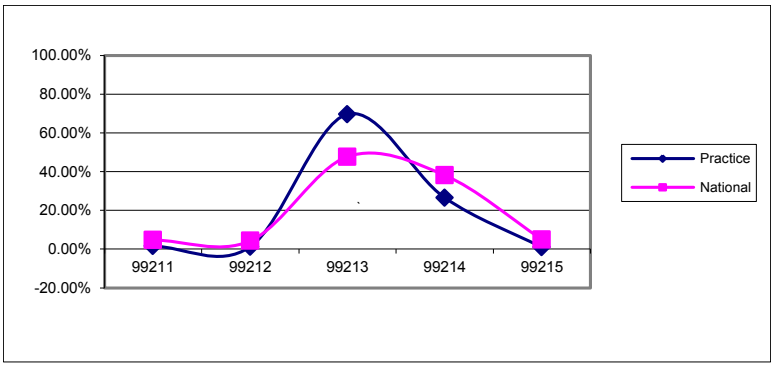
Evaluation and Management (E/M) codes are well-known targets for external audits. E/M codes make up around 1.6% of all procedure codes within the Physician Fee Schedule Database (PFSDB) but they account for approximately 20% of approved services and 43% of Medicare Part B payments. They are also subject to a set of guidelines, the application of which can be subjective. A recent Strategic Medical Review Contractor audit of Medicare payments for E/M

codes 99214 and 99215 found a 61% error rate, 39% of which was due to insufficient medical documentation. The key to determine if your utilization of E/M codes may target you for an external audit is to benchmark your utilization of E/M codes with others in your specialty as indicated in the Medicare Part B database. This is generally done by comparing intra-categorical relationships. In other words, you should look at the distribution and utilization of, for example, each new office visit as a percentage of all new office visit codes. By graphing these results, you can get a general idea as to the variation of your utilization of E/M codes to your peer group.

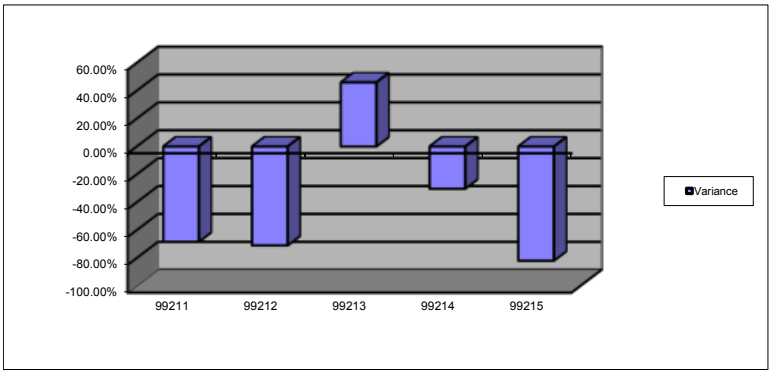
This is a bit simpler than it may sound. For example, if you want to analyze your utilization of established office visits, you would take the following steps: First, pick a date range, such as the previous month or the prior year or any other period that meets your goals. Second, list each code being analyzed (i.e., 99211, 99212, 99213, etc.) in the first column of a table. Third, enter the frequency you reported each code in the next column. Fourth, calculate your utilization distribution by dividing the frequency for each code by the total frequency reported for all of the codes in the category being analyzed. Finally, compare your utilization percentage to whatever control group you choose, such as the national average distribution. You can then look at the difference between your utilization distribution and the control group as a variance. Again, the calculation is pretty simple: Divide your utilization percentage by the national average utilization percentage (or other control group) and subtract 1. The following table was created using sample data to illustrate this example:

Code	Current Annual Frequency	Current Practice Dist. %	National Dist. %	Variance Practice v. Control
99211	28	1.50%	4.74%	-68.40%
99212	23	1.23%	4.25%	-71.03%
99213	1,303	69.75%	47.78%	45.99%
99214	497	26.61%	38.19%	-30.33%
99215	17	0.91%	5.04%	-81.93%
Totals	**1,868**	**100.00%**		

Visual representations are invaluable, so graphing the results may make it easier to understand the value of the information. For example, the following graph compares the sample practice's utilization of established office visit codes to the national utilization, providing a high-level visual representation of the difference in utilization:



It is often easier to see the magnitude of the differences in utilization by using a bar graph to depict a physician practice's variance from the national utilization as is done using the sample practice in the following graph:



In both of these graphs, it is easy to see a spike in the use of the 99213 compared to the peer group while the rest of the codes are underutilized in comparison with the peer group.

In addition to benchmarking your utilization of procedure codes, you should benchmark your use of modifiers since modifiers are subject to particular scrutiny. This will not only allow you to assess your risk of an audit, but can also identify areas of potential financial opportunity. For example, if your peers report modifier -59 (used to report code combinations not usually reported together, but which are appropriate under the circumstances) in 4.5% of all submissions and you didn't report any, your risk for audit or review is not necessarily increased. However, it should incentivize you to examine claim denials to see if you should have been using modifier -59 to report certain code combinations.

C. Other Risk Factors

There are other risk factors that cannot be avoided, such as your specialty (e.g., internal medicine) or location in an area where Medicare over-payments exceed the norm (e.g., California, New York, Texas and Florida). You should, however, be aware of these risks, stimulating more proactive behavior on your part to ensure that your billing and documentation are consistent with nationally recognized coding principles and guidelines and payers' medical payment policies.

III. TYPES OF AUDITS

A. Commercial Insurance Audits

Commercial insurance carriers have different ways of determining which claims are selected for audit, and for what reasons. In some cases, when a billing anomaly is detected for a provider, the specific claim information is forwarded to an outside third party to conduct a documentation audit.

While there are several companies that handle this type of administrative audit, it is important to note that the processes for conducting audits among these companies are similar to what occurs with government audits. Specifically, it will begin with a time-sensitive medical records request for documentation of past services that have already been reimbursed. Although records are generally analyzed by certified coders, this does not guarantee the accuracy of the audit results because of differences in interpretation between coders.

In addition to formal audits, commercial insurers are increasingly using "reviews" as a preliminary step. The results of such reviews may be challenged, but are not necessarily subject to the payers' policies governing appeals of formal audits.

B. Recovery Audit Program/RAC Audits

The stated mission of the Recovery Audit Program, frequently referred to under its former name as the Recovery Audit Contractors (RACs) audit program, is to identify and correct improper Medicare payments (both overpayments and underpayments) and to collect identified overpayments. The RAC audits started as part of a demonstration program under §306 of the Medicare Modernization Act of 2003. Because the demonstration program was successful in returning millions of dollars to the Medicare Trust Fund, it was expanded into a permanent nationwide program by §302 of the Tax Relief and Healthcare Act of 2006.

There are four regional Recovery Audit contractors that review claims on a post-payment basis. Each of these contractors receives a data file from the Centers for Medicare and Medicaid Services (CMS) containing data from the National Claims History (NCH) 100% Nearline File derived from claims processed within its region. The Recovery Audit contractors then review this data using proprietary methodologies, which vary among the contractors. They are required, however, to use the same Medicare policies as Fiscal Intermediaries (FIs) and Medicare Administrative Carriers (MACs), including CMS rules and regulations, and national and local coverage determinations. This method is similar to those conducted by FIs/MACs to identify improper payments and fraudulent claims. However, Recovery Auditors are paid based on a contingency fee of between 9 and 12.5% of any identified improper payments. Recover Auditors can also report any potential fraud to CMS and potential quality issues to the Quality Improvement Organizations (QIOs).

Types of Recovery Audits

There are three different types of Recovery Audits.

1) **Automated reviews** are conducted without the review of medical records. The Recovery Auditor determines that claims have been improperly paid using its proprietary data mining techniques. Each error found in an automated review must be the result of a non-covered service or incorrect application of coding rules. Each error must also be supported by Medicare policy, approved articles or coding guidance.

2) **Complex reviews** require the review of a provider's health record. Claims subject to complex review are first identified as having a high probability of error based on the Recovery Auditor's data mining methodologies. There are limits regarding the number of records that can be requested from providers per 45-day period based on the type and size of an organization.

3) **Semi-automated reviews** begin as automated reviews, and progress to the level of complex review based on other problems with the claims in the view of the RAC contractor. Unlike complex reviews, there is no limit to the number of records that can be requested under the semi-automated review process.

CMS requires that employees of Recovery Auditor contractors (and subcontractors) include a medical director, clinical professionals, and certified coders.

C. Other Public Payer Audits

1. ZPIC Audits

The primary goal of the Zone Integrity Program Contractors (ZPICs) is to find and pursue cases of suspected fraud and take immediate action. All cases of potential fraud are referred to the Office of the Inspector General (OIG) for consideration. ZPICs support law enforcement during investigation and prosecution of these cases. Unlike the Recovery Auditor program, ZPIC contractors are paid at a fixed contractual rate, rather than with a percentage of recoveries. They can receive bonuses above and beyond the contract for high quality service and administrative actions. ZPICs are also contracted to conduct fraud and abuse training for the MACs and their staff as a way to identify future cases of inappropriate payment.

ZPICs picked up where the Program Safeguard Contractors (PSCs) and the Medicare Prescription Drug Integrity Contractors (MEDICs) left off with a very similar scope of work to:

- Establish baseline data to enable contractors to recognize unusual trends, changes inutilization over time or schemes to inappropriately maximize reimbursement;
- Handle referrals from law enforcement and other sources for possible fraud and abuse;
- Identify where there is a need for a Local Coverage Determination (LCD);
- Identify claim review strategies that efficiently prevent or address potential errors (e.g. prepayment edit specifications or parameters);

- Produce innovative views of utilization or billing patterns that illuminate potential errors;
- Identify high volume or high cost services that are being widely over-utilized. This is important because these services do not appear as outliers and may be overlooked when, in fact, they pose the greatest financial risk; and
- Identify and target program areas and/or specific providers for possible fraud investigations. This data analysis program must involve an analysis of national data furnished by CMS as well as review of internal billing utilization and payment data to identify potential errors. http://www.cms.gov/transmittals/downloads/R279PI.pdf

2. MIC Audits

In order to examine potential overpayments by state Medicaid programs, CMS entered into contracts with Medicaid Integrity Contractors (MICs). There are three types of contractors for this program:

1) Review MICs, that analyze claims data to identify payment vulnerabilities;
2) Audit MICs, that conduct post-payment audits of documentation to identify overpayments; and
3) Education MICs, that educate the provider community as needed based on discovered issues.

Physicians will most often interface with the three regional audit MICs when they receive and respond to requests for additional documentation.

3. UPIC Audits

CMS has announced plans to implement a new Medicare and Medicaid audit program to find and pursue issues of suspected fraud, the Unified Program Integrity Contractor (UPIC). The UPICs will replace certain functions of the ZPICs and MICs and will operate on a regional basis, providing a single contractor with each region to conduct Medicare and Medicaid integrity audits and investigations.

4. MAC Service Specific Probes

When the Comprehensive Error Rate Testing (CERT) program contractor identifies problem areas specific to one Medicare Administrative Carrier (MAC), the MAC pursues these issues as part of what is called Progressive Corrective Action (PCA). The most common action taken is in the form of a Service Specific Probe. The MACS are increasingly reviewing claims on a pre-payment basis.

These probes are prospective audits of a limited number of claims for services identified as problematic by the CERT contractor. Generally, the MAC contractor will announce that a probe review will be conducted of the targeted specialties and services involved (i. e., 99214 for internal medicine). A limited number of claims matching the probe criteria are pulled from

those submitted through the standard claim processes for payment. An additional documentation request is sent to the affected provider, who must submit the documentation within a specified time frame. If the documentation is not submitted, the claim is found to be invalid and is not paid. If the documentation is submitted, it is reviewed for the appropriateness of billing the code at issue, and paid only if the documentation supports the billed code. After review, the results are forwarded to the providers, with the overall results of the review released on the MAC website at the conclusion of the review.

5. SMRC Audits

The goal of the Strategic Medical Review Contractor (SMRC) audits is to lower improper payment rates and increase efficiencies in the medical review functions of Medicare and Medicaid programs by conducting specific reviews as determined by CMS. One of the SMRC's initial projects was an audit of Medicare payments for CPT E/M codes 99214 and 99215, which found that 61% of such payments were in error.

6. Other Audits

Other audits may move out of the civil realm and into the criminal realm, involving such organizations as the Office of the Inspector General (OIG) and the Department of Justice (DOJ).

V. THE AUDIT PROCESS

Regardless of the type of audit or the reason for its initiation, there is a great deal of commonality regarding the workflow, or process that occurs during an audit.

A. Audit Notification

Except for Automated Recovery Auditor (RAC) reviews, which begin with a demand for payment, most audits begin with a detailed documentation request letter. Because your response to this letter can dictate the course of an audit, it is critical that the documentation request letter be immediately placed into the right hands within your organization. The most commonly requested type of information is health record documentation. However, there are times when additional billing documentation is also requested.

There are generally no limitations on the number of records that a private payer may request. Depending on your state law or your provider contract, there may be limitations on the period of time which may be audited. However, most state laws and contractual provisions have certain exceptions, such as for the reasonable suspicion of fraud or for self-funded plans. In addition, many commercial insurers require physicians to sign a document indicating that the records provided constitute the entire medical record, and do not allow supplementation of the records on appeal. Therefore, you should review all records provided for completeness before submitting the records.

There are specific limits on the number and scope of records which may be requested by governmental auditors with different rules applying for different governmental entities. These are highlighted in the table below:

AUDITOR	# OF RECORDS AND LIMITS
RAC	Three year look back period with limits on the number of medical records which can be requested determined by the size of the physician practice http://www.cms.gov/Recovery-Audit-Program/Downloads/PhyADR.pdf
ZPIC	No record request limits.
MIC	Five year look back period with providers given timelines as to record submission requirements.
MAC	Uses CERT data to determine the type and number of records requested.

B. First Steps on Receiving Notification of an Audit

On receiving notification of an audit, you should immediately place it in the hands of the person designated to respond within your organization and carefully note any deadlines.

At this point, you should also consider whether to call an attorney. This decision generally depends on the type and extent of the audit. If it is a criminal or an integrity (e.g. potential fraud) audit, you should seriously consider calling an attorney. If it is a commercial payer or Recovery Auditor audit, you should realistically assess your risk of an adverse finding and the amount of money at stake. If your risk and/or the amount of money at stake is significant, it is generally wise to retain an attorney.

C. Assessing Your Risk after Notification of an Audit

To assess your risk, you need to see yourself in the same way that an auditor sees you. Remember, auditors don't know who you or your patients are or what you believe or how you think. Their first impression is based almost solely on your data, which they have already reviewed before notifying you of the audit. Therefore, you should determine whether the issue identified in the audit notification letter has been found to be a common payment error, for example by the Recovery Auditors (RACs) or the Comprehensive Error Rate Testing (CERT) program, or whether your billing of a particular code or code combination is out of the norm for your specialty. This risk analysis, which should be performed after receiving an audit letter, is the same risk assessment used to assess whether a physician practice is likely to be the subject of an audit, which was described in section III of this white paper.

D. The Post-Audit Review

After the completion of an audit, you will be provided with a report of the audit findings, which often includes a request for repayment. You should review the audit findings carefully. There

are two primary components to the post-audit review: qualitative and quantitative. A qualitative review looks at the reasons the auditor has given for each overpayment demand to determine whether you agree with the auditor's findings. A quantitative analysis looks at the methods used to calculate overpayment, particularly when extrapolation is involved.

Due to the need to produce sometimes massive amounts of documentation and to meet frequently tight deadlines, physicians often fail to exercise their appeal rights. Many physicians believe that paying the requested sum is the easiest and least time-consuming option. However, you should remember that failure to appeal, without any change in billing patterns, could result in a continual cycle of similar documentation requests and claims denials.

1. Post-Audit Qualitative Review

Before deciding whether to appeal an audit finding or to simply repay the amount demanded, it is important to analyze the audit findings to determine if you agree. For example, an overpayment may be sought on a claim because the auditor found that it was medically unnecessary. Because medical necessity is a matter of clinical judgment, this may be grounds for appeal. Similarly, an auditor may have deemed a claim to have been overpaid due to coding errors. Because nationally recognized coding principles may be subject to broad interpretation, such claim denials may also be candidates for appeal.

The main categories of demands for overpayment from both RAC and commercial insurance audits are:

1) Failure to meet medical necessity for services;
2) Incorrectly coded claims;
3) Insufficient (or no) documentation submitted; and
4) Billing for services twice (duplicate payments).

Below is a listing of some of the most common errors identified by the Recovery Auditors, which are similar to the errors commonly identified by private payers:

1) Medical necessity;
2) Status errors on facility claims (inpatient, outpatient, observation);
3) E/M during the Global Period;
4) Place of service conflicts;
5) Incident-to vs. non-incident-to errors;
6) Duplicate Billing;
7) Pharmaceutical unit billing;
8) Debridement coding; and
9) Principal diagnosis coding

2. Post-Audit Quantitative Analysis

Regardless of whether you agree with the auditor's reasoning, you should assess any repayment demand from a quantitative standpoint. First, check the math. In addition, many auditing entities utilize statistical and analytical techniques to determine potential overpayment amounts. This is particularly true when extrapolation is used. Extrapolation is a statistical technique used to estimate overpayment amounts for a universe of claims based on a sample of that universe.

3. Extrapolation

There are three major components to extrapolation: random sampling, central data point estimates, and extrapolation methodology. There are many opportunities for errors in each of these components that should be explored for possible avenues of appeal. This white paper includes some basic tests which you can use to test the validity of each of these components.

a. Statistically Valid Random Sampling

The purpose of a random sample is to allow an auditor to get an idea of what the entire universe of claims looks like. For example, any given practice can submit thousands, if not millions, of claims every year. Most physicians would benefit from a review of 100% of the claims submitted for an audit period because the claims could include under-payments as well as overpayments. However, this is impractical in most cases for both the auditor and physician practices because of the cost and time involved.

A statistically valid random sample for a medical audit is a sample where every single claim has an equal opportunity to be included within the sample. This is far more critical than most people think. A biased sample can result in a vast over-calculation of overpayment amounts when extrapolated to a larger universe. Stated differently, if a sample represents a higher average paid amount than the universe of claims, it may translate into a higher average overpayment amount than would be calculated from a true random sample. For example, in a

universe of 10,000 claims, a difference of $10.00 could result in an overestimate of $100,000.00 in the overpayment demand.

While there are specific statistical tests that can be conducted in order to determine the true statistical validity of the randomness of the sample, there are some basic tests that you can easily conduct.

One common way to test the true randomness of the sample is to compare the average paid amount per claim for the universe with the average paid amount per claim for the sample. For example, if the average paid amount per claim for the universe is $100.00 and the average paid amount for the sample is $104.00, you could be relatively comfortable that the sample was in fact random. If, however, the average paid amount per claim for the sample was $164.00, it would indicate a greater likelihood that the sample is biased.

Another way to test randomness is to compare the rank order or frequency of procedure codes in the sample to the rank order of procedure codes within the universe. For example, if a particular code shows up as number two (in rank order) in the sample, representing 30% of all the codes, yet is reported as number 40 in the universe representing 0.4% of codes, the sample may not have been random.

b. Distributions and Central Data Point Estimates

The second component of extrapolation is calculating the central point of the data, which is used to compute the amount of the overpayment per claim in the sample. In determining the central data point, the average is generally used. In medical audits, however, averages rarely measure the central data point because of the distribution of the data. Averages only apply when the data are "normally distributed" in what most people refer to as a "bell curve." In healthcare, however, data are rarely arranged in a normal distribution because most of the data are bounded by zero on the left. In other words, there are no variables less than zero because physicians don't charge less than zero for an office visit or spend less than zero seconds seeing a patient or see fewer than zero patients a day. Therefore, the average usually overestimates the center of the distribution. A better measure in these cases is the median which looks at the *location* of points within the data set rather than the *value* of the points within the data set. Simply stated, the median is the middle number in a group of numbers. This means that in medical audit cases the average overpayment estimate is usually overstated, resulting in overpayment demands higher than those that would be calculated using the median.

Consequently, in testing the validity of an overpayment demand, you should determine whether your data are normally distributed. If not, you should then determine if the amount of overpayment per claim in the sample was determined by using the average or by using the median amount of claims.

To test this, physician practices should graph the data (the amount paid per claim and the estimated overpayment amounts in the sample) in Microsoft Excel or another similar program

and see what the data distribution looks like. If it looks like a bell curve, your data are likely normally distributed and it would be appropriate to use the average in extrapolation. If the data have a long right tail, in other words more data points to the extreme right of center, it is normally better to use the median.

You should also calculate both the average (also referred to as the mean) and the median of your data. When the mean is higher than the median, it normally indicates that the data have a longer right tail, or more data points to the extreme right of center. The opposite is true when the mean is less than the median. When these differences are extreme, it is normally better to use the median in extrapolating the amount of overpayments due.

c. The Extrapolation Methodology

The third component is the extrapolation methodology itself. As previously stated, the purpose of extrapolation is to use a random sample to infer the total overpayment amount for the universe of claims. There are, however, a couple of things you can look at to see if extrapolation was fairly applied.

First, check to see whether the 90% confidence level was used. The confidence level indicates how certain the auditors are that the central data point used to calculate the overpayment amount is accurate. It is used to eliminate sample error which necessarily results from auditing just a sample as opposed to the entire universe of claims subject to the audit. The confidence level is usually expressed as a percentage between a lower and upper range. For example, if the average overpayment per claim is $100.00 with a 90% confidence value of $10.00, it would mean that the auditors are 90% confident that the true average is somewhere between $90.00 and $110.00. Because of this potential for error, most auditors use the lower bound of the range. In this example, $90.00 would be used rather than $100.00. This is standard practice for all government auditors, but it is not necessarily the case for all commercial payers. Therefore, you should verify that the 90% confidence level, rather than the actual average was used.

Second, you should make sure that claims that have a zero paid amount were eliminated from the universe. It makes no sense to include these claims in the calculation of overpayment when no initial payment was ever made.

Lastly, you should verify that any outliers were eliminated from the calculation. Outliers are data points that are either significantly higher or lower than the range of variance around the central measurement. This is normally a statistical determination. However, if you create a histogram (a graphical representation visually showing the distribution of data) or box plot, you can usually see where those outliers are located within the database.

To create a histogram in MS Excel, activate the Analysis ToolPak provided in versions 2007 and 2010. The instructions for creating a histogram in MS Excel can be found at http://support.microsoft.com/kb/214269. For box plots, you can review the article by Microsoft at http://support.microsoft.com/kb/155130.

IV. APPEALING AUDIT FINDINGS

Just because the auditor says you have made a mistake or were paid in error doesn't make it true. In fact, depending on which study you review, appeals are overturned in favor of providers in 35% to 65% of the cases. For example, if an auditor reviews 30 claims and finds 20 of those to be paid in error, an appeal would result in a reversal of those findings for anywhere between seven and 13 of those claims. This is why it is critical that you appeal every single claim where you don't agree with the auditor's findings.

A. Commercial Appeals

There can be no more frustrating process than appealing a negative determination from an insurance company. While the bigger commercial insurance carriers clearly define their appeal processes, navigating the process can be problematic. Providing a catalog of different methods and forms would be prohibitive in a document such as this. However, the following overview can be seen as "best practices" for disputing an audit determination. Your state medical society may have more information about the commercial appeals process for payers in your state and state laws governing audits and overpayment recovery.

The first issue that you need to determine is whether the audit entity in question has its own appeal process, or whether it falls under the usual appeals process of the insurance carrier. When a third party audit entity makes a negative audit determination, the results letter sent to the provider will normally detail the steps to dispute the findings. If you decide that filing an appeal is warranted, it is best to collect all pertinent information and follow the dispute steps outlined in the results letter**.**

If the insurance carrier conducts the audit and provides results on its own, the appeals process is closer to a standardized process. In most cases, the larger payers have their own appeal forms, usually available on their respective websites. If a payer's forms are not readily available on-line, you should contact the insurer directly because an insurer can delay, or even deny, any appeal that it views as being submitted outside the insurer's pre-defined parameters.

It is important to review all pertinent information related to the claim prior to the submission of the appeal. Commercial insurers may delay appeal decisions if they believe that a portion of needed information is missing. Providers should send all information with a service that provides tracking and verifies receipt. In addition, you should follow up by telephone in 15 to 20 days to verify that the appeal materials were received by the individual or department responsible for handling your appeal.

B. Recovery Auditor/Medicare Appeals

If you believe that a Recovery Auditor (RAC) contractor letter requesting overpayments is incorrect, you should take advantage of the five level Recovery Auditor appeals process. One important aspect of the Recovery Auditor appeals process is the opportunity to discuss the audit findings. Therefore, the best practice upon receiving a negative RAC determination is to

begin at the discussion level, before dollars are recouped. Forms for requesting a discussion period can be found on the website of each Recovery Auditor contractor and should be submitted within 15 days of receiving an overpayment request letter.

Requesting a discussion period in and of itself does not begin an appeal. The first level of appeal, referred to as the "redetermination," must be filed within 120 days of receiving the overpayment letter. There is, however, an important consideration regarding the timing of filing a redetermination appeal. If you file it within the first 30 days, you will not be subject to automatic recoupment. However, if you ultimately lose your appeal, you will be charged interest on the overpayment amount. Conversely, if you appeal after recoupment and eventually win the appeal, CMS will pay you interest at the rate of 10.25% (effective January 21, 2014) *every 30 days* in addition to the overturned recoupment. This emphasizes the importance of reviewing all facts regarding the case in question prior to submission of the appeal. This analysis is particularly important now because CMS has imposed a moratorium on referring appeals to Administrative Law Judges, the third level of appeal, until after the current backlog has cleared.

If you lose at the redetermination level, you may file a second level appeal, which is referred to as a "reconsideration," before a Qualified Independent Contractor (QIC). The QIC has 60 days to conduct its review. If the finding is adverse, you have 60 days to file a third level appeal to an ALJ. If the ALJ likewise upholds the overpayment finding, you have 60 days to appeal it to the Health and Human Services Appeals Board. If this body again upholds the overpayment, you have 60 days to file a fifth level appeal to a federal district court.

The table below outlines the complex RAC appeal process and timelines associated at each level.

Recovery Auditor (RAC) Timelines		
	Physician Action Deadline:	**Agency Action Deadline:**
RAC Determination	Record date notified of medical records request	
Request extension	Prior to 45 days from date notified of records request	
Comply with records	Up to 45 days	
RAC records review		Up to 60 days
Rebuttal/Review	15 days for rebuttal	
Appeal - 1st level (FI/MAC)	Within 120 days from initial RAC review Notice of Decision (but must be filed within 30 days to avoid automatic recoupment)	FI/MAC has 60 days to conduct review
Appeal - 2nd level (QIC)	Within 180 days from day of FI/MAC Notice of Review Decision	QIC has 60 days to conduct review
Appeal - 3rd level (ALJ)	Within 60 days from notice of QIC decision	ALJ has 90 days to conduct hearing. However, there is a current moratorium on submission of appeals to the ALJ.
Appeal - 4th level (DAB)	Within 60 days from notice of ALJ decision	DAB may take 90 days or more
Appeal - 5th level (US District Court)	Within 60 days from notice of DAB decision	Judicial Review may take 90 days or more

Throughout the appeals process, it is critical that you submit the necessary documents on a timely basis. The checklist below outlines the necessary components to be submitted at each Recovery Auditor appeal level, which you can use to monitor the process:

Level I Appeal - Redetermination

- ❑ Health Record
- ❑ Additional evidence documentation

- ❑ Appeal Letter
- ❑ CMS Form 20027 *(Optional if all required items are included in the appeal letter)*

Level II Appeal - Reconsideration

- ❑ Additional evidence documentation – *This is the last time to submit without having to show "good cause"*
- ❑ Appeal Letter – *(Be sure to address any new items that may have surfaced from the redetermination Contractor's denial notice)*
- ❑ CMS Form 2033*(Optional if all required items are included in the appeal letter)*

Level III – Administrative Law Judge

- ❑ Appeal Letter or Legal Brief
    - *Thorough record of circumstances surrounding the review and previous appeals (chronological record of events leading up to the request for ALJ hearing)*
    - *Include all clinical justification including specific references to the medical record documentation or additional evidence submitted*
    - *References to CMS Regulations, LCDs, NCDs, Screening Criteria, etc.*
    - *Any additional supportive legal arguments related to the case*
- ❑ CMS Form 2034a-b *(Optional if all required items are included in the appeal letter/brief)*

V. FINAL TIPS

While the size of your organization goes a long way in determining the response to an audit request, there are several steps that can be taken when receiving a documentation request that can ensure complete and timely response.

- Designate someone trusted within your organization to handle all correspondence. This person should receive training on visual recognition of audit correspondence from as many commercial insurance and CMS-approved review entities as is possible.
- You should pay particular attention to the date on the letter since there can be wide divergence between this date and the postmark on the envelope containing the letter.
- Be aware of time limits that must be followed by the audit entity. If it is a private payer audit, determine if there is a specific time frame in your provider contract or state law beyond which the payer may not seek repayment. (Be aware, however, that most provider contracts and state laws have exceptions for the suspicion of fraud and for self-funded plans.) If it is a Recovery Auditor (RAC) audit, remember that RAC contractors can only go back three years from the

date of payment of the original claim. If you establish that the date on a Recovery Auditor letter falls more than three years after the payment, the request for documentation may not be valid.

- Be certain to verify that all of the information regarding the provider (NPI, billing address, etc.) included in the correspondence is correct. Any irregularities in these areas should be reported to the requesting audit entity immediately. All correspondence should be promptly stamped with the date of receipt.

- Establish a contact at the offices of the requesting entity. This person would become the main conduit for all information related to the specific audit in question.

- Date and page-stamp all correspondence and either copy or scan all correspondence and documentation prior to submission to the requesting entity. This is to ensure that there is a direct match between the documentation submitted and the documentation audited. This could become important in the appeals process. Be sure to send all documentation with a service which provides tracking and verifies receipt.

- Any irregularities, for example exceeding the time allowed for an audit or making improper requests, should be reported to the designated oversight agency upon discovery as audit entities with patterns of poor performance may be replaced at CMS' discretion.

VI. CONCLUSION

With increased concern over the cost of healthcare and with the wide availability of physician data, physicians must expect and prepare for claims' audits and reviews. As discussed in this White Paper, you can mitigate your risk of being subject to an audit by ensuring that your coding is appropriate and that your documentation supports your coding. In addition, you can assess your risk of an audit by comparing your utilization of codes with your peers and by examining your use of codes identified as widely billed in error by the CERT report. These analyses should be done as objectively as possible so that you fully appreciate your risk of an audit.

If you are audited, you should ensure that the audit is as accurate and fair as possible by:

- providing complete records;

- determining that the timeframe and records requested by the audit are done in accordance with applicable law;

- verifying the accuracy of any audit findings from both a qualitative and quantitative standpoint; and

- appealing adverse findings that you believe are erroneous.

Although medical audits and reviews can challenge and burden physician practices, they should be considered standard in the business operation of physician practices as federal and state governments and private payers all search for ways to control health care spending. The information and tools provided in this White Paper were designed to assist physicians and their staffs in anticipating, preparing for, and responding to medical audits as effectively as possible so that you can continue to devote your maximum time and attention to patient care.

Notice: The information provided in this White Paper constitutes general commentary on the issues discussed herein and is not intended to provide legal advice on any specific matter. This

White Paper should not be considered legal advice and receipt of it does not create an attorney-client relationship.