Attorney-Consultant Collaboration in Healthcare Provider Documentation Audits

If there are two things healthcare providers dislike, it is increased risk and spending money.

When a situation arises for a provider to appeal a medical claim, they may want to take the opportunity to make their case on their own to avoid additional costs. But, providers are often not equipped to develop the most compelling case on their own. Savvy providers turn to attorneys. Attorneys often need to persuade providers to allocate the funds required to engage a consultant for additional expertise. Hiring consultants for an appeal may not always be an easy sell, but experience continues to prove that it is usually money well spent. Attorneys need to be skilled at justifying how a consultant's involvement can significantly improve the outcomes when audits occur.

There are many factors for Attorneys to consider when engaging additional resources for medical claims appeals. Appeal situations can range from several claims denied by a payer, up to many claims involved in an audit conducted by a Unified Program Integrity Contractor (UPIC.) Providers need to understand that an attorney led team's assistance with a simple claims denial may cost several thousand dollars, but a government audit could result in hundreds of thousands (or even millions of dollars) in overpayments owed.

Many healthcare providers don't realize they have a problem until a UPIC starts requesting medical charts, or perhaps they understand the seriousness of the situation after receiving the dreaded "Demand Letter" with audit results and an overpayment amount. It is at this moment when most healthcare providers engage a healthcare attorney. In turn, attorneys usually receive assistance from expert auditing teams that review the medical charts. This process is performed to identify coding and documentation opportunities to support an appeal. The audit process is completed by way of a thorough, expert review of each CPT or DRG code to verify if the documentation supports the code submitted and paid.

Any denial reversal, even a single code, can have a significant impact on the overall overpayment amount the healthcare provider is responsible to return. For example, if a UPIC contractor audited 100 randomly selected claims from a predetermined set of claims (the "claims universe") and the audit results showed a total $2,500 in overpayments, the UPIC would extrapolate the overpayment amount across the claims universe to determine a payback amount. In this example, $2,500 divided by 100 would result in a $25.00 per claim average. The next calculation is based on how many claims are in the original claim universe. If there were 10,000 claims, multiplying $25.00 times 10,000 would result in a mean point estimate of $250,000. The statistical software also calculates with a 90% Confidence Level (in this case $225,000) which is often used as the final amount owed by the provider. This is further compounded by a look back period, usually 6 years. So, depending on the size of the health care provider, it is easy to see how a relatively small payback amount could quickly balloon to a $1m plus issue!

So, how should a provider, with the assistance of their legal counsel, appropriately address an audit such as this?

Upon receipt of the UPIC audit notification, carefully review the scope of the audit, including the number of claims under review, the time period involved, and the specific issues or codes being targeted. This will help to understand the potential risks and exposures. This is also the time to engage a multidisciplinary team that includes legal counsel, compliance officers, coding and billing experts, and possibly medical professionals. This team will coordinate the response and ensure all relevant documentation is gathered and analyzed.

With the team in place, it is time to conduct an internal audit of the claims and documentation under scrutiny. This should include a thorough review of the medical necessity, coding accuracy, and compliance with CMS guidelines for each claim. Place close attention to potential weaknesses or inconsistencies in the documentation, such as incomplete records, coding errors, or issues with medical necessity justification; address these proactively before submission. If errors or deficiencies are identified, the client should develop a corrective action plan to rectify these issues. This plan may also include steps to enhance future compliance and prevent similar issues from occurring.

Once consultants have a thorough understanding of what appears in the documentation, attorneys and consultants collaborate in the development of a response strategy. One common tactic is to challenge the extrapolation methodology employed by the MAC. If the UPIC audit includes an extrapolated overpayment calculation, start with the statistical sampling and statistical methods used. Argue that the sample size was too small, unrepresentative, or not in line with CMS's guidelines, which could invalidate the extrapolation. You can further this argument by creating a robust defense based on the completeness and accuracy of the documentation. Highlight where the

documentation supports the medical necessity and coding accuracy of the claims. Use CMS guidelines, medical literature, and expert testimony to bolster the argument. Break out those case law texts and provide examples of previous audit outcomes, or CMS rulings that support the legitimacy of the billing practices in question. This can help frame the audit findings within a broader legal context that may be more favorable to the provider.

Communicating with the auditors, if possible, can prove helpful in understanding their specific concerns. Take this opportunity to clarify any ambiguities in the audit notice and negotiate timelines for document submission. If the initial documentation review identifies additional relevant materials (e.g., physician notes, lab reports) that were not originally submitted, prepare and submit this supplemental documentation with a legal cover letter that explains how it supports the claims.

After the initial audit findings are issued, attorneys should oversee preparation of a detailed rebuttal that addresses each finding. This should include legal arguments, expert opinions, and any newly discovered documentation that was not initially considered. If the UPIC issues an adverse determination, prepare to appeal the findings. The appeal should be grounded in the arguments developed during the audit response phase and include any new evidence or expert testimony.

Often, the appeal process will go through at least the Redetermination and Reconsideration level, followed by the Administrative Judge (ALJ) hearing level. Appeal strategies may be based on several factors including documentation, coding, medical necessity, the extrapolation process, and the Centers for Medicare and Medicaid Services (CMS) guideline interpretation. Having an experienced healthcare attorney who is familiar with the appeal process is crucial. Attorneys will have ongoing relationships with professional coders, auditors, statisticians, and physicians to provide expert analysis and provide expert testimony, when appropriate.

Regardless of the outcome, the provider should implement any necessary corrective actions to address the audit findings. This could involve retraining staff, updating documentation protocols, or revising billing practices. Smart providers will use the audit experience to improve the provider's overall compliance program. This may include more frequent internal audits, enhanced documentation practices, or additional training for staff.

While it may not be a popular option, there is great value in continuing to monitor the provider’s billing and documentation practices to ensure ongoing compliance. Yes, this comes at a cost. But it is likely cheaper than completing additional audit processes.

As they say, "an ounce of prevention is worth a pound of cure."

As important as it is for a healthcare provider to know when to bring in professional help, it is more important for them to know the best way to prevent an audit from occurring in the first place. As part of their comprehensive compliance plan, providers should develop detailed plans-of-action that addresses how to handle document requests from a payer - and especially from a government contractor. Additional document requests (ADR) are likely a routine part of the revenue cycle process, however, they can also be a predictor of things to come. Providers should regularly review and evaluate ADRs to see if there is a common theme or pattern and rectify any documentation deficiencies immediately. During this process, providers should review all claim denials, review the pattern of feedback being received and use those findings to drive improvements to their internal processes and procedures.

Each year, many healthcare providers find themselves involved in a Target Probe and Educate (TPE) audit. For a TPE, the Medicare Administrative Contractor (MAC) will request medical records for 20-40 claims. If there are any claims denied, the provider will be invited to a one-on-one education session. After 45 days there will be another round of audits to determine if there is improvement and if additional one-on-one education if needed. A provider that fails to improve after three rounds of TPE will be referred to CMS for next steps, which could include a 100 percent prepay review, extrapolation, referral to a Recovery Auditor, or other actions.

Providers need to take the TPE process very seriously. MACs use complex data analysis to identify providers for the TPE program. Providers and suppliers who have high claim error rates, unusual billing practices, or who often identify items and services that have high national error rates that are a financial risk to Medicare can expect additional scrutiny. If a provider passes the second or even third round of a TPE, it may seem like an opportune moment to breathe a sigh of relief. While this means that CMS will not review charts for the same reason for at least one year, it does not mean that the provider is safe from additional scrutiny for other concerns.

Depending on the type of claim errors found, CMS might engage in a look back audit and a voluntary self-disclosure repayment. Common lookback periods are 6 years or a specified date range if the claims errors could be tied to a guideline modification, certain code or even individual provider. CMS has other types of audits in their arsenal as well. These include the SNF 5-Claim Probe and Educate (SPE) audits that target Skilled Nursing Facilities (SNF), Review Choice Demonstration (RCD) audits for Inpatient Rehabilitation Facilities (IRF), and other probe audits that are mapped out in the OIG Workplan.

Any type of document request has the potential to snowball into additional document requests that result in a government audit or investigation. The last thing any provider wants is to enter into a Corporate Integrity Agreement (CIA) because of a preventable situation. All document requests outside of a routine ADR should be analyzed for potential ramifications and reviewed prior to submission to confirm that all relevant documentation is included.

The bottom line is healthcare providers always need to be on the top of their game – and ready to engage with outside resources when situations arrive. A compliance plan needs to include internal controls, procedures, and policies to ensure proper coding and billing is taking place, along with a robust auditing and monitoring component. Periodic internal probe audits can detect problems in advance that can be mitigated before a TPE, UPIC or other type of audit even starts.

The best place to start this process is with a qualified, knowledgeable healthcare attorney, who can guide providers throughout the entire process – and prevent additional costs along the way.

About LW Consulting, Inc.

For nearly two decades, LWCI has delivered operational and compliance improvements to acute, post-acute, and sub-acute providers and government entities involved in healthcare. This expertise is also applied to compliance actions and legal proceedings, with a specialty in serving as an independent review organization (IRO).

As part of our practice, LWCI offers interim staffing, executive placement, and compensation review services for healthcare organizations, with positions across all levels of the business. Harnessing the power of data, coupled with our real-world, provider-side experience in senior living, our consultants are poised to assist your organization in a variety of ways.

Do you or your client require expert assistance with how to properly execute documentation audits? LW Consulting, Inc. can help! Our experienced team can guide you through the audit and/ or medical claim appeal process. Learn more on our website at www.lw-consult.com.

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