Payer Requested Audit Protocol

Initial Request for Records:

The initial request for records should be reviewed carefully to identify the type of review, what information is being requested and the timeframe involved for record return. A clear process for notification of appropriate personnel should be outlined internally or in a compliance plan.

If for any reason, the office cannot comply with the provision of records within the time frame allowed, immediately communicate with the carrier.

The carrier acts on the basis of information submitted in response to the carrier request for documentation and care must be taken to insure sufficient documentation is provided to support each service.

Prior to sending a letter of response, consider action based on the following items.

1. Date stamp everything and retain envelopes with postmark.

2. Consider seeking input sources such as the IMA, legal counsel, consultants, specialty societies.

3. Keep notes of all conversations; put the notes in writing. Consider sending notes to the carrier to verify what you believe you were told was the carrier's intent.

4. Print a copy of the patient's bill that shows all services billed for a specific date or for a date span. Be sure to send documentation for all services billed within the timeframe specified by the carrier. If there are multiple services and the documentation request is general, request the carrier to be specific. DO NOT ASSUME YOU KNOW what the carrier wants.

5. Prior to sending the requested information, determine if any elements will not be met, e.g. signature on file. **Implement corrective action as needed**.

6. Retain a copy of all correspondence received and SENT to Medicare. This includes all of the medical record documents sent by the office to the carrier. Know what information is sent to Medicare and how the documentation supports the codes billed.

7. Failure to meet signature on file requirements is one of the most common Medicare electronic media claims (EMC) audit findings. What process is in place to insure this requirement is met?

8. Establish a process to follow up and obtain a response when records are requested. Do not assume "no news" is "good news."

Carrier Response:

1. Date stamp everything and retain envelopes with postmark.

2. Keep notes of all conversations; put the notes in writing. Consider sending your notes to the carrier for verification as to the verbal discussion.

3. <u>Request all decisions and instructions from the carrier be made in writing.</u> Request carrier provide published information which supports carrier determination. Accept no verbal understandings.

4. Establish a process to follow up and obtain a response when records are requested. Do not assume "no news" is "good news."

5. Review response letter from carrier carefully.
   A. Identify if physician will be audited again.
   B. Identify if carrier indicates you received prior notices of adverse findings, e.g. previous EMC audit. Do you have these notices?
   C. C. If you are told that you attended a seminar and the issue was discussed, ask for copies of the hardcopy information provided and/or a transcript of the meeting. Carriers retain seminar rosters of attendees.
   D. Identify if physician is on pre-pay edits.
   E. Verify actual and potential overpayment amount. The IMA can do this or furnish the formula.
   F. Were some claims assigned and some non-assigned? Relates to WoL (ABN) and calculation of overpayments.
   G. If there is an ABN, was the modifier appended? Send the ABN.
   H. Always verify if the date of service was prior to any carrier notice used to substantiate adverse action.

6. Request directly from the carrier (may have to be done under a FOI request.):
   A. Copy of any previous notice of problems identified in 5.B. What is the relationship of the notice date to dates of service?
   B. Individual waiver of liability (WoL) decisions for each item considered not medically necessary
      and
   C. Documentation supporting carrier WoL decisions.
   D. Copies of audit worksheets. Services after May 1998 should be audited using <u>both</u> the 1994/95 and 1997 worksheets.
   E. Copies of any citations, i.e. CAR3, 2070.4 (e.) (1.), used by the carrier.
   F. What specialty is the audited physician listed as in the carrier system? Is this correct or is another specialty more appropriate? If carrier listed specialty not accurate, request specialty listing and request comparison with the more appropriate specialty.

7. Review findings and make any determinations of **carrier error** based on what was sent to carrier.

8. If the carrier made an error, e.g., keyed code wrong, request the service be pulled from sample. Watch for carrier keying errors on DX, CPT, number of services and audit sheet. Rely heavily on the information from the CPT and the AMA's *CPT Assistant* to verify information pertaining to history.

9. If medical decisions are not supported by a published policy that was **in place at the time of service**, what protocol was followed by the auditor and was a medical specialist consulted?

11. If discussions reveal carrier agrees to change an audit finding, request new calculation of overpayment. When letter is received, check for timeframes and verify new findings reflect changed carrier decision.

12. Does the carrier letter state physician will be re-audited? What is the timeframe?

13. When overpayments are refunded, patient accounts need to be zeroed out which means private payments or secondary payments have to be refunded as well.

14. If there is an adverse finding, assume you will be audited again. Keep in mind that whenever the physician agrees with the carrier or agrees by virtue of NOT RESPONDING, future findings similar in nature could be construed as fraud and civil and criminal penalties applied.

15. Consider a compliance plan or implement some process to insure the problem does not reoccur. A prepay prospective audit may serve this purpose. Any audit should be followed by retrospective audit as well to insure compliance once prospective audit has been discontinued.

16. Determine if the potential overpayment is based on “charges” or “allowed.” This answer will affect par physicians who have one fee schedule and par and non-par claims for non-covered services.

17. Is there to be subsequent audit? How soon will this take place? A physician can be under pre-pay audit for the findings of the initial audit, can be appealing the initial audit and be requested to submit records under a subsequent audit all at the same time. Maintaining timelines for each situation is critical.

18. If audited physician has been placed on pre-pay edits, what timeframe does carrier have to review claims prior to payments? What notice does physician receive on any adverse pre-pay decision? If documentation supports pre-pay codes, what is carrier discretion in removing edit, e.g., how long will edit be in place once documentation indicates services clearly supported by documentation?

19. Become familiar with the appeals process. Request information from the carrier or the IMA. IMA staff is ready to assist you.