Your practice checklist: Trends in payor audits and disputes
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Physician practices are often no strangers to government and commercial payor audits. In this episode of AMA Thriving in Private Practice, a discussion on trends in both Medicare reimbursement audits and commercial payor audits, as well as strategies for audit response, understanding the impact of audits and ways to minimize the burden of responding to an audit request.

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Transcript

**Vargo:** Hello and welcome to AMA Thriving in Private Practice, a ten-episode series exploring the unique needs of physicians in private practice settings. In our show, we'll talk about efficiency solutions and how to transition into the world of private practice. We will also focus on other tips and tools to free up time so you can focus on your patients. I'm your host, Carol Vargo, director of physician practice sustainability at the American Medical Association. Today we're going to discuss trends in payer audits and disputes. No one wants to contemplate an audit of their practice. Audits can
be time-consuming, administratively costly and can potentially result in monetary penalties. However, there are best practices one can take to minimize the chance of an audit or to minimize the administrative burden associated with an audit.

Before we start, I want to emphasize that this episode is for general informational purposes and should not be relied on as medical, legal or other professional advice. Listeners as always are encouraged to consult a professional advisor for any such advice. With me to unpack this complicated topic is Dr. Kathy Blake, a senior advisor at the AMA and a former private practice physician herself. Kathy, it's great to see you. Welcome. How are you doing today?

Dr. Blake: Well, thank you, Carol.

Vargo: Great. Let's get started and dive right in. So to start us off, could you please set the stage for our listeners by sharing your experience in private practice and how this topic may have affected you personally?

Dr. Blake: So, Carol, this is a topic I'll first say that probably most of our listeners wish that they didn't need to know anything about it and I certainly fell into that same camp. But I was managing partner of a large statewide practice of cardiologists, cardiac surgeons, vascular surgeons, with a number of mid-level clinicians and other staff. We had offices all over the state of New Mexico, I think many people know that's where I practice. So one of our offices received a letter from an auditing firm that had been contracted with CMS, which was a request for very, very detailed records—some in the office, others at the hospital, others at referring physician practices and was asked to provide those as part of a review in terms of perhaps overpayment.

The way that it affected us personally and we'll go through the different steps that are involved, is that the first reaction is oftentimes the reaction of your staff. And they read it, it's unfamiliar, they are somewhat frightened by it, so it's human nature they set it aside. And part of what we'll talk about shortly is how important it is that your first response be comprehensive, that it truly answers all of the questions and that it be on time. So I think my mission for this and for other discussions about audits is that people do the best job possible from the beginning. We didn't and it was something that then turned out to be a much larger burden and worry than it needed to be.

Vargo: That is very helpful background because I think it really has informed the approach that we have been trying to take here at the AMA, which is to take potentially an overwhelming situation and demystify it a bit, and provide some stepwise opportunities so it doesn't become an overwhelming challenge to the practice. So why don't we dig in a little bit in terms of some of these stepwise just audit 101 type issues?

Dr. Blake: Sure.
Vargo: So let's start at a high level. Can you tell our listeners about the different types of audits and their key characteristics?

Dr. Blake: Sure. So I think an easy way to separate the types of audits, though they have some features in common, is to first think about the types of audits that will be done by CMS, the Center for Medicare and Medicaid Services. Their approach has evolved over the years; they now have what is called a targeted probe and educate approach, and this is where the local Medicare contractors actually work with you. But the work with you is very time and labor-intensive because they’ve identified for reasons that hopefully they will share with you that there may have been some errors made in billing or in documentation. So they will ask you to provide a lot of documents, there will be multiple rounds of review of documents, education and it's important to take this really seriously because what’s on the line is that you may go into a program that extends for a long period of time of having to provide much more information than any of your peers in your community and that can be costly. And it may be that in the course of that activity, the evaluation itself gets ... or the probe is expanded to other areas, so take those seriously.

The second category is commercial payer audits. These can be audits that they will perform as part of routine business, usually, these are allowed in the contracts you've signed with them. One of the challenges is that the rules, the terms of the engagement, including with the audit, can vary greatly from one payer to the next, especially if the contract you have is quite old. Prepay audits are those where the payer, the insurance company, the plan, they'll ask you for a lot of documentation beforehand before they pay you. A post-payment audit is that they will ask for more documentation and you should be prepared that at some point they will ask you to return money that they have already paid to you. So in both instances, really important to have your processes and procedures set up so that you can literally respond right away to any such request.

Vargo: So let's talk a bit about potentially prevention, so you're not actually triggering an audit in the first place. Are there specific activities based on your experience, whether they be unintentional or intentional besides obviously fraudulent billing, of course, that would trigger an audit? And are there any best practices that can minimize the chance of that occurring?

Dr. Blake: Sure. So I have to say as an overarching recommendation, that physicians running their own practices should assume that at some point they will be audited. If you make that assumption, then the things you need to do to be ready and responsive get put in place. And that has to do with such things as training of your staff—and that means anybody who touches the mail, opens it, reads it, anybody who looks at an explanation of benefits, someone who looks at a payment statement. So that they notice when something doesn't look right, when more information is being requested or when repayment is being demanded, things like that.

The second has to do with realizing this is not just about the people in your coding and billing department, this is about the people who are billing, meaning the doctors, the advanced practice...
professionals. So there has to be training for them in terms of how to properly code and bill, especially as some of, we know, the evaluation management guidelines have changed as recently as a year ago. And the other is again a mindset of saying, "Because I expect to be audited, I want my peers in my practice or in my billing and coding department to spot check my claims, spot check my documentation, so that if there is a need for improvement that gets done before questions are raised by external payers." And then the other part is just good practice management, which is know where your contracts are and know what the terms they and conditions are, and know therefore what you might need to be set up for to be responsive to a request for records.

Vargo: Those are all great tips and wonderful points. So let's start at the beginning then. If and when a physician is notified that their practice is being audited, what is the first thing they should do?

Dr. Blake: So the first thing is they should take a deep breath and then once they've done that, they need to tell other people. By other people, I mean, it might be the managing physician in the practice, it could also be the chief operating officer or the person who manages your staff, someone in billing and coding. And then the third is to then very deliberately go back over the letter or the request and understand exactly what's needed and by when, so that you can start to lay out with the others that I mentioned what the response will be. And then also find out whether there are other physicians in the practice who have received similar letters. Is this targeted just at you or is it something more general? So those would be the initial steps.

Then what typically happens is that you then contact a member of what I used to call our kitchen cabinet. In our case, this was our attorney who specialized in health care practices, who then connected us to someone who specialized in this kind of work.

And you might say, "Well, do I have to do that right away? Can't I just respond on my own, bring them in later?" And I would really discourage that because you want a more neutral set of eyes looking at your response, holding you responsible for being on time and making sure that everything you send is needed to make the response no more, no less and that you put your best foot forward. So talk to the managers, both physician and operational and talk to the attorneys. And find out, have other physicians in the practice received similar letters or are you the only one?

Vargo: So those are great first steps, and then you are now in the process, hopefully potentially working with a legal expert or a legal counsel. Based on your experience, what are some of the payer audit tactics physicians need to be aware of or look for during the process?

Dr. Blake: So one tactic and it goes back to the contracts is depending on the age of the contract but if it's an older one, they may not be adhering necessarily to, shall we say, the process that was outlined in the contract and may be acting in a much more speedy fashion to come to a resolution, whereas you may have more time. The second also has to do with time. They may say to you, "You have 10 working days," for example, "to compile all of these records." Some of which may come from
your office but you may need to get hospital records, records from other physicians that explain why they asked you to see a patient. So if you think you're going to be constrained by that timeframe, reach out soon and ask for an extension while at the same time you're expressing your commitment to being responsive.

The other thing that can happen and it's especially a challenge, is that they may not pay you for any of your claims during the time that the audit's being conducted. And so, you may have a cash flow problem and you want to be able to discuss that and determine, again, with counsel, are you entitled to receive payment for all uncontested claims or claims that don't fit into that particular category that they've raised questions about? You want to find out, does it affect just one physician or one office if it's a multi-site practice or does it affect all of them? So it is to be responsive, but firm, and to be acting in a way where you don't show anger but you show that you are truly focused on this.

**Vargo:** That cash flow point is really important and one that perhaps people don't think about, because I think about in an audit situation, I can only imagine that this could go on for months, years. What's your experience with how long an audit could take?

**Dr. Blake:** It can take exactly that range of time that you've mentioned, Carol, so that's why it's so important to confine the scope of the audit, get it confined if at all possible. And secondly, to have an agreement, if necessary, for what we might call partial payment as opposed to withholding of all payments and it may involve really looking at your time equals money kind of equation. And yes, we would all love to not have to pay back money or to be penalized in any way but that in and of itself, the aiming for the perfect result, is I'd say a questionable approach unless you have very deep pockets. So what we looked at was how much were we spending on the various professional experts that we needed, one was an attorney, the other was a coding person. That went into our budget, it was an unbudgeted expense.

Then we looked at what income was being withheld or was in jeopardy, and that had to go in as a potential liability. And then our goal was to make the settlement amount as small as possible so that we could get back to business what you might call as normal as possible. So this is about documentation, it may have nothing to do with the quality of the care that you deliver. Now, can you describe your thought process? Absolutely. If you think something was missing, it can go in a letter but that trade-off of how much of your resources are you willing to commit to getting to that perfect result, I think that's the conversation you have with your attorney right from the beginning.

**Vargo:** That's I think sort of that practical experience that is really helpful, I think, to our listeners and that leads into a question I wanted to ask about appeals. I mean, obviously, in the Medicare program, the AMA has worked to ensure that there are ample appeals processes. What are your thoughts about that in terms of, have you gone through the appeal process or does it go back to what you were just saying in terms of understanding how important it is to really figure out how much time, energy and resources you have to devote to an audit?
Dr. Blake: Yeah, so we've actually done both. I should say that one of the audits that I was very involved in was not an audit of our practice but of the hospital where we performed most of our procedures. So there can be some joint decision-making about how far you will go and how deeply you'll get involved but the sort of stick that CMS, as well as commercial payers, can hold over your head is that you may be terminated from participation in the program. And that can really shutter your practice, turn off the lights, lock the doors and you're not able to practice anymore. So our goal with the practice audit for the outlying office that we had was to be sure that the auditors knew and we were interviewed by them almost like a deposition. They knew exactly our analysis of why, in that case, it was that the doctor's billings suddenly went up. Why was that?

In their community, they had had five cardiologists, it dropped down to two. So, our cardiologist and the other person practicing were swamped. We were able to show what time our physician started work, 5:00 in the morning. What time was his last dictation sign-off? Typically, about 11 o'clock at night. It was important to us to be able to say, essentially, you have somebody who's working the job of probably two people. And the other piece that we worked to resolve was that we have in our state, a form of licensure, a clinical nurse specialist. That individual's billings were all audited. And we realized pretty quickly that the auditor had not dealt with that category before, so again, we took that chunk of work and we got it off the table.

Then you have to say, "Are there any cases here? Let's just be frank, are there any cases here that we don't think can be defended?" And if there are, we acknowledge that and get those off the table, there will be payment made. And then you have to decide how much is left and how hard you are going to fight, and will you go to an administrative law judge? I have fellow cardiologists who've done that, they've won but they have generally been physicians who've worked at very large institutions with deep pockets to be able to pay for this. With the hospital audit, the physicians were not being audited but what we realized was that because we were the people caring for those patients, that we weren't going to leave the hospital on its own, and in fact, they needed us to walk through all the cases. And with that, we were able significantly to change, again, the scope, the number of cases that needed repayment and the cases that were absolutely fine.

Vargo: So as I listen to you speak, again, it emphasizes for me the two takeaways that you've been leaving with us, really is first that piece of documentation. Because when I think about how now there are all these tools that could trigger an audit which may in fact be, let's say, AI involved and they're just looking for certain things, the fact that you made about having documentation at your hands to show, for example, that yes, this physician billing and working from 5:00 A.M. to 11:00 P.M. may look like an outlier but there was a legitimate reason and it was all documented, so I think that's very important. And then the next high-level takeaway I'm getting from this conversation is this need to have a strategy in place ready to go when this does happen because it more likely than not is going to happen. So talk a little bit about the AMA resources that I know that we've worked on together with others to really help physician practices have that strategy in place.
Dr. Blake: So AMA has produced a checklist and it describes a number of the steps that we’ve talked about here. That should be part of the orientation or continuing education of every person in your practice so that they can review it, ask questions and literally assign names and know who to go to in each of the circumstances that we talk about, that this is not something that anybody should go through by themselves.

Vargo: Right, I think it’s great that the AMA have been able to put these resources forward for practices, and as usual with all of our resources, they are free and open to anybody. So I would underscore Kathy’s point that please avail yourselves of them at the AMA website when I’ll give you the information about that in our close. But before I go to the close, I do want to ask you, Kathy, just given obviously your level of experience and also what I think we all appreciate, which is your real care and compassion for physician practices and wanting them to succeed and certainly getting through this audit process. Is there anything else that you want to share with our listeners and think that they might need to know in closing?

Dr. Blake: A couple of things. First of all, don’t be embarrassed and don’t be embarrassed to talk to other people all and to find out who else in the practice might have received a letter or to talk to your attorney. There is no shame in being asked to provide these kinds of records. Secondly, and I should have mentioned this almost from the get-go, do not alter the records. That is absolutely prohibited. And just as if you were in a medical liability case, your credibility will be questioned if there is alteration of records, so resist and know that you have through a letter, a cover letter, what have you, a way of communicating additional information.

Then thirdly, it’s something where as a physician practice, what you want is to be able to get back to normal. And normal may look different, you may have changed your documentation and that’s okay, but it is something where I would almost hesitate, but this is a bit the cost of doing business. So you want to keep that cost as low as possible in terms of your psychological stress, the time you spend, the money you spend and the time that you’re away from your patients and from your families.

Vargo: Thank you so much, Kathy. Really this has been, I think, taking this potentially off-putting conversation around audits and really making it practical and helpful for our audience, so we really appreciate that. As always, it’s a pleasure to speak with you.

Dr. Blake: Thank you, Carol. I think our audience can probably tell how much we care. You and I, and the AMA care about physicians navigating this kind of situation.

Vargo: Absolutely. The AMA has developed, as Kathy mentioned, a payer audit checklist. It’s intended to help practices respond effectively to payer record requests while minimizing the administrative burden associated with responding to those requests. For the checklist and other resources and tools in support of your private practice, visit [the AMA website]. I’m Carol Vargo, and until next time, this has been Thriving in Private Practice. Thank you so much for listening today.