Medicare Reimbursement Audit Checklist

A Practical Guidance® Checklist by Stephen Bittinger, Jess Franzese, Joan Gilhooly, and Brittany Latour, K&L Gates LLP

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This checklist assists providers and suppliers, and their representatives, understand the primary types of Medicare reimbursement audits. It provides a high-level roadmap for successfully navigating the audit process. Although this checklist is not exhaustive, it provides fundamentals that are useful across the full spectrum of government and commercial payor audits.

For more information on Medicare generally, including the general framework of the Medicare program, reimbursement, and appeals, see Medicare Fundamentals, Medicare Reimbursement, and Medicare Reimbursement Appeals.

Types of Medicare Audits

Medicare reimbursement audits vary greatly in terms of the timing, triggering event, types of claims reviewed, contracted entity conducting the review, and the level of legal risk. Procedurally, Medicare reimbursement audits can be grouped into two categories: prepayment reviews and post-payment reviews. Reviews are either error-based (i.e., they focus solely on recovery of improperly paid funds), or they are integrity-based (i.e., they focus on investigating fraud, waste, and/or abuse).

- **Prepayment Reviews.** These consist of reviews of claims and the supporting medical records prior to claims being adjudicated (paid or denied). Prepayment reviews can occur with both error-based and integrity-based audits.
  - **Service specific prepayment reviews.** These are typically conducted when the Medicare program or the Medicare Administrative Contractor (MAC) has identified a trend or concern within the claims data. This type of audit often looks at specific medical service and procedure codes (e.g., Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis Related Group (DRG) codes) or a set of codes across multiple providers or suppliers.
  - **Provider/supplier specific prepayment reviews.** These are typically based on errors that an organization has made in the past, which the Medicare program or the MAC wants to ensure are supported in the documentation and are payable before they send the claim for adjudication.
- **Post-payment Reviews.** These consist of reviews of claims and the supporting medical records after claims have been adjudicated and paid by Medicare. The look-back period varies based on the type of audit being conducted. The following examples are the primary types of Medicare audits:
  - **Comprehensive Error Rate Testing (CERT) program audits.** These are used to measure improper payments within the Medicare Fee-for-Service (FFS) program (also referred to as "original Medicare"). These are audits of the Medicare contractor, although provider/supplier documentation is needed to determine whether the claim was properly paid under Medicare coverage, coding, and payment rules. Claims are selected through random sampling and the supporting

medical records are reviewed. The combined results allow for national improper payment rates to be calculated. CERT audits are error-based, but they can trigger audits focused on the provider or supplier. The Centers for Medicare & Medicaid Service (CMS) provides more information regarding CERT, including audit backgrounds, provider information, and reporting, on its website here.

- **Targeted Probe and Educate (TPE) audits.** These are used for providers or suppliers with unusual billing practices or an abnormally high denial rate (i.e., outliers). The audit is designed to identify errors and assist the provider or supplier in correcting them. If you are selected for a TPE audit, your local MAC will review 20 to 40 of the Medicare provider's or supplier's claims, as well as the supporting medical record documentation. If you are compliant, you will not undergo additional review for at least one year. If the MAC identifies any errors upon review, the Medicare provider will have 45 days to correct the deficiencies. You may also be required to participate in a one-on-one education session hosted by the MAC. TPE audits are performed for up to three rounds. If the provider or supplier fails to improve after three education sessions, they will be referred to CMS for further review or other actions, including up to exclusion from Medicare. TPE audits are error-based but can trigger integrity-based audits. See the CMS website here for additional TPE provider/supplier information.
- **Recovery Audit Contractor (RAC) audits.** These are utilized to detect and correct improper payments to allow the Medicare program or the MAC to implement corrective actions to prevent improper payments from happening in the future. These are topic-specific audits. The RAC contractors must first obtain approval for each topic or service type they will be reviewing. While these audits typically cover claims paid within the past 12 months, the RAC may request records up to four years after the date of payment, upon showing good cause for reopening the claim. RAC audits are error-based but can trigger integrity-based audits. See the CMS website here for more information and topics on the Medicare FFS RAC program.
- **Unified Program Integrity Contractor (UPIC) audits.** These are integrity-based audits utilized to investigate suspected fraud, waste, and/or abuse. If the record request includes 30 or more claims, usually over a broad range of service dates, this typically signifies that the UPIC has selected a statistically valid sample as a means for review. Accordingly, the UPIC will extrapolate the results of the audit across the entire universe of claims that existed during the selected dates of service. UPIC audits can also result in payment suspensions and referral of matters to law enforcement. For a UPIC example, including a discussion of its audit functions, see Noridian Healthcare Solutions.
- **Health and Human Services Office of Inspector General (HHS-OIG) audits.** These are integrity-based audits used to investigate fraud, waste, and/or abuse and often result in a referral to the Department of Justice (DOJ). For an analysis of a recent HHS-OIG audit, see this data brief.
  - **Office of Audit Services (OAS).** It oversees nonfederal audit activity and HHS's annual financial audits and provides assistance in criminal, civil, and administrative investigations. See The Office of Audit Services.
  - **Office of Evaluation and Inspections (OEI).** It conducts national reviews to form a broad, issue-based perspective. Their purpose is to prevent fraud, waste, and/or abuse while improving efficiency and effectiveness of HHS programs. See The Office of Evaluation and Inspections.

Know When to Seek Assistance

When an audit request is received, your first step should be to determine whether you can handle the request on your own, or if you will need to seek outside assistance from an appropriately qualified expert or legal counsel.

- Typically, you can respond to service specific prepayment reviews, CERT audits, and first round TPE audits on your own.
- You should engage a reimbursement expert to assist with provider/supplier specific prepayment reviews, secondary (or tertiary) rounds of TPE audits, and RAC audits.
- You should consider engaging an attorney who has healthcare reimbursement expertise to assist with responding to OIG audits, UPIC audits, or failed Medicare appeals for any type of audit where you plan to pursue the next level of review.

Responding to an Audit Request

After you have determined if an expert or legal representation is needed, you should next docket the date that the documentation must be received by the audit contractor. If you have determined it is not feasible to complete the document compilation and internal review for completeness by that date, you should immediately reach out to the contractor identified in the audit request letter to seek an extension.

Once you have confirmed the date the documentation is due, the critical part of the document preparation process begins. Well-prepared production can make the difference between passing and failing an audit and must always be completed from the reviewer's perspective.

The primary tasks when responding to an audit are as follows:

- Secure copies of the 1500 or UB04 claim form that the healthcare entity submitted to Medicare for each claim identified in the audit request.
- Create a comprehensive list of services covered by the audit request.
  - If the services are paid on an "à la carte" basis (including outpatient hospital, ambulatory surgery center (ASC), or ambulatory payment classifications (APCs)), create a list of payable CPT/HCPCS codes included in the audit request.
  - If the services are paid on a prospective payment model, such as DRGs, create a comprehensive list of the relevant codes included in the audit request.
- Identify which of the services listed above have Medicare coverage policies specific to those services.
  - For example, policies include Medicare local coverage determinations (LCDs) and national coverage determinations (NCDs).
  - Review and summarize the relevant coverage criteria for each of the services for which one of the above types of Medicare coverage policies is in force.
- Review the relevant chapter(s)/section(s) for both the Medicare Benefit Policy Manual (Pub 100-2) and the Medicare Claims Processing Manual (Pub 100-4). If the services include durable medical equipment (DME), review the DME Supplier Manual for the supplier's Medicare jurisdiction.
- From the reviews in the previous three steps, create a comprehensive list of documents that:
  - Supports that the service was provided based on the official American Medical Association (AMA) / HCPCS definition of the code reported
  - Demonstrates the service met the Medicare contractor's definition of a medically necessary service –and–
  - Demonstrates any additional coverage requirements outlined in the policies and/or manuals have been met
- Provide the list of documents needed to the provider/supplier staff who will be responsible for copying all documentation needed to support the charges for each claim in the review.
  - Ensure the documentation pull is complete.
  - Create a spreadsheet to track the documents received for each claim.
- Determine the order in which the documents should be organized to facilitate a clean and logical review by the Medicare contractor's auditor.
  - Put yourself in the auditor's shoes: the auditor will be trained in the coverage requirements for the services under review.
  - Organize the documents in a manner that would seem logical to the auditor to best identify support for coverage.
- Perform an internal review/audit of the documents before submitting them to the auditor.
  - Do you have all required documents?
  - Have they been arranged in the order determined in the previous step?
  - Does each copied page have the patient's name and unique identifier noted (e.g., date of birth, medical record number, etc.)?
  - Are the documents that are required to be signed by the treating/ordering provider signed with the legible identifier of the signatory?
    - If the signature is not legible, create a signature log to accompany the documentation submission.
    - If a document is not signed, create a signature attestation form for the treating provider to sign that will accompany the documentation.

    Example. A copy of a sample signature attestation form can be found at Signature Attestations Statement (noridianmedicare.com).

- Create a cover page for each documentation packet that identifies each claim in the audit.
  - Include the patient's name and date of service (or date range, if applicable).
  - Include the health insurance claim number (HICN) and the internal control number (ICN) of the claim under review.
- Make a copy of each documentation packet for your records, then submit the required documentation to the auditor in the manner described in the audit request.

When conducting the documentation review, keep a running list of issues identified during your internal review. While you cannot change any of the documentation you will be submitting to the Medicare contractor, you can use the time between your documentation submission and the contractor's report to develop and implement a corrective action plan (CAP) for the issues you anticipate the reviewer will also see in the records submitted.

Appealing an Overpayment Demand

When an audit is complete, the reviewing entity will issue their findings to the provider or supplier. If it is determined that an overpayment has been made, the MAC will send the provider a demand for repayment. The provider may dispute the overpayment determination through Medicare's appeals process set forth in 42 U.S.C. § 1395ff. Please note there are different procedures for an HHS-OIG audit prior to a demand being sent by a MAC.

Medicare's appeals regulations allow for five levels of review as follows:

- **Level One: Redetermination.** After the initial determination that an overpayment has been made, a denied claim may be submitted to a MAC for redetermination. 42 U.S.C. § 1395ff(a)(3)(A). Upon receipt of the request, the MAC has 60 days to issue a decision. 42 U.S.C. § 1395ff(a)(3)(C)(ii).
- **Level Two: Reconsideration.** If the redetermination is unfavorable, the appealing party may submit a request for reconsideration. 42 U.S.C. § 1395ff(b), (c). A reconsideration is a review of the MAC's redetermination conducted by a Qualified Independent Contractor (QIC). 42 U.S.C. § 1395ff(c)(B)(i). The QIC has 60 days to issue a decision upon receipt of the request. 42 U.S.C. § 1395ff(c)(3)(C)(i).
- **Level Three: Administrative Law Judge (ALJ) Hearing.** A party that is dissatisfied with the QIC's reconsideration may request a hearing and de novo review before an ALJ with the Office of Medicare Hearings and Appeals (OMHA), provided the amount in controversy is met. 42 U.S.C. § 1395ff(b)(1)(E). The ALJ must conduct and conclude the hearing and render a decision no later than 90 days after the request for a hearing was filed. 42 U.S.C. § 1395ff(d)(1)(A); 42 C.F.R. § 405.1016(a).
- **Level Four: Medicare Appeals Council (Council) Review.** The final administrative option for an appeal of an unfavorable decision occurs with the Council. 42 U.S.C. § 1395ff(d)(2); 42 C.F.R. § 405.1108(a). Under 42 C.F.R. § 405.1100(c), Council undertakes a de novo review and issues a decision, dismisses the appeal, or remands the case to the ALJ within 90 days of receipt of the request for Council review.
- **Level Five: Federal District Court and Escalation.** If Council does not issue a decision, dismissal, or remand within 90 days, the appealing party may file a request to escalate the case to federal district court for judicial review. 42 C.F.R. § 405.1132(a). Upon Council's receipt of the escalation request, Council has five days to issue a decision, dismissal, remand, or provide notice that it is unable to do so. 42 C.F.R. § 405.1132(a).

For more information regarding Medicare's appeals process, see MLN006562 – Medicare Parts A & B Appeals Process (cms.gov).

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