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Medicare Provider Audits Increasing

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Medicare estimates that it overpays providers (both hospitals and physicians) by billions every year. In an effort to reduce overpayments, Medicare has increased its auditing of Medicare providers. The increased auditing effort has led to millions of dollars of recovery for Medicare and has many providers scrambling to make repayment to Medicare. Medicare has made much of this recovery through a program known as Recovery Audit Contractors (or RAC for short).

Although limited to six states during the testing stage of this new program, Medicare has recovered approximately $700 million dollars over the last three years in Medicare overpayments from hospitals and health care providers through the RAC program. RAC is scheduled to roll out in Ohio sometime after January of 2009. RACs are private companies that are paid a percentage of the overpayments they recover from Medicare providers. Their purpose is to detect and correct overpayments and underpayments to Medicare providers. In early auditing done by the RAC program it found over $900 million in overpayments and only around $38 million in underpayments.

In its auditing, Medicare has a limited period of time that it can go back through provider records to recover overpayments. Typically the look back statute of limitations for Medicare is longer. Under the nationwide program RACs will only look for overpayments on or after October 1, 2007.

Under the RAC program, the auditor reviews a sampling of claims. After reviewing the sample an error rate will be determined based on the audited claims, that rate will be extrapolated and applied against all claims. For example, if a Medicare provider has 1000 services over a period of one year, the auditor may choose to review only 100 medical records. If it determines that 25 medical records lack documentation to support the billing rate used it will find there is a 25% error rate. That 25% error rate will be multiplied by the 1000 services. If it is determined the provider should have billed at a lower code that would have paid $10 less, the Provider will get a bill for $2,500 (25% X 1000 X $10). This multiplier effect quickly can add up to significant dollars.

When facing an audit there will be no substitute for sufficient documentation in a medical record. Auditors are primarily focused on three items:

- incorrectly coded services (provider coded for a higher level of service than the record indicates was provided);
- medically unnecessary services; and
- missing or insufficient documentation of services provided.

It is extremely important that providers take the time to correctly and adequately document the service rendered at the time of service. For purposes of the audit, undocumented care is care that did not occur.

Currently, the largest area of recovery for auditors is in reducing coding for services provided. In other words, looking at the medical record and determining that the level of documentation does not support the level at which the service was billed. Services will be allowed only at the level for which there is sufficient documentation, not the level of actual services provided. For example, if there are three billing levels for a service provided, the differentiation between billing levels is often for the complexity of the decision making and level of care provided. If a provider bills at the highest billing level but does not have the necessary supporting documentation (showing the complexity of the decision making and higher level of care) in the medical record, the auditor will reduce the reimbursement to a lower billing level. When this is extrapolated it can lead to a large overpayment determination. Now more than ever, appropriate documentation of care provided is a necessity for good medical care and keeping the reimbursement that is rightfully yours.

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If it has been determined that you, as a provider have received an overpayment there is an appeals process. There are four levels of administrative appeals prior to reaching a court. The administrative appeals process is more flexible and less cumbersome than a court case. In the appeals process there are strict time lines that must be followed.

Physicians should immediately contact a qualified health care attorney when an audit notice is received.

For further information regarding Medicare audits, please contact Mr. Devaney or Ms. Dobrzykowski (419-241-6000).

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