

Health Law Bulletin

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Tips For Avoiding Audit Findings

Although you have no control over whether and when you are the subject of a Medicare or Medicaid audit, there are some steps that you can take on a day-to-day basis that will minimize the likelihood of negative findings if you do get audited. Over the last several years, we have represented numerous clients in responding to Medicare and Medicaid audits. These suggestions are based on audits of various provider types:

- **DOCUMENTATION IS CRITICAL**—There are more specific recommendations below regarding documentation, but it is important to keep the idea of documentation always on your mind and the minds of your staff. Remember that when the auditors come to your facility or request records and review them at their own offices, they are not going to know what you and your staff did last year, last month, or even last week. The only way they know something occurred is if it is documented. If you bill based on level of service, be sure that your documentation is adequate to justify the level of service that you bill. Read the Medicare and Medicaid manuals carefully. Pay attention to notices that come from Medicare or Medicaid. Even though it may take time and be cumbersome, good documentation will be well worth the effort if an audit occurs.
- **DO PERIODIC SELF-AUDITS**—Periodically, review a sample of your own records to see whether you and your staff are complying with the various Medicare and Medicaid program requirements. If you find something wrong, re-educate yourself and your staff to the correct way to perform or document the task. These periodic self-audits not only help you detect mistakes—they are also a sign of good faith on your part if you are ever investigated.
- **DON'T CREATE DOCUMENTATION AFTER THE FACT**—You might be tempted to read the first two recommendations and conclude that if you find a mistake in documentation, you should go back retroactively and fix it. For example, if care plans from a year ago weren't dated, do you just go back and date them now with last year's date? If services were billed last year but are not documented in the file, do you go back and create treatment notes to justify the services? The answer is no, no, no! If auditors and investigators suspect you have held a "charting party" (retroactively creating charts for services that were already billed), you are more likely to face legal issues in addition to the audit. While there are occasions when an error in documentation has occurred, there are proper ways to correct it, e.g., mark through the error, write in the correction, initial and date it with the date of the correction.
- **PAY ATTENTION TO SIGNATURE AND DATE REQUIREMENTS**—Providers are often in a hurry and forget to sign or date a treatment plan or progress note. If the signature or date is a program requirement, then the auditors are likely to disallow all services that are part of that treatment plan or all services provided before the plan was actually dated. This is an easy target for auditors.
- **IF A PROGRAM REQUIRES DOCUMENTATION OF TIME OF SERVICE, BE SURE THE TIMES ARE ACCURATE**-- In some programs and with some services, the provider

is required to document the start and stop time for the service. Pay careful attention to these requirements. If the times are missing, the auditors will likely disallow the service even if the note demonstrates clearly that the service was provided. Auditors will also check for overlapping times; for example, two client charts show that an individual provider was treating both clients at the same time. Again, these are easy for auditors to find, and the auditors will usually disallow payment for both services, even though you have documentation that the overlap was just human error. Also pay attention to travel time. It is impossible to finish providing a service to a client in Little Rock at 10:00 a.m. and start treating another client in Hot Springs at 10:15 a.m. Start and stop time requirements are a headache. But they are required in some programs, and you and your staff should follow the requirements as completely and as accurately as possible.

- **SIGNATURES AND INITIALS SHOULD BE ORIGINALS AND WRITTEN BY THE INDIVIDUAL**—When auditors review progress notes or other documentation, they can see differences in handwriting. If two entries are in different handwriting, but initialed as provided by the same individual, that raises a red flag for the auditor. If one individual is signing for another, it should be clear that the person was given the authority to sign on the non-signer's behalf and that the non-signer is aware of what is being signed and has approved it. If one individual treats several individuals and uses the same form for documentation, you may be tempted to sign one blank form and then make photocopies; that way, you avoid the need for signing every form. Avoid this practice. If original signatures are required (and they usually are), then get **original** signatures.
- **GUARD AGAINST COOKIE-CUTTERS**—If all your records for your various clients look alike, you have a problem. Auditors zero in on uniformity like bears to honey. They do not consider it feasible, for instance, that it took the same amount of time to treat every client, or that a service was delivered at the exact same time every day, or that every patient required a particular diagnostic test that the provider owns and bills for.
- **TRY NOT TO BE AN OUTLIER**—If you are an outlier—in amount billed, types of procedures, patients seen, etc.—you are much more likely to draw scrutiny from auditors. Obviously, this cannot be helped if you are a provider who treats certain very ill populations, but you will have to work harder than other providers to keep good documentation.
- **WHEN IN DOUBT, BILL DOWN**—If you find yourself in a gray zone where it is unclear which of two codes should be billed, or whether you can bill certain codes separately, and similar quandaries, odds are that the auditors will use an interpretation that says you should have chosen the code that pays the least. So, either go with the lowest-paying amount, or preferably, get clear guidance from the agency or your legal counsel before you proceed.
- **KEEP YOUR RECORDS ORGANIZED AND AVAILABLE**—Follow the program requirements for storage and retention of patient records. If an audit is being done off-site, you will have some time to gather all of the records together, photocopy them, and send them to the auditors. But if the audit is on-site, the auditors will expect the records to be at your site and available. Many audit findings are the result of a provider not being able to find a record or part of a record until after the auditors have completed their audit. It is easier to have the records available and avoid that audit finding in the first place. We have recently seen an audit where the auditors stated their concern with the amount of documentation that was missing from the initial audit and provided after the fact; in fact, the auditors in that case threatened the possibility of recoupment or other corrective action if records are not immediately available for future audits.

At this point, you may be asking, “What about patient care? This is all about records and documentation.” That is because records and documentation are the tools that the auditors use to make determinations about whether care was provided in accordance with the program requirements. While it is true that some audits involve observations of

treatment and recommendations for improvement, the audits that generate demands for repayments or recouments are typically based on documentation. Therefore, you cannot neglect this important part of your practice.