How to Respond to a Medical Records Audit

By Paul Cirel

It is no longer a secret that third party payers – including Medicare, private insurance companies and HMO's –have substantially increased their oversight of physician practices. The most commonly used method is the medical records audit. From the targeted physician's perspective, such audits begin with the receipt of a request for patient records. That request may be for a random sample of all patient records, or it may identify specific procedure codes or diagnostic codes; it may be for certain patients' complete medical clients, or it may specify specific dates of service. Regardless, before responding physicians will do well to consider that, in fact, the audit really began long before the notice arrived.

True, some audits are really random. And some traffic stops are really routine. But, don't count on either being the case.

Most likely, the audit was planned weeks – or even months – in advance and the prudent provider should assume that there is some common denominator to the records that were selected, or to the nature of the physician's billing or practice patterns, which the auditing agency considers suspect. Of course, not responding is not really an option. Failure to do so will likely result in future payments being withheld, disenrollment/debarment from the provider network and, if it's Medicare, the issuance of a subpoena for the same (and probably more) records.

The first task in responding is to insure that the records are complete. The only way to do that thoroughly is to compare each medical record with its corresponding billing record. Remember, the billing data are all the auditors originally had, and therefore it is where the audit began. Thus, a sample checklist before sending any records in response to an audit request should include the following:

- Is there a note for each visit?

- If a lab test or x-ray was ordered is the report in the chart?

- If a consult was billed is there a report to the referring physician?

- If a referral was made, is there an entry documenting it?

Two notes of caution in producing records in response to an audit. First and foremost never, ever, create or alter a missing or wanting entry or document. Nothing will lead more quickly to a healthcare fraud prosecution than the production of tampered records. If the records are incomplete or less than thorough, that can be addressed in a cover letter that explains and provides the missing information. If the need for such an addendum becomes obvious when preparing the responsive records, so too should the advice and/or assistance of counsel.

Second, the current trend in audit requests is for particular dates of service rather than complete medical files. Such requests can be traps for the unwary. Medical records – and a physician's knowledge of his or her patient – are cumulative by their very nature, and isolated entries are often inadequate to reflect the complexity of either the patient's medical history or the physician's medical decision making. Since those are two of the key components in determining the appropriate evaluation and management (E and M) service level to be billed, failure to provide sufficient documentation to support those decisions will always result in the auditor down-coding – if not disallowing – the level of service billed. When that happens, the dollars identified for "recoupment" add up awfully fast, especially when the audit sample is used as a basis to extrapolate a more fulsome overpayment. Isolated service dates also run the risk of overlooking related test results, x-ray reports or consultations (each of which likely contributed to the E and M coding decision). In short, this is not a situation where less is best. Although most insurers have an appeals procedure to contest their audit findings, the after-the-fact submission of additional materials may be resisted and probably viewed with a jaundiced eye.

One last point in responding to an audit. Unless absolutely demanded, do not produce original records. Regardless, be sure to make at least one complete copy of what is submitted and number the pages.

Other, more intrusive methods of oversight – especially by Medicare – include HIPAA subpoenas and unannounced visits by investigators from the Office of the Inspector General. Discussion of those tactics will have to wait for another day since this is more than enough information to take in one dose.

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