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Medical Association of the State of Alabama: Top 4 Dos and Don'ts For Audits and Investigations

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In the spirit of college football season and the inevitable argument about which four college football teams are in the college football playoffs, this article addresses the undisputed top 4 dos and don'ts that physicians should follow during an audit or investigation. I have represented countless medical practices and individual physicians with a variety of federal payor audits, false claims investigations and DEA investigations. The following top 4 dos and don'ts are the top issues I see frequently repeated, oftentimes to the detriment of the provider under investigation.

 # 4 – Keep an Exact Copy of Everything Produced or Viewed. Most of the time I am not retained until after the practice has turned over the requested documents and, in some cases, has also turned over non-requested documents. The usual response by the practice, when asked why it did not keep a copy of what was released, is something along the lines of "we did nothing wrong" or "we know what we turned over and can make a copy if needed." However, when I ask for the documents produced, the practice oftentimes cannot replicate what was produced. This puts the practice at a competitive disadvantage from the start. It also makes citing to a particular document extremely difficult when legal counsel does not know (1) if a particular document was actually produced, or (2) if it was produced, wherein the mountain of records the document is located. Defending the practice's conduct or fighting a recoupment becomes challenging without a

copy of the documents. Thus, the practice should go ahead and make an exact copy of what is produced and maintain the copy until the practice is reasonably sure nothing will come from the audit or investigation. It is also recommended that the practice hire legal counsel before producing records, so as to ensure that only responsive documents are produced.

 # 3 – Review All of the Medical Records Before Producing. While this seems like a no brainer, I cannot state the number of times a medical practice has printed what it believes to be the entire medical record only to learn when receiving a recoupment demand or allegation of false claims that the entire medical record was not produced. Another common issue in this age of electronic medical records ("EMR") is that the printed record looks substantially different than the electronic record. Some EMR systems will print a paper copy differently if the "print" function is used versus the "print screen" function. I have experienced numerous occasions when the paper copy looks suspicious or incomplete, particularly the patient's history or prescription records, because of the way the EMR prints the record. On a related note, if the practice wishes to use a consultant to conduct a simulated audit, it is important to make sure that the consultant either has access to the EMR or that the printed paper records are complete and identical to the electronic records.

 # 2 – Maintain Signature Logs of Alabama Medicaid Patients. The Alabama Medicaid Agency requires that providers maintain evidence that the patient actually attended the appointment. It does this by requiring providers to keep a signature on file to prove the patient's attendance at each appointment. I have represented quite a few physicians and practices in Medicaid audits, and I do not recall an audit that did not request copies of the patients' signatures. However, the signature requirement is not well known by Alabama providers, as many of my clients are unaware of the requirement and fail to keep a copy of the signatures. While there are other ways to prove that a patient attended the visit, it is very simple to satisfy the signature requirement and avoid having to gather other forms of proof–simply use the removable signature logs and paste the patient's signature into the record for that particular visit.

#1 Never, Ever, Ever Voluntarily Surrender A License/Permit/Participation Without First Obtaining Advice of Counsel. Without question, the undisputed defending champion and current #1 is never ever voluntarily surrender a license, permit or participation in a payor's program without first obtaining advice of counsel. I have heard on multiple occasions that a particular investigator says something along the lines of the following to a licensee "Things will go much easier if you voluntarily surrender your license." I have never in my experience seen where things have gone easier for the physician when he/she has voluntarily surrendered his/her license. However, it does is make things easier for the licensing body, so the statement above is true as phrased. The voluntary surrender substantially compromises the physician's ability to defend his/her case, as the physician has lost any leverage he/she may have had – the agency already has what it wants – the physician's license. Most licensing agencies have due process requirements that must be followed before it can revoke, suspend, or take any adverse action on a license. One of the most important due process requirements is giving the physician the right to a hearing where the physician can be represented by counsel and present evidence. The hearing process affords the physician the ability to test the agency's evidence and interpretation of its regulations, which are oftentimes flawed. The hearing

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process also gives the physician the ability to reach a compromised resolution of the matter, oftentimes allowing the physician to keep his/her license. By voluntarily surrendering a license, the physician loses such rights and abilities.

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