Talking Sleep Season 4
Episode 14
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Dr. Gabriela de Bruin, Guest

Episode Transcript

DR. KHOSLA: Thank you for joining us for Talking Sleep, a podcast of the American Academy of Sleep Medicine. I'm your host, Dr. Seema Khosla, medical director of the North Dakota Center for Sleep in Fargo.

Now, some of you may not want to hear this, but if you provide sleep services to Medicare beneficiaries, you could be subject to audits from the Centers for Medicare and Medicaid Services.

CMS uses audits to uncover fraud and abuse of the system. No need to panic, though. The AASM has all of the resources you need to survive a Medicare audit. Here to walk us through what to expect if you're audited is Dr. Gabriela de Bruin, vice chair of the AASM Coding and Compliance Committee. She is a sleep medicine physician and a professor of neurology at Washington University in Saint Louis.

Thanks for joining us, Dr. de Bruin.

DR. DE BRUIN: Oh, thanks for having me.

DR. KHOSLA: So talk to me about the Coding and Compliance Committee.

DR. DE BRUIN: Yeah. So the Coding and Compliance Committee works on coding and compliance. So what we do is we are constantly reviewing the codes that are out there and we work to make sure that those codes are accurate and reflect the work that our members are doing. We represent sleep medicine, physicians and providers at the RUC and with CMS and advocate for changes in codes that allow us to better capture the work that we're doing.

But we also do a lot of work in terms of educating our members on how to utilize those codes effectively and correctly. And that's, you know, the compliance piece that we do. So we, when a code comes out, there is language around, you know, who should use that code and how that code should be used. And sometimes that can be generic or it can be a lot of information. And part of what we do is, you know, really review all of that in depth and package that information for our members in a way that allows them to really understand what those what those codes are and how they should be using them.

DR. KHOSLA: So this is this is what was kind of surprising to me. So when I think about the coding and compliance committee, I think about billing codes and I think about the RUC. But today we're talking about Medicare audits. So how does this, how did you guys get into this area?

DR. DE BRUIN: Yeah. So I think it falls under that sort of compliance and education umbrella. So we heard from our members that they you know, their practices were being selected for

Medicare audits, which as we're going to talk about, could happen to anybody but that they, you know, wanted more resources to help them navigate these audits. And and sailing through a Medicare audit is all about being compliant with Medicare rules. And so we took it upon ourselves to really create resources for our members to understand those rules and be prepared for these audits so that they can feel supported and do well with them.

DR. KHOSLA: So enlighten me. What is what is the purpose of an audit?

DR. DE BRUIN: Yeah. So a Medicare audit looks to check whether a particular service that was, you know, for which a claim was submitted was that service provided, was that provider, that patient and that, you know, service eligible for Medicare benefits, and was the way in which that claim, you know, was submitted, was that compliant with Medicare requirements for that service.

So so for PSG, for example, they're going to be coming in and they're going to say, okay, you know, did you do this PSG? Was it an adequate PSG? Is the documentation correct? Was this patient eligible for this PSG? Were all the people who performed the service, you know, correctly credentialed and and the people that should be doing this and submitting this claim and was this claim submitted correctly? So that's what that audit is going to be generally looking for.

DR. KHOSLA: Oh, so then how are practices or r clinicians, how are they selected for an audit?

DR. DE BRUIN: So one of the things that I think is really important is that people understand and is that at any point in time, Medicare is on a rolling basis auditing about 10% of providers.

DR. KHOSLA: Oh, wow, that's a lot.

DR. DE BRUIN: It is. So they're always auditing people and some of that selection is random. So I think it's important that people realize that anybody who serves Medicare patients could be selected for an audit. There's nothing you can do that prevents you from ever being selected. And in being selected doesn't necessarily mean you did anything wrong, so so anybody could be targeted. Having said that, there are certain things that you could do or not do that might kind of like trigger.

DR. KHOSLA: Trigger? That's what I'm wondering. Is there something that maybe puts their antenna up and says, Oh, hang on, we need to edit, we need to audit. Sorry, this this practice?

DR. DE BRUIN: Absolutely. So. So though anybody could be audited, there are certain behaviors that if that if they happen that could put up that red flag and make it more likely that that practice could be audited. The most common thing is submitting an unusually high number of a specific claim over a time period. So, for example, if you bill for ten times as many PSGs as a comparable practice of the same size as yours, that is a red flag that might say, well, you know, maybe we should look at this one.

That would be a common trigger for an audit. But there are other triggers, too. If you're always billing for the same codes. So there's a general understanding that there may be a typical patient that a practice serves. And so it's not uncommon for there to be a code that that practice bills more frequently. But patients are not the same, right? All patients are a little different. So even

though that might be your most common code, it shouldn't always be that code. Some patients are going to be more straightforward and maybe more appropriate for a simpler code, and some people are going to be more complicated and maybe you should be billing a more complex code. So especially when it comes to E&M codes and office visits, be careful of always billing the exact same code because that can be a red flag.

And similarly, be careful of all your notes looking exactly the same, which has become more of an issue now that we have electronic health records which allow us to build templates and copy notes, and though those things are permitted, they should serve as a basis for a document that's going to be tailored to accurately reflect that patient in front of you. So if Medicare is seeing that notes look very canned or exactly the same, that could be a red flag also.

DR. KHOSLA: Well, and you hit on something really important. It's not just overbilling. It's you know, if you're let's say you're billing all OSA patients as level three across the board, that's probably not appropriate either.

DR. DE BRUIN: No, it's over billing and under billing. So they really want that code to match that patient in front of you. So saying, well, I'm just going to bring everybody down one notch and under bill for everybody actually makes you less compliant, not more compliant.

DR. KHOSLA: I think that's a really important point because so many people are worried, right, about overbilling that they will just sort of under bill to try to sort of be safe. And that's not the right thing to do then.

DR. DE BRUIN: That's right.

DR. KHOSLA: Huh. So let's say you get audited. What exactly happens during this whole process?

DR. DE BRUIN: Sure. So if you get selected for an audit, you're going to get a letter. It's going to arrive at your practice in the mail and it's going to say, surprise, you've been selected for an audit. This is the date the audit is going to happen. These are the auditors that are going to come to your practice. This is the address and this is the scope of the audit.

Then at that specific date, those auditors are going to show up. They are going to settle down in a specific part of your practice. They're going to need a desk, chairs. They're going to put all their things down. They're going to ask for documents. They're going to ask for policies, procedures. They're going to ask for notes. They're going to want to talk to people. They're going to want to walk through your practice. They're going to want to look at the space. They might take pictures, open drawers. They're going to ask you questions. They're going to want to ask questions of other people, staff in your practice, and then they're going to leave. That's that's what's going to happen.

DR. KHOSLA: So it sounds like a site visit.

DR. DE BRUIN: Yeah. Yeah, it does. I think it has a lot of similarities to that. You know, it's an inspection kind of visit.

DR. KHOSLA: So then if you get audited, you know, if you get selected for an audit, what I'm hearing you say is it's not the end of the world.

DR. DE BRUIN: No. I mean, if you if you get selected for an audit, I would say the best advice is don't panic. Remember, a lot of audits are selected randomly. This doesn't mean you did anything wrong. So don't panic and start getting organized. Yeah.

DR. KHOSLA: So then what happens after the audit? So they've closed all the drawers and they've picked up their papers and they're gone. Then what happens afterwards?

DR. DE BRUIN: Well after the audit it really depends a lot on the scope of the audit of what type of follow up you're going to get and what timeframe there is going to be for that. But as they leave, they may ask you for documents that you didn't have available for them on the day of the audit. So, you know, you it's okay that if there is some very specific thing they wanted to look at and you didn't have it, that's fine. You make a note of it. So they might ask, oh, please send us this, please send us that. So you may need to do that after the audit. You may get follow up action items, meaning we found this, it was concerning. We would like you to address that practice definitely should act upon those because audits can also trigger audits. So if you've been if you've been audited once and maybe some things were identified as areas of weaknesses, you could have a follow-up audit that's going to confirm that you addressed those. So you should, anything that was identified or brought to your attention, you should work on those right away.

And we really encourage practices also to debrief after an audit. See what you learned from that audit and what can you do better to prevent any issues with audits going forward, but also to just improve workflows in the practice in general.

DR. KHOSLA: Okay. So those are some of the basics about Medicare audits. Let's take a quick break. And when we come back, we'll talk about how to ensure you're prepared for an audit.

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DR. KHOSLA: Welcome back to Talking Sleep. Our guest today is Dr. Gabriela de Bruin, vice chair of the AASM Coding and Compliance Committee.

So what is the best way to prepare for an audit?

DR. DE BRUIN: If you're selected for an audit, stay calm and get organized. I would say the best way to prepare is access a Medicare audit toolkit or preparation document. If your practice already has one as part of your compliance program, that's great. The American Academy of Sleep Medicine very soon will have a Medicare Audit Toolkit document available at the AASM Medicare Resources web page that you can use because you really want to be organized and step wise in making sure you're checking all the boxes to get ready for the audit.

So for example, once you know you're going to be audited, you want to get your office ready. So you want to, first of all, just contact that auditor that's going to be auditing you, make sure that the date they selected works for you, that your office is going to be open, that the key people that have to be present are going to be available. If you need to make a change, contact them about making that change. Get written confirmation of that. If not, confirm that date with them. Make sure they know how to get to your practice. If you have COVID safety protocols in place, for example, if masks are mandated in your location, let them know about those things. Then you want to start almost "auditing" yourself to make sure that your practice is ready.

So walk through your practice, make sure any licenses that you have up, any documents and certificates that they're all current, make sure your office looks clean, that there are no safety hazards anywhere. Make sure your staff is ready for the audit, knows that the auditors are coming and that they may want to speak with them. Get all your policies and procedures ready, available and up to date.

Make sure you understand the rules for the coverage of the visits and codes you use frequently and make sure you understand the scope of the audit. That will be in your letter so you have a sense of what they're going to be looking at so that you also know how to be prepared to answer questions.

DR. KHOSLA: So I like that they could be fairly specific then.

DR. DE BRUIN: They could and they should tell you, you know, are they going to be looking at a random number of charts? Is it going to be very focused on, you know, electronic health records or on a specific code? All that information should be available in the letter that you get. Having said that, some sort of general rules always apply, right? You want to make sure things like safety and that your space looks good, that there's a space for them to be, and that your policies and procedures are up to date. All those things are going to be important no matter what the scope of the audit is.

DR. KHOSLA: So you mentioned a toolkit. So what's in the toolkit?

DR. DE BRUIN: Yeah. So there is a lot of great information in the toolkit. It has preparation tips. It actually walks you through. It has a checklist. You know what to do when you get the letter. What are your pre-audit steps? What are your steps for the day of the audit? What should you be ready to do? What should you expect and what are your steps for after the audit?

The toolkit also provides a lot of background information about what types of audits there are, what are the different scopes, how people can be selected, what are these triggers that can lead to an audit and how, if you have not been selected for an audit, can you make sure that you're not doing these things that could, you know, cause you to be selected?

No one wants to be audited. But and it has a lot of links to CMS resources as well of how to prepare and what to expect. And it also has links and information about building a compliance program, which is really the best way to prepare for an audit in the future and to make sure that if you ever are audited, you're going to do you're going to do great.

DR. KHOSLA: Okay, that's great. And we'll include a link to that in the in the show notes. So it sounds like a lot of what you're describing is a compliance program.

DR. DE BRUIN: Yeah, a compliance program is the best way to prepare yourself for a Medicare audit. With the understanding is that anybody who serves Medicare patients could be audited, having a compliance program sets you up for being successful if that audit were to happen and small programs can have a compliance program. Small practices and large practices can have, can and should have compliance programs as well. So really, everybody should should set that up for themselves. And the Academy has resources to help you do that.

DR. KHOSLA: So is there such a thing as failing an audit?

DR. DE BRUIN: Well, I guess…it's not a pass or fail test, but there are certainly outcomes that you want to avoid. So the goal is for Medicare to come through and to review your policies, to review some of your notes, to talk to your staff and to say, you know what, you're really aware of the rules and the regulations that go around these services and you do a great job.

Your space is clean is safe for our patients. Your notes reflect the patients in front of you, and you're ordering services and billing for services that meet medical necessity for those patients. And that's all adequately documented. And your staff, you know, is knowledgeable about these rules as well and has mechanisms for bringing up any concerns. So that's the outcome that you want.

DR. KHOSLA: So this is what this is where my brain went when he started talking about the audits. You know, these articles that we see splashed over the news saying some doctor somewhere defrauded Medicare for like $9 million.

DR. DE BRUIN: That's the outcome you don't want.

DR. KHOSLA: Well, then that's kind of it, right? So those guys, when that happens, they will have already been audited and sort of told what the issue was and I'm guessing they just didn't remediate.

DR. DE BRUIN: Yeah. So I can't really speak specifically. You know, every case is a little different and how concerns get brought to Medicare and how quickly they act upon them is different depending on the level of the concern and what is happening. But generally speaking, if you're a sleep doctor out there that's, you know, providing care in good faith to your patients, the audits would escalate.

So you would get, you know, an audit that's more exploratory, that's reviewing your practice. If there are concerns, then they can bring, you know, a more in-depth audit that might want to recoup payments. So that could happen with an audit. They might review claims paid. And they and they are they have the prerogative to request repayment for anything they feel was overpaid going back three years from the date of payment.

DR. KHOSLA: Oh, three years?

DR. DE BRUIN: Yeah. So if they find that well, this and this and this, you know, did not meet our threshold for this service, and we paid for it. They may say we want that money back. And that goes three years from the date it was paid, not from the day the service was done.

DR. KHOSLA: So isn't it funny, though, we get a year to submit billing, but they can look back three. That's really interesting.

DR. DE BRUIN: Yeah, the rules are definitely a little different for, for the different people involved here. But yes. And, you know, that's not something you want. So making sure that you know what the rules are so that you're only getting paid for the things that really meet that medical necessity criteria and that Medicare criteria is also in your best interest because you don't want to find yourself in a situation that you need to pay things back.

DR. KHOSLA: So you talked about some of the resources that the AASM provides to help build a compliance program. Tell me more about that.

DR. DE BRUIN: Yes. So within our Medicare Audit Toolkit, there are there are lots of references to compliance programs and links to resources to build compliance programs. The ASAP also has a module that's just about building a compliance program. In a nutshell, a compliance program is almost like having your own little regular internal audit program. So you have a system where you're constantly educating yourself on the national and local rules for the services you provide, and you do a survey of your claims that you're submitting. You're making sure that those are compliant with those rules. If you identify any areas of weaknesses, you provide education to your staff and workflows to address those areas. And then you kind of revisit to make sure it's fixed. And even when things are going well, you periodically reserve a random, you know, samples of your practice to make sure you're in compliance so that if there are problems, you're finding them first and you're not waiting for you to be audited to find that you're doing things wrong.

DR. KHOSLA: So I think all of us already do this key way where you have to look at a few charts, you know, every year for Medicare. Could you use those same charts to do this?

DR. DE BRUIN: Yeah. So how do you build your internal compliance program is up to you. There is a few things that you need to think about. So one, the goal of the compliance program is to find problems so that they can be fixed. So if you're using a number of charts, you want to make sure that it's enough that you feel like it's enough to give you a cross-section of the services you're providing and that that sample is random. You're not just selecting the best charts so that you can find problems if they're there.

You also you definitely want providers to be clinical providers to be part of your compliance program because you want to be thinking about reflecting the clinical needs of the patients, medical necessity, adequate clinical documentation. But you also need somebody from billing, coding and compliance to be part of that compliance program and to be looking at those charts.

So if you're using the same charts, you want to make sure you bring in that that other group of folks to make sure that that review is meeting the goals of the of the compliance program.

DR. KHOSLA: So let me ask you about something that has been sort of top of mind for a lot of my colleagues in the last few weeks. And there's this disconnect where you order a polysomnography to requalify somebody for CPAP, right, because that's what the DME says you have to do. But then Medicare says, no, we're not going to pay for it. And so there's a disconnect between Medicare Part D and Medicare Part B, and so we're seeing more denials of PSG. So how do we navigate this? Do you have any advice?

DR. DE BRUIN: Yeah. So I think that could have its own podcast and is definitely a big issue right now. And it's something that is very much in flux and ongoing. So I don't think I have any definitive answers about, you know, this is what is going to happen and this is when and this is how. What I can say is that this is this is a real issue because it does put our providers a little bit in the crossroads of different rules and trying to make sure that they're doing what's clinically appropriate for their patients and getting, you know, that treatment that they need in a way that is compliant with the rules around medical necessity. So it creates a little bit of an impossible situation. But the Academy is very aware of this issue and is advocating very intensely on behalf of the members to get this resolved quickly. There was an Insider article that came out last week on the ninth and I think the listeners should definitely refer to that if they're interested in seeing what steps are already being taken to address this.

DR. KHOSLA: Yeah, there was a link to the letter…no, you're right. And there is a link to the letter that they that they created, which I thought was pretty good.

DR. DE BRUIN: Yeah, I think it. You know, we want to make sure that this, you know, gets resolved so that people can really focus on providing medical care and getting patients the treatment they need without having to worry about, you know, about these different these different conflicts.

DR. KHOSLA: And so it sounds like thoughtful documentation, you know, instead of sort of the reflex requalify, the oh, well, they've had interval change and medical history and weight change or, you know, whatever.

DR. DE BRUIN: Absolutely, and that's good advice. Any time there is, you know, a situation where maybe it's a little bit more complex and more convoluted, I think documentation is one area where more is more. So you might be ordering a new study for a patient that needs to requalify, but maybe there are other reasons they need it. You know, maybe it's been ten years since they were studied and they've had health changes and their weight's changed a lot. They have new symptoms and all those things can make it a lot easier for that repeat study that they need to be well supported. So if they're so make sure you're documenting everything that will support the test that you're that you're getting.

DR. KHOSLA: Yeah I think you're right because during that interval, I mean, it's likely that there have been significant changes. And so it behooves us to to document those.

DR. DE BRUIN: That's right.

DR. KHOSLA: So we've been talking a lot about Medicare audits. Is this only a Medicare thing or can you be audited by a private payer?

DR. DE BRUIN: You can. Any payer that you serve can audit you. But private payers don't really do rolling audits like CMS does. So those are really a lot less common and come up a lot less often. And if you have a compliance program and you're following CMS rules, you're pretty much going to be ready for any audit from any payer, even though those are not nearly, you know, not nearly something that comes up as often.

DR. KHOSLA: So any final thoughts?

DR. DE BRUIN: I think that the main take home points are anybody could be audited. Having a compliance program is the best way to make sure that you're going to cruise through an audit if one ever happens to you. If you do get audited and access an audit resource, the AASM Medicare Toolkit is great and that is a resource for all our members. And just stay calm, be organized.

DR. KHOSLA: Don't freak out.

DR. DE BRUIN: Don't freak out, prepare. And when that auditor comes, I think are really important advice says they're going to ask you questions answer those questions truthfully. It's okay if you don't know answers to say you don't know never make things up. It's better to say you don't know and you're going to get the information then to give an incorrect answer and don't volunteer any information. They're going to ask you the things that they want to know and bringing in a lot of extra information to the conversation could expand the scope and the timeline of your audit, which is not something most people want. So answer their questions truthfully and simply, and silence is okay.

DR. KHOSLA: So be comfortable with silence.

DR. DE BRUIN: Be comfortable with silence, be calm, have a compliance program and you'll be okay.

DR. KHOSLA: And I love that that's that that bit about if you don't know the answer, don't make it up. That was always something I would tell my residents and medical students in the ICU that don't fake it. If you don't know what the potassium is, don't pretend you do. We'll figure it out together. So that's good advice.

Well, thank you so much for this discussion. You know, I certainly wouldn't necessarily welcome an audit, but it's really good to know how to be better prepared with all of these resources that the ASM has developed.

DR. DE BRUIN: Oh, it's my pleasure. Thank you so much for having me.

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