



# Weekly Auditing and Compliance Tip

National Alliance of Medical Auditing Specialists | 877-418-5564 | [namas.co](http://namas.co) | [namas@namas.co](mailto:namas@namas.co)

## Legibility and the Crackdown by Payors

In recent months, I have been tasked with providing representation for numerous medical practices and hospital systems tied to illegible provider signatures resulting in significant take-backs by multiple payors. The leader of the charge, as many of you might have already guessed, is United Health Care. Below is a recent letter received by a client which highlights 34 claim lines were reviewed for a seven (7) month period and indicates there were no findings on 20 claims lines reviewed and documentation not supporting services billed for 14 lines. The damages turned out to be a whopping \$187.88 which they then projected to the entire patient universe resulting in a \$12,989.64 refund demand.

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United Payment Integrity  
 Attn: Recovery Investigations  
 P.O. Box 105128  
 Atlanta, GA 30348-5128  
 Phone: (952) 205-0712  
 Fax: (888) 866-3198

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May 11, 2018

ATTN: BILLING/REFUND DEPARTMENT

Letter Reference No.: [redacted]  
**INITIAL REQUEST—OVERPAYMENT DETERMINATION**  
Explanation of Preliminary Findings

Dear Sir or Madam:

UnitedHealthcare recently reviewed your paid UnitedHealthcare Medicare claims for service date(s) 5/25/2017-12/9/2017. The purpose of the review was to verify The Centers for Medicare and Medicaid Services (CMS) billing and coding requirements were followed and to verify you received the correct payment for the service you provided. As a result, we determined we overpaid the following claim(s) and we are requesting a refund by the amount listed:

A sample of 34 UnitedHealthcare Medicare Solutions Plan records comprising 34 claim lines paid between 5/25/2017 and 12/9/2017 was reviewed and the findings are identified below:

- We had no findings on 20 claim lines reviewed.
- Documentation does not support the services billed on 14 claim lines.

Based on the findings of the reviewed claims, an overpayment of \$187.88 has been identified. The findings of this review were projected onto the audited paid claims universe from 5/19/2017 through 1/11/2017, which resulted in a total overpayment identification of **\$12,949.64**. (Please see attached summary for additional details).

If you agree we overpaid the listed claim(s) please send a refund check payable to UnitedHealthcare along with a copy of this letter to:

Now, there are a lot of interesting things about this letter:

1. There is no explanation as to how the sample was selected...
2. They do not use the term sample frame in an attempt to avoid scrutiny regarding the testing performed to confirm the confidence interval on the upper and lower bound (*for more information on this topic read "The Truth About ZPICs; Authors: Weiss, Cohen, and Waesch, 2017)...*
3. They avoid using the term extrapolation in favor of "Projected" in an attempt to get around having to qualify the individual responsible for the statistical sampling and extrapolation... however, we know what they have done and precisely how to argue the findings.

In this matter, the main issues were not surrounding "Medical Necessity" or the appropriateness of the documentation contained within the patient encounters. Instead, they focused on the legibility issues with the providers' signatures and thus, determined the documentation did not support the services billed.

Fortunately, through strong relationships with several supervisors within the Payment Integrity Department at United Healthcare, I'm afforded the opportunity to pick up the phone and speak directly with them. My goal is always to explain the circumstances and provide additional information to ensure they are able to appropriately adjudicate the claim and close the case in a most expeditious manner.

### Corrective Action:

As with any identified opportunity within your organization, you want to move quickly to cure the potential liability and ensure the go-forward is clean... In this case it was a simple fix:

1. Create a Provider Master Signature Log - for example:

 / Sean M. Weiss;

2. Require every note that your providers affix their signature to also contain their printed name directly under it;

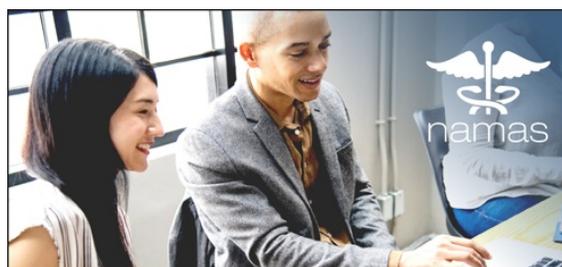
3. When requested by a payer to submit documentation for



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3. When requested by a payor to submit documentation for pre or postpayment audit make sure to include the Provider Master Service Log to ensure you are dotting your I's and crossing your T's to avoid potential denials;
4. If you have a policy regarding provider signature and legibility and the use of a signature log, send that along as well to the payor to further demonstrate that compliance is absolute within your organization...

Taking the time to think through how to effectively respond to an audit down to the most minute of details can save a lot of time, money, and headaches in the long run and prevent further scrutiny of your practice's documentation.

### This Week's Audit Tip Written By:



**Sean Weiss, CHC, CMCO, CEMA, CPMA, CMPE, CPC-P, CPC**

Sean is a Partner and the Vice President of Compliance for our parent organization, DoctorsManagement, LLC.



NAMAS is proud to offer the following webinars in June:

#### **QA vs. Precision Testing** (Auditing Webinar Series)

June 18, 2018- **Note Updated Date**

2pm EST

Speaker: Shannon DeConda

#### **Corporate Integrity Agreements (CIA)** (Compliance Webinar Series)

June 25, 2018- **Note Updated Date**

2pm EST

Speaker: Robert Liles, JD

#### **Hands On: Inpatient E/M Services** (Hands On Webinar Series)

June 26, 2018

2pm EST

Speaker: Kathy Pride

If you are interested in registering for the webinars above, please email us at [names@names.com](mailto:names@names.com)



November 2018 | Clearwater Beach, FL  
Wyndham Grand Clearwater Beach

**Pre-Conference:** Sunday, Nov. 11, 2018

**Conference:** Monday, Nov. 12 -

Wednesday, Nov. 14, 2018

**Venue:** Wyndham Grand Clearwater  
Clearwater Beach, FL

[Click Here to View the Conference Agenda](#)

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