

Know Your Audit! Operational Considerations Under Every Kind of Audit (Advanced)

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Lindsey Loneragan, Senior Associate
General Counsel

Wellspring Health

sloneragan3@wellspring.org

Ross Burris, Health Care
Shareholder

Polsinelli, P.C.

rburris@polsinelli.com

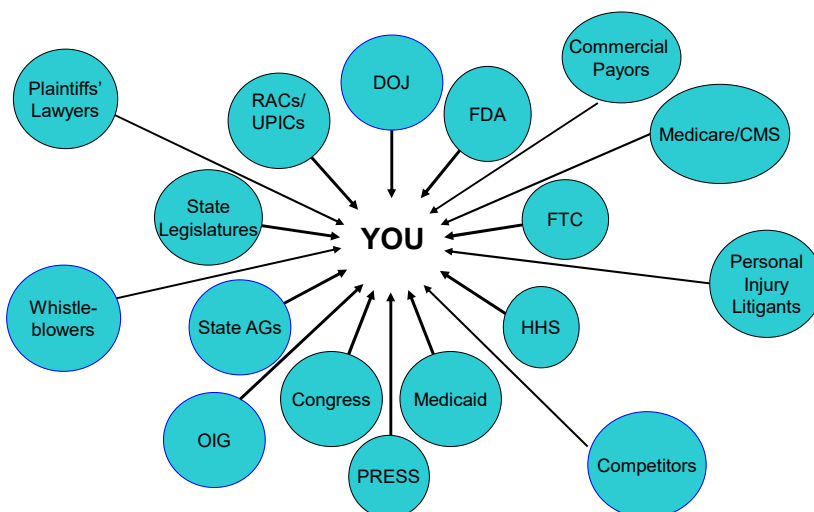
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They're All Watching You



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2

Understanding the Audit Landscape

CMS Claims Review Programs and Their Contractors



CMS Claim Review Programs

Generally, government reimbursement operates as a “pay-and-chase” model

CMS utilizes **two** types of claim review programs:

- Pre-payment review to reduce improper payments
- Post-payment review to recover improper payments

Programs are categorized as either:

- “Complex” – requires licensed professionals to review additional documentation associated with a claim; or
- “Non-Complex” – does not require a clinical review of medical documentation

CMS Claim Review Contractors

What is Appealable?

- *Initial determinations* on claims for benefits under Part A or Part B based on reviews conducted by Medicare contractors

Medicare Administrative Contractors (MACs)

- Process claims from physicians, hospitals, and other health care professionals, and submit payment to those providers according to Medicare rules and regulations
- Includes identifying and correcting underpayments and overpayments

Unified Program Integrity Contractors (UPICs, formerly known as Zone Program Integrity Contractors (ZPICs))

- Perform program integrity functions for Medicare Parts A, B, DMEPOS, Home Health and Hospice, Medicaid, and Medicare-Medicaid data matching.
- Primary goal is to investigate instances of suspected fraud, waste, and abuse in Medicare or Medicaid claims.



5

CMS Claim Review Contractors

Supplemental Medical Review Contractor (SMRC)

- Conduct nationwide medical reviews
- Includes identifying underpayments and overpayments

Comprehensive Error Rate Testing (CERT) Contractors

- Collect documentation and perform reviews on a statistically-valid random sample of Medicare FFS claims
- Produce an annual improper payment rate

Medicare FFS Recovery Auditors (also known as Recovery Audit Contractors or RACs)

- Review claims to identify potential underpayments and overpayments in Medicare FFS, as part of the Recovery Audit Program



6

Claim Denial Determination

Ultimately, audit contractors are tasked with determining whether a claim must be denied

Denial reasons include:

- The item or service is not a covered benefit of the healthcare program;
- The item or service is statutorily excluded from coverage by the healthcare program;
- The item or service is not reasonably necessary; and/or
- The item or service does not meet other program requirements for payment determinations of coverage governed by health care program policy, including but not limited to, national coverage determinations (NCDs) or local coverage determinations (LCDs)



7

CMS Program Integrity

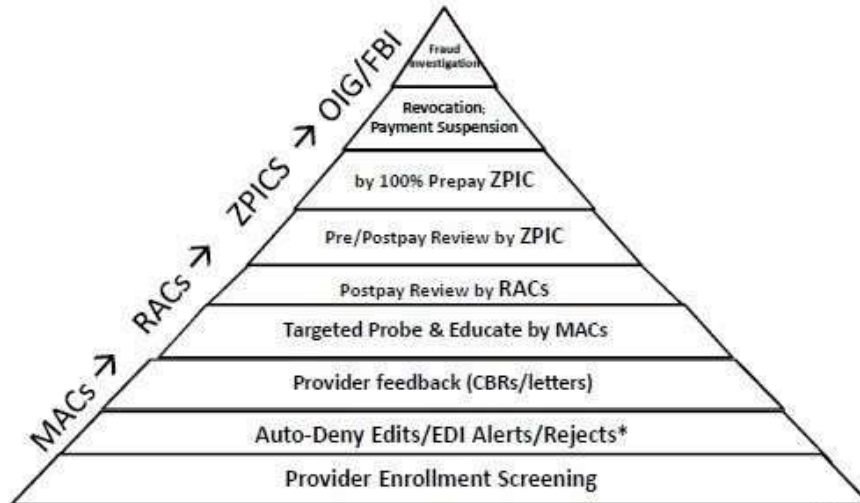
Focuses on:

- Enrollment
 - Provider Screening, Moratoria & Revocation
- Payment
 - Detect fraud & improper billing
 - Deny payment, collect overpayments
 - Data mining, audits
 - Educational tools to encourage compliance
- Information Sharing
 - Share info across programs
 - Share info with law enforcement



8

Who Performs Reviews?



9

Targeted Probe and Educate Audit (TPE Audit)

These audits focus on providers who have historically high claim denial rates, billing practices that vary from their peers, or when evidence suggests there is a risk to the Medicare Trust Fund

MACs

- May only request/review an 20-40 claims per provider per topic

Must send detailed denial reasons after reviews are completed

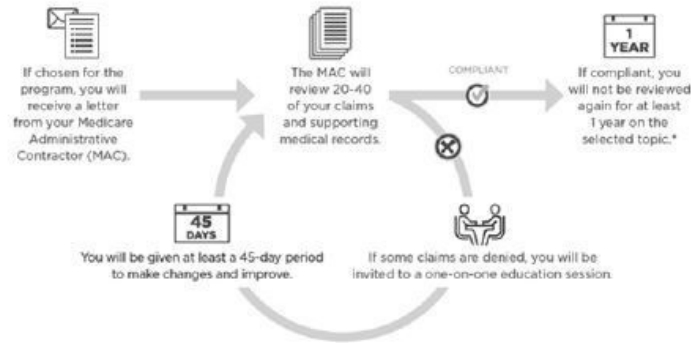
Must offer 1:1 educational call to discuss the denial reasons

Must wait 45 days ("improvement period")

- May repeat for up to 3 rounds; then must STOP reviews and refer (or "escalate") the provider for stronger corrective action
- After 3 unsuccessful rounds, provider is referred for a post-payment review/overpayment demand

10

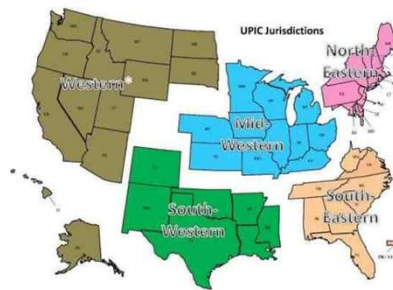
Targeted Probe and Educate (TPE) Program



*MACs may conduct additional review if significant changes in provider billing are detected.

11

Unified Program Integrity Contractor



*Other territories of the Western Jurisdiction to include American Samoa, Northern Mariana Islands and Guam

The purpose of the UPIC is to:

- Coordinate provider investigations across Medicare Parts A/B and Medicaid, including DMEPOS and Home Health and Hospice;
- Improve collaboration with States by providing a mutually beneficial service
- Increase contractor accountability through coordinated oversight
- Includes Medicare Parts A and B, DMEPOS, Home Health and Hospice,

12

UPIC Focus

- Focused annually on CMS priorities relating to fraud, waste, and abuse for potential investigations
 - Proactive Audits
 - Data Analysis
 - Reactive Audits
 - Complaints or allegations of fraudulent behavior
 - On-site reviews
 - Patient interviews/visits
 - Physician interviews/visits
 - Prepayment reviews (often 100%)
 - Postpayment reviews (Extrapolations)
- } Sometimes simultaneous



13

Current Status of UPICs

Midwestern Jurisdiction – awarded to CoventBridge Group

Northeastern Jurisdiction – awarded to SafeGuard Services, LLC

Western Jurisdiction – awarded to Qlarant

Southeastern Jurisdiction – awarded to SafeGuard Services, LLC

Southwestern Jurisdiction – awarded to Qlarant



14

60-Day Overpayment Rule



15

Identification of Overpayments

The Act provides that an overpayment must be reported and returned by the later of:

- i. the date which is 60 days after the date on which the overpayment was identified; or
- ii. the date any corresponding cost report is due, if applicable.



16

Historical Requirements Under 60-Day Rule

Historically, CMS specified that an overpayment is deemed “identified” when the person has or should have, through the exercise of reasonable diligence, determined that the person has received an overpayment **and** quantified the amount of the overpayment

Duty to exercise reasonable diligence arises when that person receives or obtains “credible information” that a potential overpayment exists

At that point, a provider has up to six months (or 180 days) to investigate the potential overpayment and determine whether it exists (and the amount)



17

Major Changes to the 60-Day Rule

The CY 2025 Medicare Physician Fee Schedule updated the 60-day Rule to change the definition of an “identified” overpayment to when a provider “knowingly receives or retains an overpayment”

A provider knowingly receives or retains an overpayment when they:

- (1) know about the overpayment,
- (2) act with deliberate indifference to whether an overpayment exists, or
- (3) act with reckless disregard of a potential overpayment.

Under the new rule, a provider does not need to quantify an overpayment for it to be considered identified



18

Changes to Timeline for Reporting Overpayments

Overpayments must still be reported and returned within 60 days from their identification

However, the 60-day deadline may be suspended for up to 180 days in instances where:

- The provider has identified an overpayment but has not yet completed an investigation to determine the existence of related overpayments that may arise from the same or similar cause or reason as the initially identified overpayment

Deadline to report and return the initially identified overpayment as well as any related overpayments that arise from the same or similar cause or reason is the earlier of

- (1) date that the investigation of related overpayments has concluded and the aggregate amount of the initially identified overpayments and related overpayments is calculated, or
- (2) or 180 days from the date on which the initial identified overpayment was identified



19

60-Day Rule Takeaways

1. An overpayment may be identified even if it is not quantified
2. The lookback period is six years (no change from prior rule)
3. Identification of overpayments is based on the when a provider “knowingly” receives or retains an overpayment, and “knowingly” has the meaning set forth in the federal civil False Claims Act
4. Providers must report and return overpayments within 60 days of the date of identification
5. The 60-day report and return deadline may be suspended up to six months where a provider investigates whether related overpayments exist
6. Only applies to Medicare Parts A and B
7. The methods to report and return overpayments are considerably more flexible



20

New Audit Trends



1. Commercial versus government activity

2. Impact of new administration

3. Criminal DOJ investigation into UnitedHealthcare

4. Increased focus on copay collection efforts

5. Corrective Action Plans

6. AI Audits and Medical Necessity

Commercial Audits on the Rise?

- Commercial audits appear to be increasing in frequency across all payors
- Explanation?
 - Increased shareholder pressure
 - Significant increase of Medicare Advantage members in past decade combined with increased insurer costs due to COVID
 - Corporate greed
- Downturn in government audits, or relative to commercial audit increase?
 - Difficult to say with certainty; data will most likely not be available until next year
 - Anecdotal evidence indicates fewer government audits in traditionally targeted practice areas

Uncertainty with New Administration

- Targeting perceived fraud, waste, and abuse in government-sponsored programs, including Medicare and Medicaid
 - Waste by whom?
- Potential legislation aimed at cutting spending for federal health care programs
 - How will this impact resources for CMS contractors?
 - Fewer resources = fewer audits? Not necessarily a direct relationship
 - Increased pressure for contractors to recover more \$
- Rhetoric vs. reality



23

DOJ Probes UnitedHealthcare

- DOJ is investigating UnitedHealth Group (which includes UnitedHealthcare) for possible criminal Medicare fraud related to its Medicare Advantage business and other potential violations, including Medicare billing practice violations and antitrust violations
- Has been ongoing since at least the summer of 2024
- Investigation adds to increased stock pressure for UnitedHealthcare
- Further erosion of public trust, particularly on the heels of the Change Healthcare data breach
- Increased audit aggression?



24

Copays Are in Play

- Increased commercial audit scrutiny for provider efforts to collect copays
- Large overpayment demands (often based upon statistical extrapolations) due to alleged lack of documentation showing effort to collect copays or deductibles from patients
- Payors consider such conduct as potentially fraudulent and in violation of the federal Anti-Kickback Statute or state parallels
- Frequently see this with providers who have large Medicaid patient population or patients who qualify for Low-Income Subsidy ("LIS")



25

Corrective Action Plans for OON Providers?

- Some plans, such as Cigna, have been conducting intrusive audits for out of network providers and holding up the payment of claims for months
- Often working around state prompt pay statutes, by seeking "additional documentation" related to claims
- In some cases, payors require "Corrective Action Plans" in order to resolve payment demands, even though the providers are not in network



26

The [Ab]use of AI

- Payors across the country are becoming more reliant on AI for audits and overpayment determinations
- Issues with payor AI use?
 - Artificial reductions in reimbursement—e.g., improper down-coding for E/M claims
- *Fremont Emergency Services (Mandavia), et al. v. UnitedHealth Group, Inc.*
 - Suit filed against UnitedHealthcare for underpayment of out-of-network emergency room healthcare providers
 - Nevada jury unanimously found UnitedHealthcare liable for breach of contract, unjust enrichment and two forms of unfair insurance practices and then awarded \$60 million in punitive damages after awarding \$2.65 million in compensatory damages.
 - Also awarded \$20 million in punitive damages to each of the three emergency room provider groups that sued UnitedHealthcare and its affiliates



27

Pay it Backward: Reporting and Refunding Overpayments



28

Mechanics of Reporting/ Returning Overpayments

Providers may report and return overpayments through the OIG Self-Disclosure Process (SDP) or the CMS Voluntary Self-Referral Disclosure Process (SRDP) by requesting a claims adjustment or a voluntary offset, by using the credit balance process, or “another appropriate process.”

The 60-day time period will be tolled while going through the SDP or SRDP process.

Sampling should be conducted “in a manner that conforms to sound and accepted principles” and be based on a statistically valid random selection of claims.



29

Ancillary Overpayment Observations

CMS Views Identifying and Refunding Overpayments as a Ministerial Task.

- CMS suggests that each overpayment should require about six hours to report and return the overpayment, a task that generally should be completed by “miscellaneous in-house administrative personnel,” but sometimes accountants and auditors

CMS notes that, “We believe only the rarest of circumstances (such as potential fraud or certain investigations of potential violations of the physician self-referral law) would necessitate more costly personnel, such as legal counsel, to comply with the final rule.”



30

Ancillary Overpayment Observations

Offsetting Overpayments with Identified Underpayments.

- CMS declined to permit providers to offset identified overpayments with underpayments that may be identified in the course of the same review.
- Underpayment issues are beyond the scope of the Final Rule.

Overpayments Associated with Unlicensed Personnel.

- Provision of covered services by unlicensed personnel is not a bright-line test for overpayments
- Must look to “relevant laws, regulations and billing rules” to see if there is a nexus between licensure and Medicare payment.



31

Overpayments and the False Claims Act



32






33

Implied Certification Theory Concerns *Post-Escobar*

- Health care providers are required to comply with innumerable state and federal laws and regulations
- Under the implied certification theory, providers are exposed to harsh False Claims Act ("FCA") penalties for failure to comply with any of these laws/regulations despite no express false claim or false statement being made.

34

	Condition of Payment	Condition for Coverage (CfC)	Other Laws/Rules
Definition	<ul style="list-style-type: none"> Rule expressly ties payment to compliance 	<ul style="list-style-type: none"> Enrollment or participation requirements 	<ul style="list-style-type: none"> Other applicable laws or rules (e.g., AKS, Stark, CMPL, state laws, etc.)
Prior Analysis	<ul style="list-style-type: none"> High FCA risk 	<ul style="list-style-type: none"> Low FCA risk because rule not basis for payment 	<ul style="list-style-type: none"> Low if comparable to participation; high if comparable to payment rules
New Analysis	<ul style="list-style-type: none"> High FCA risk 	<ul style="list-style-type: none"> Underlying legal theory similar, but FCA risk inherently increased Risk analysis may vary based on factual scenario 	<ul style="list-style-type: none"> Dependent on underlying law/rule Underlying legal theory similar, but FCA risk inherently increased Risk analysis may vary based on factual scenario
	 <p>No change under <i>Escobar</i></p>	 <p>Increased risk under <i>Escobar</i> may lead to different mitigation strategies</p>	 <p>Increased risk under <i>Escobar</i> may lead to different mitigation strategies</p>

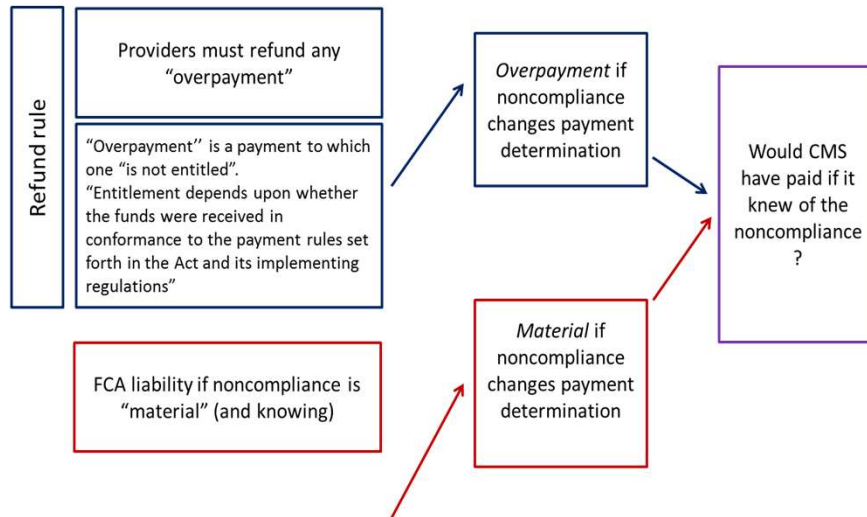
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FCA Risk Analysis of Potential Overpayments

- **Before *Escobar***
 - If overpayment, then recommend refund
 - Refund addresses overpayment rule and FCA risk
 - If no overpayment, low FCA risk
 - No further mitigation likely needed
- **Post *Escobar***
 - If overpayment, then recommend refund
 - Notice and refund address overpayment rule and increased FCA risk
 - If no overpayment, may have FCA risk
 - *Escobar* permits fact argument that the noncompliance is material
 - Substantial ambiguity regarding materiality/effect of legal arguments

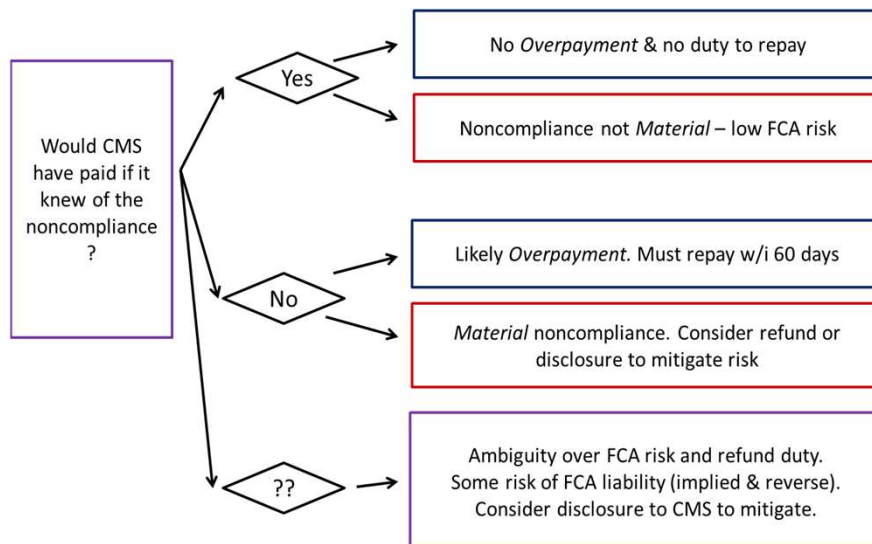
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Escobar and Refund Rule



37

Escobar and Refund Rule



38

What has *Escobar* and its progeny taught us?

Operationalize your compliance program.

- Supreme Court, in *Escobar*, crafted a materiality standard that they believed allowed providers to anticipate and prioritize compliance obligations.

Know who you are employing.

- Supreme Court relied on these issues to make its decision despite it not being highlighted in earlier litigation.

Know and follow the regulations.

- Due to lack of consistency in federal court application of *Escobar*, depending on your location, they are all in play.



39

Hypothetical Audit Scenarios

What would you do?



40

Scenario One AI Audit

Regulation requirement for clinical review to be performed by physicians

Is it AI or not?

Unlicensed/corporate practice of medicine?



41

Scenario Two: OIG-OAS Audit



RE: Potential Overpayments Identified by the Office of Inspector General
Provider Name:
Provider Number:

Dear Sir/Madam:

The Office of Inspector General (OIG) has identified potential overpayments related to some claims the Centers for Medicare & Medicaid Services (CMS) previously paid to you. These claims were identified during the OIG audit titled, Medicare Hospice Provider Compliance Audit. The objective of this audit was to determine whether complied with Medicare billing requirements when billing for hospice services provided to Medicare beneficiaries.

As required by 42 CFR 401.305, a provider/supplier who has received an overpayment must report and return the overpayment within 60 days after having identified the overpayment. (The overpayment can also be reported and returned by the date any corresponding cost report is due, if applicable.) This requirement applies to overpayments identified within six years of the date the overpayment was received. In addition, when a government agency informs a provider/supplier of a potential overpayment, the provider/supplier has an obligation to accept the finding or make a reasonable inquiry to determine whether an overpayment exists.

If overpayments exist, you have several options for returning the overpayments such as provider-initiated claims adjustments, requesting the Medicare Administrative Contractors (MACs) to adjust the claims, sending a check, or requesting an extended repayment plan.

The following OIG Recommendations require your review and attention:

Recommendation 2: "based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation."

Please provide your MAC with written confirmation that you performed a self-assessment of the claims as set out in the recommendation(s) above and determined that either no claims were submitted in error, or you have identified and returned, or are working to return, applicable overpayment(s) to the

1

- OIG-OAS performs audit, identifies alleged overpayment
- Per findings, OIG-OAS recommends provider performs its own lookback pursuant to the 60-day rule
- How do you move forward based on this letter? What are your appeal rights?



42

Report in Brief
Date: _____
Report No.: _____

Why OIG Did This Audit
The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of 6 months or less who have elected hospice care. Previous OIG audits and evaluations found that Medicare inappropriately paid for hospice services that did not meet certain Medicare requirements.

Our objective was to determine whether hospice services provided by _____ complied with Medicare requirements.

How OIG Did This Audit
Our audit covered 21,537 claims for which _____ (located in _____) received Medicare reimbursement of \$101.5 million for hospice services provided from _____. We reviewed a random sample of 100 claims. We evaluated compliance with selected Medicare billing requirements and submitted these sampled claims and the associated medical records to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Hospice Provider Compliance Audit:

What OIG Found
_____ received Medicare reimbursement for hospice services that did not comply with Medicare requirements. Of the 100 hospice claims in our sample, 79 claims complied with Medicare requirements. However, the remaining 21 claims did not comply with the requirements. Specifically, for 19 claims, the clinical record did not support the beneficiary's terminal prognosis, and for the remaining 2 claims, there was no documentation to support the hospice services that Franciscan billed to Medicare.


Improper payment of these claims occurred because _____ policies and procedures were not effective in ensuring that the clinical documentation it maintained supported the terminal illness prognosis and the hospice services billed to Medicare. On the basis of our sample results, we estimated that _____ received at least \$13 million in unallowable Medicare reimbursement for hospice services.

What OIG Recommends and Franciscan Comments
We recommend that _____: (1) refund to the Federal Government the portion of the estimated \$13 million for hospice services that did not comply with Medicare requirements and that are within the 4-year reopening period; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen its policies and procedures to ensure that hospice services comply with Medicare requirements.


In written comments on our draft report, _____ disagreed with our findings for 12 of the 19 sampled claims for which the clinical record did not support the beneficiary's terminal prognosis and said that a physician's clinical judgment is fundamental in determining that prognosis. _____ also disagreed with our use of extrapolation across the audit period. _____ agreed with our second recommendation and disagreed with our first and third recommendations.

After reviewing _____ comments, we maintain that our findings and recommendations are valid. Federal regulations require that clinical information and other documentation support the beneficiary's terminal prognosis and be filed in the medical records. The report contains the details of our response.

- OIG-OAS will also publish a Final Report detailing the audit and related findings, which is **publicly available**
- Prior to the Final Report's publication, providers will have the opportunity to submit response to OIG-OAS' findings
- Here, OIG's Final Report identified an estimated overpayment of **\$13 million**



43



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: _____

INITIAL REQUEST
RE: Claims Accounts Receivable - MMA 935
Overpayment Amount: \$590,913.00
Outstanding Balance: \$590,913.00
Provider Number: _____

Dear Sir/Madam,

This letter is to inform you that you have received a Medicare payment in error, which has resulted in an overpayment subject to section 935(f)(2) of the Medicare Modernization Act (MMA), section 1863(f)(2) of the Social Security Act, Limitation on Recoupment, in the amount \$590,913.00. **The purpose of this letter is to request that this amount be repaid to our office.** The attached enclosure explains how this happened.

NOTE: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding please follow the instructions found at the end of this letter.


Why you are responsible:
You are responsible for being aware of correct claim filing procedures and must use care when billing and accepting payment in this situation, you billed and/or received payment for services you should have known you were not entitled to. Therefore, you are not without fault and are responsible for repaying the overpayment amount.

If you dispute this determination, please follow the appropriate appeals process listed below. Please be aware that you may appeal all of the claims from this overpayment demand letter or any part of the claims. (Applicable authorities: section 1870(b)(3) of the Social Security Act; Subsections 405.350-405.359 of Title 42 CFR, Subsections 404.506-404.509, 404.510 (a) and 404.512 of Title 20 of the United States Code of Federal Regulations.)

This amount is subject to section 935(f)(2) of the Medicare Modernization Act (MMA) (Section _____)

National Government Services, Inc.
PART A OVERPAYMENT RECOVERY, WINGS-MSD1
PO BOX 6474, Indianapolis, IN 46206-6474
www.ngmedicare.com

MEDICARE
Part A Intermediary



- Following the OIG-OAS Final Report, CMS (through the MAC) issued an overpayment demand
- Time to follow the Medicare overpayment appeal process
- But wait...the overpayment amount is much smaller! What about the rest of \$12.4 million? Am I off the hook?

44

Scenario Three: UPIC Medicare Audit

Overpayment Summary:

Claims were selected for medical review as a result of proactive data analysis by the NE UPIC. A medical review was used to determine if the claims and submitted documentation met Medicare requirements set forth by federal statute (Title XVIII of the Social Security Act) and regulations, the Medicare Program Integrity Manual, and the Medicare Administrative Contractor's Local Coverage Determination(s). Forty-nine (49) of the forty-nine (49) Medicare beneficiaries' medical records contained paid claims and were subjected to detailed medical review. All relevant documents and pertinent information were subjected to detailed medical review. All specific rules, regulations, and guidelines utilized for this medical review were in effect when the review service was performed.

A review of the medical records resulted in: 173 of the 177 service or 98% being denied, and four (4) services or 2% being allowed. Three (3) services were not subject to review as they were previously denied. Notable findings from the medical review include:

- Documentation submitted does not support medical necessity of the service billed.
- Documentation submitted does not support the service billed or modifier used.

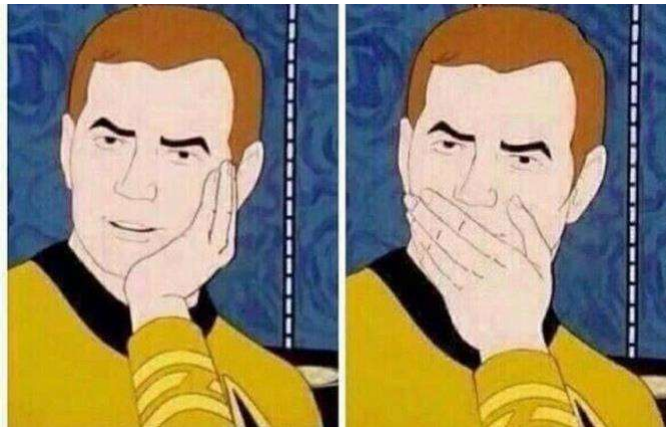
Based on our medical review, we have determined an overpayment amount for each claim in the sample and have totaled the claims to identify the overpayment. The calculated overpayment determined from the sample is **\$13,249.06**. The Error Rate is 95.34 percent.

From the sample, the total projected overpayment is determined. Based on the findings of this medical review, an extrapolated overpayment of **\$817,238.83** is due to the Medicare Program. A spreadsheet with a detailed explanation of the denied claims and the overpayment computation is enclosed.



45

Seeing a sample overpayment of \$13,249.06
v.
Seeing an extrapolated overpayment of \$817,238.83:



46

Scenario Four: TPE Audit



Re: **Notice of Review**
Targeted Probe and Educate Round 1
Case Number:
National Provider Identifier (NPI):
Billing Provider:

Dear Provider:

In order to fulfill our contractual obligation with Centers for Medicare and Medicaid Services (CMS), Novitas Solutions, Inc. (herein Novitas Solutions) your Jurisdiction J.L. Medicare Administrative Contractor (MAC), performs reviews in accordance with the CMS instruction. CMS has authorized Novitas Solutions to conduct Targeted Probe and Educate (TPE) reviews. The TPE review process may include three rounds of a pre or post payment probe reviews with education. If there are continued high payment adjustments after three rounds, Novitas Solutions may refer the provider/supplier to CMS for additional action. These actions may include additional rounds of TPE review, 100% prepayment review, extrapolation, referral to the Recovery Auditor Contractor (RAC) or Unified Program Integrity Contractor (UPIC), referral for revocation, etc. Discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

This letter serves as notification of the TPE process and to notify you of the initiation of the review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations.

Reason for Review:

Novitas Solutions is tasked with preventing inappropriate Medicare payments which is accomplished through provider education, training, and the medical record review of claims. Novitas Solutions performs data analysis on a regular basis on all providers that it services to assure compliance with the Medicare Program requirements.

You were chosen for a TPE review for procedure code(s) 99214 – Established patient office or other outpatient visit, 30-39 minutes, due to having a high allowed amount of \$175,311.98 and allowed dollar per beneficiary that is over the jurisdictional average. The time frame of this analysis is based on claims finalized from [REDACTED] through [REDACTED].

A random sample of 20-40 claims will be selected for review to determine if you are billing and coding according to Medicare guidelines and to ensure services are reasonable and medically necessary.

Novitas Solutions, Inc.
www.novitas-solutions.com



47

Scenario Four: TPE Audit

- How do I make sure the audit doesn't get to Round 2? Round 3?
 - Company hygiene
 - Take these audits seriously
- What happens if there are still issues after Round 3?



48

Questions?



Lindsey Lonergan
Senior Associate General Counsel
WellSpan Health
slonergan3@wellspan.org



Ross Burris
Health Care Shareholder
Polsinelli, P.C.
rburris@polsinelli.com
(404) 253-6010
Twitter: @ATLHealthLawyer

