UNRAVELING THE MYSTERY OF INSURANCE AUDITS

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PHYSICIANS ADVOCACY INSTITUTE "PAI"

- Founded in 2006 as Result of MDL Managed Care Litigation, in which MSNJ Involved
- PALC Committee Comprised of Legal Counsel for States Involved in MDL Litigation, Including Larry Downs

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PAI MISSION

To Advance Fair and Transparent Payment Policies and Contractual Practices by Payers and Others in Order to Sustain the Profession of Medicine for the Benefit of Patients

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THE IMPORTANCE OF MEDICAL AUDITS

- OIG and DOJ's Budgets Augmented by "Fraud and Abuse" Recoveries=Billions.
  - OIG Recovery Ratio: $7 collected to $1 spent
  - ACA's Integrity Laws as "Pay Fors"
  - Medicare Growing @ >10,000 Baby-Boomers/day.
- Extrapolation is used by Gov't and Health Plans to Demand Large Overpayments on Small Samples.
- Software Programs Allowing Automated Review of Claims and Billing Patterns for Potential Issues of Inappropriate Billing and Fraud, e.g. Predictive Modeling
- Contingent Payments to RAC Auditors Incent Overpayment Findings

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WHAT THE IMPORTANCE OF MEDICAL AUDITS MEANS

- Medical Audits are Here to Stay
- Physicians Should Consider Medical Audits as Regular Part of the Business of Practicing Medicine and Plan Accordingly

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INITIATION OF THE AUDIT PROCESS

- Typically a Letter Requesting Medical Records
- Governmental Audits Initiated by an Additional Request for Records (ADR)
- Audits Can Be Triggered by Review of Claims Data or Based on CERT Findings
- Sometimes Triggered by Calls from Staff or

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UNRAVELING THE MYSTERY OF INSURANCE AUDITS: TOP TEN TIPS

- Benchmark Your Coding and Documentation Practices with Others of Your Specialty
- Do Not Use Default Settings on EHRs
- Objectively Evaluate Audit Findings

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TIP #1: ASSESS THE RISK OF AN AUDIT BEFORE IT OCCURS

- RAC, Other Governmental and Private Payer Auditors Use Software Programs to Identify Possible Issues with Medical Claims and So Should You
- Analyze and Understand Reasons for Outliers in Advance of an Audit
- Review Electronic Medical Records Product and Your Practice's Use of It to Ensure Output of EMR Complies with Coding Rules
- Conduct Peer Review Audits Among Physicians in Medical Practice
- Ensure Software Programs Allow Your Practice to Verify Accuracy of Claim Payments
- Regularly Review Changes in CPT and Payers' Medical Policies

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TOOLS FOR BENCHMARKING

- Part B Nationalization Summary Data File (BESS) Allows Benchmarking of Code Utilization with Others in Your Specialty
- Medicare's Comprehensive Error Rate Testing (CERT) Report Can Be Used to Determine Billing Codes Commonly Found to Have Errors

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THE IMPORTANCE OF BENCHMARKING

- Allows Physicians to Determine if Their Billing is Consistent (or Out of Line) with Others in their Specialty
- Allows Physicians to Determine if There are Reasons Why Billing Differs from Others in Their Specialty (e.g. Subspecialized Practice, Patient Mix, etc.)
- Prompts Physicians to Verify Billing in Accordance with CPT and Medical Policies
- Has Implications on Other Payer Policies Impacting Physicians' Bottom Lines – Profiling, Tiered Networks, etc.
- Always Verify that Practice is Correctly Classified by Payers so that Proper Benchmarks Apply

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TIP #2: BE PROACTIVE IN ENSURING PROPER CODING AND BILLING

- Report
- CS STARS Software
- Level 4 and 5 E/M Codes
- Coding Rules, Documentation and Relevant Medical Policies All Important
- CERT
- Should Be Part of Every Practice's Compliance Program
- Coding Applied by EHR Systems Not Always Accurate
- Provides Strong Defense if Audit Occurs

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ELECTRONIC HEALTH RECORDS

- Do Not Set at Default Settings
- Do Not Blindly Copy and Paste Between Records
- Past History Should be Reviewed, Not Merely Copied
- Update Information as Necessary
- History of Present Illness Based on Symptoms on D/O/S
- Diagnosis Codes Only for Conditions Addressed on D/O/S
- Review Coding to Ensure Accuracy

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TIP #3: DETERMINE PAYOR AND TYPE OF AUDIT BEFORE RESPONDING

- Payers Often Contract with Outside Vendors Who Don't Necessarily Disclose Payer on Whose Behalf the Audit is Being Conducted "Proxy" Audits
- Determine Payer, Scope of Audit and Type of Audit Before Responding
- Necessary Not Only to Learn More About the Audit and Process, but Also to Verify that Access to the Records is Permitted Under HIPAA and State Law
- Respond to Any Requests for Medical Records as if an Audit Because Medical Record Requests are Often Precursors to Audits
- Consider Retaining an Attorney or Other Consultant (Highly Recommended for UPIC/ZPIC Audits)

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TIP #4: PAY ATTENTION TO DEADLINES AND PROCEDURES

- Designate Individual Responsible for Responding Before Audit Occurs
- Calendar All Deadlines
- Respond Promptly or Seek Extensions
- If No Deadline Specified, Ask and Document
- Failure to Meet Deadlines and Comply with Procedures Can Have Consequences
  - Failure to Comply with Authentication Requirements Can Result in Documents Not Being Considered

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TIP #5: ENSURE THAT MEDICAL RECORDS COMPLETE

- Important Because Payers Do Not Always Permit Records to be Supplemented
- Verify that Medical Records are Legible (and Provide Transcript of Illegible Portions)
- Verify that No Information Has Been Cut Off in Copying
- Complete the Medical Records with Any Documents that Had Not Yet Been Added to the Chart (but Do Not Alter the Medical Record)
- Include Explanation/Support for Any Unusual Services/Tests
- Send Records in a Manner that Allows Tracking and Maintain Record of What Has Been Sent

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TIP #6: WHEN USED, ENSURE FAIR EXTRAPOLATION

- Extrapolation – Statistical Sampling Used to Determine and Project an Error Rate
- RACs May Not Use Extrapolation Unless:
  - Determination of Sustained or High Error Rate
  - Educational Corrective Action by the MAC has Failed to Correct Errors
- But, a RAC's Determination to Use Extrapolation Cannot be Challenged on Appeal
- Commonly Used by Commercial Payers
- Extrapolation Limited by New Jersey Law

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STATISTICALLY SOUND/FAIR EXTRAPOLATION

- Ensure that Outliers are Removed from the Calculation
- Ensure that Zero Paid Claims are Removed from the Calculation
- Ensure that Underpaid Claims, as Well as Overpaid Claims, are Included
- Consider Seeking Review of 100% of Claims to Ensure Accuracy and Inclusion of Underpaid Claims
- PAI's White Paper

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TIP #7: VERIFY AUDIT FINDINGS

- Often Erroneous
- Approximately 44% of RAC Audit Findings Overturned on Appeal at the ALJ Level (3rd Level of Appeal), but Only 6% of Providers Appeal)
- Check the Math
- Determine Whether Auditor's Conclusions Regarding Incorrect Codes or Insufficient Documentation Justified
- Review Audit Findings Objectively

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TIP #8: UNDERSTAND APPELLATE RIGHTS AND APPEAL ERRONEOUS ADVERSE FINDINGS

- Determine Payers' Appeals Process
- Calendar All Dates
- Timely Appeal Erroneous Adverse Findings
- Take Advantage of Opportunities to Informally Discuss Audit Findings with Auditor, but Understand that Such Discussions Do Not Stay Deadlines
  - RAC Appeals Informal Discussion Process
  - Conversations with Medical Director When Under Pre-payment Review

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NEW JERSEY LAW

- Health Care Claims Authorization, Processing and Payment Act
- Limits Overpayment Recovery to 18 Months
- Requires Payer to Provide Written Documentation, Identifying Payment Error and Justifying Overpayment Request
- Does Not Apply to Fraudulently Submitted Claims, Claims Submitted by Providers with a Pattern of Inappropriate Claims Submission, or Claims Paid under Coordination of Benefits

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TIP #9: INCLUDE ALL NECESSARY INFORMATION TO REFUTE ERRONEOUS AUDIT FINDINGS ON APPEAL

- Restate and Refute Every Element of Audit Finding Being Appealed, Assuming Individual Reviewing the Appeal Does Not Have Any Background About Your Audit
- Cite any CPT Coding Policy or Reference Material, Medical Policy or NCD and LCD Relied On
- Cite any Pertinent Medical Literature for Medical Necessity Denials
- Include Summary of Why Audit Findings Erroneous
- Consult with Counsel and Outside Experts as Appropriate in Preparing Appeal (but Should be Strongly Considered in Cases of Suspected Fraud)

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TIP #10: CHANGE ANY IDENTIFIED ISSUES WITH CODING AND BILLING

- Auditors May Identify Genuine Issues in a Physician Practice's Coding and/or Documentation
- Objectively Assess Audit Findings
- Correct any Identified Problems
- Notify Payer of Corrective Action
- Negotiate Payment Plan if Necessary

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THE FAIR MEDICAL AUDITS ACT (H.R. 2568)

- Designed to Make Audit Process More Transparent and Fairer
- Requires that Detailed Information be Provided to Providers Regarding Audit and Audit Findings
- Specifies Qualifications for RAC Auditors
- Prohibits Recouping Alleged Overpayments from Providers Until After Second Level of Appeal
- Promotes Provider Education
- Requires Compensation to Providers for Providing Medical Records
- Shortens Look-Back Period to Two Years

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AFIRM (SENATE FINANCE)

- Audit and Appeal Fairness, and Reforms in Medicare Act
- Establishes CMS Ombudsman for Providers
- Reduces Levels of Appeals
- Creates Medicare Magistrates to Hear Appeals from Appeals with Lower Dollar Amounts
- Creates ADR Process
- Develops Qualification Standards
- Requires Publication of Auditor Accuracy Statistics
- Provides Incentive Payments for Provider Education

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PAI RESOURCES FOR AUDITS

- Fair Medical Audit Toolkit
- White Paper: *Medical Audits: What Physicians Need to Know*
- Checklists for Responding to Audits and Appealing Audit Findings
- www.physiciansadvocacyinstitute.org

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