

Third-Party Payor Audits: Impact on Physician and Healthcare Provider Clients

by Andrew B. Wachler and Abby Pendleton, Esq.

A healthcare provider's claims for medical services may be audited by payors (e.g., Medicare, Blue Cross Blue Shield of Michigan ["BCBSM"] and Medicaid) for a number of reasons. Some audits are a result of random selection, and some result from data analysis reflecting that the provider is outside the norm among their peers in the provision of services. Audits may also arise from complaints by individuals – including patients, disgruntled employees, and competitors – about the provider's billing practices.

Regardless of the initial reason for the audit, once the audit process is in place, the healthcare provider is likely to be dissatisfied with the results. Due to the negative consequences that often follow an audit, it is very important for the provider to appeal the audit results in conformance with the applicable appeals process. Failure to do so can lead to large monetary paybacks, continuing problems with the ongoing submission of claims, re-audits, placement on pre-payment utilization review, suspension of Medicare payments, or termination/disaffiliation from the program. Although many providers who receive audit results requesting small monetary payback amounts do not believe that it is necessary to exercise the appeals process, in many circumstances it is in the best interest of the provider to appeal, as the provider can continue to face problems with future claim submissions and re-audits.

The General Audit Process

The audit process varies depending on the third-party payor at issue. Medicare, BCBSM and Medicaid are the most active payors for auditing in Michigan. In many cases, the provider becomes aware of the audit through notification requesting that the provider send copies of identified medical records to the payor or through notification that the payor will be performing an on-site review of medical records (which may or may not be identified beforehand). At this stage in the audit process, many providers will not seek the assistance of legal counsel. It is, however, advisable for providers to contact legal counsel even

at this early stage in the audit process. Counsel may be able to discern what the primary issues will be in the audit and may have a better understanding of the direction the audit will take. Counsel will also be able to direct providers from the start to best protect their interests. For example, counsel will advise providers that under no circumstances should records be altered in an effort to correct deficiencies after a notification of audit has been received. Such correction, which may be a natural reaction for some, may result in criminal and licensure problems for the provider.

When audits are performed on-site, healthcare legal counsel often advise their provider clients that they should have a trusted employee sit in the room with the auditors during the review and photocopying process. Stories of original medical records being inadvertently thrown away, destroyed, or lost by auditors are not uncommon. Further, an employee familiar with the record-keeping system may be able to direct auditors to the records they need. For example, some practices keep laboratory results in separate charts. An employee familiar with the office's organizational system may be able to decrease the number of erroneous denials. As some providers have experienced, many auditors do not take the time to make sure they have carefully looked for all pertinent documentation and thus the records should be easily accessible for the auditors. In many circumstances, the auditors will hold entrance and exit interviews with provider staff. Again, the individual(s) chosen to attend the entrance and exit interviews should be trusted employees. Providers should be cautioned to take care before discussing claims decisions with auditors. Statements made by providers in exit interviews or at any other time during the audit may be utilized against a provider later. Given that audits sometimes serve as the springboard for more serious sanctions including criminal investigation, providers are best advised to be cautious when speaking with auditors. Depending on the circumstance, some providers may not wish to speak with the auditors directly at all.

Upon completion of the record review, the payor will notify the provider that the claims are payable, partially payable, or denied. The most common denials, by way of example, are denials based on lack of medical necessity to support the claim, denials based on insufficient documentation and denials based on up-coding. Depending on the payor, when the provider is sent a post-payment audit denial letter, the letter will make an overpayment demand, provide a time frame for recovery of the overpayment and set forth the steps in the appeals process.

Of particular importance for providers involved in Medicare audits are the new changes in Medicare law that address repayment plans and time frames for recoupment. As part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (passed into law on December 8, 2003, and hereinafter referred to as “the MPDIMA”) drastic changes were made to the Medicare recoupment process. Specifically, for those providers who request a Medicare Hearing of an overpayment determination, the law now in effect prohibits the Medicare carrier from instituting recoupment on the overpayment demand until after a decision has been rendered by the Medicare Hearing Officer. Thus, while providers were previously forced to begin the repayment process prior to obtaining any meaningful independent review, the new law does not permit recoupment to take place until after the first level of appeal has occurred. In cases involving alleged overpayments of high amounts, this provision will prove beneficial for providers by allowing providers to properly work up their cases for the hearing officer level of appeal rather than rushing the process in an attempt to stop a financially devastating withhold process. Some Medicare carriers are not aware of the changes in the law and thus providers, with assistance of counsel, may need to seek intervention by the

Regional Office and/or the Office of General Counsel that oversees the Medicare carrier. Legal counsel should also be aware that with regard to BCBSM audits, the recoupment process cannot begin until after exhaustion of the appeals process. Thus, once the provider timely begins the appeals process, BCBSM cannot begin recoupment until completion of the appeals process.

Providers and their counsel should also know that in many cases where the payor believes that the post-payment audit has uncovered potential fraud, it will not request a refund from the provider until the fraud issue is resolved. Instead, it will refer the matter to the fraud unit. Accordingly, providers may have reason for concern if an audit process has begun but no audit results are forthcoming.

After receiving the audit results, providers must be careful to timely exercise their appeal rights. It is advisable for legal counsel to prepare the appeal paperwork to ensure that all requirements are met and that the appeal is timely filed. For example, the Medicare appeals process requires that the provider request the first level of appeal (i.e., a Medicare Fair Hearing) within 180 days from the audit determination. Providers and their legal counsel must also be mindful of the various statutory and regulatory appeal requirements that may apply. For example, with regard to Medicare audits, as a result of the MPDIMA, as of October 1, 2004, providers are prohibited from presenting evidence at later stages in the appeals process if such evidence was not presented at the hearing officer stage. If the amount-in-controversy threshold is met, providers dissatisfied with the results at the hearing officer level may then request a hearing in front of an administrative law judge. After that, the provider may appeal to the appeal council and then ultimately to federal court. With regard to BCBSM audits, the provider must first

request an informal managerial level conference and then, depending on the nature of the issues, the provider may pursue either a contractually set forth arbitration process, circuit court, or the insurance bureau review process. Providers who choose to request a review and determination by the insurance commissioner after being dissatisfied with the informal managerial level conference have subsequent appeal rights to an administrative law judge and then to circuit court.

Audit Defenses

In addition to defending the audit on the substantive merits, which may include providing written medical summaries of the claims at issue focusing on the services that were denied and the medical explanation for why the services were medically necessary (this may involve retaining a physician expert in some cases), providers may also take advantage of other legal defenses, including:

- Challenging the statistical sampling in audits involving extrapolation (this will usually entail retention of a statistical expert);
- For Medicare audits, arguing the "treating physician rule" (i.e., the treating physician is in the best position to make determinations of medical necessity and his determination should prevail over a reviewer who merely reviews paper);
- For Medicare audits, arguing "waiver of liability" and/or the "provider without fault" defense;
- In BCBSM audits, showing that BCBSM violated various provisions of PA 350 of 1980 and the accompanying administrative code regulations in conducting the audit and in making its denials (this law is BCBSM's enabling legislation and sets forth many prohibitions and mandatory requirements that BCBSM must follow); and
- Challenging denials based on lack of payor policies or notice to the provider community or failure of the payor to follow its own published policies.

In defending the audit, it is often useful to submit a “position paper/statement” setting forth the substantive and legal defenses. This document is typically submitted prior to the hearing and can be used as a guide at the hearing and also sets forth the arguments and positions in writing so that the decision-maker has all of the information clearly set forth for use before and after the hearing. Legal counsel will be in the best position to draft the paper but will need assistance from the provider client with regard to the substantive merits portion of the document.

Summary

Undergoing a payor audit can carry serious consequences for healthcare providers. As such, legal counsel should advise their healthcare provider clients that the best way to protect themselves against the negative potential impact of third-party payor audits is to implement an effective compliance program. Compliance programs can be useful in identifying problems and providing the opportunity to correct problems before an audit. An effective compliance program should include substantive policies setting forth the various payor billing and documentation requirements as well as having a system in place to obtain and maintain the various payor policies, rules and guidelines.

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