Private Payor Audits of Health Care Providers: Know Your Rights

8/12/2010

Deborah J. Williamson

The recent focus on Recovery Audit Contractor (RAC) audits and health care reform has not distracted private third party payors, including Blue Cross Blue Shield of Michigan (BCBSM), from their usual audit practices. Post payment audits by private payors are alive and well in Michigan.

What Triggers An Audit?

The biggest mystery in the audit process is its origin. Often, no discernable reason ever emerges as to why a provider has been selected for an audit. However, over the years, we have been able to identify some general circumstances that often lead to an audit. I have outlined three of them here.

1) Computer Monitoring of Practice Patterns

A higher-than-average use of certain procedures and the existence of outlier payments are probably the most common audit triggers. Periodically, some third party payors compare utilization patterns among physicians with similar practices in the same geographic area. For example, BCBSM prepares Business Practice Profiles every six months, which compare the practice patterns of physicians within the same "peer group." A provider might be flagged for an audit if he or she bills more of specific procedures than peer averages. Similarly, if a provider receives overall reimbursement exceeding a certain guideline set by the payor, then the provider might be targeted for an audit.

Additionally, an audit may be triggered if a practice's billing patterns or reimbursement amounts change substantially over a short time. Yet there could be a perfectly reasonable explanation for the increase, such as the purchase of a new piece of equipment. If that's the case, it may behoove the provider to proactively notify the payors of the situation.

2) Employee or Patient Complaints

Unfortunately, complaints from disgruntled former employees and patients frequently will trigger audits or investigations. Employees who feel as if their concerns about billing issues have fallen on deaf ears may take them directly to the payor. Patients, particularly the elderly, may complain to payors because of a misunderstanding about their Explanation of Benefits (EOBs). For example, minor office procedures are often described as "surgery" on an EOB, prompting questions as to whether the service was billed appropriately. BCBSM and other payors encourage patients to ask questions, and Medicare even pays a

bounty in some cases. This leads to increased patient complaints, both valid and invalid. In the case of both employees and patients, it is important to listen and respond to any billing concerns.

3) Random Selection

Obviously, there is no protection from this trigger. Indeed, audits are part of the business of health care, so everyone is at risk. And even if the circumstance that triggered the audit proves to be wrong (e.g., unsubstantiated patient complaints or comparisons to the wrong peer group) it's tough to stop an audit once it is in motion.

The Audit: What to Expect, What to Do

Before the Audit

The audit will be initiated by a telephone call or letter from a third party payor requesting to review a sample of records. It is important to involve counsel experienced in audit defense as soon as possible after receiving this notification. The early stages of the audit are filled with potential pitfalls. How the provider responds at the onsent may shape the course of the entire process.

For example, auditors will often request that providers complete complex questionnaires about the medical practice, which include questions about office policies, medical equipment, the practice's financial and contractual arrangements, and the like. Completing the questionnaire provides the payor with information that later may be used against you. Involvement of counsel is crucial when determining how, or if, this information should be provided. Third party payors are entitled to billing and medical record information. Any other requests should be carefully considered.

Additionally, auditors often try to inject an element of surprise. Depending on the payor and the size of the audit, the auditors may or may not supply a list of patients in advance of their arrival. If they do, it is often shortly before the audit is scheduled to begin. Counsel may be able to help pull the reigns in on the auditors.

Counsel can help determine the auditor's credentials and the division for which the auditor works. This should shed some light on the type of audit and why it was initiated. Often, the auditor will not disclose its true nature. It is incumbent upon counsel to determine whether the audit is routine or is an investigation of fraud.

Finally, there may be ways to delay or prevent the audit. Once an audit is in motion, it is extremely difficult to stop. An evaluation of whether there are special circumstances that may allow you to delay or prevent the audit should be made at the onset.

During the Audit

You should carefully prepare in advance with counsel for your conduct during the audit. Some general guidelines to follow during the audit include:

- Sequester the auditor in an area outside of normal business operations.
- Provide the auditor with the complete medical record at the commencement of the audit in order to minimize requests for any additional information.
- Under no circumstances should medical records be altered, fabricated or back-dated. Existing information, including previously dictated notes and test results, may be placed in the file pursuant to normal office practices.
- It may be beneficial to request an entrance conference. Although entrance conferences are not common, they can be helpful in limiting the scope of the audit.
- Designate one individual in the office as the contact person, preferably the billing supervisor or someone familiar with the office's billing practices. Before the audit, this person should discuss with counsel how to answer any questions.
- Do not provide the auditor with more information than requested. Auditors do not have the right to review office financial statements, tax returns or other office records. Generally, they only have the right to see billing and medical records of the patients covered by the payor conducting the audit.
- Ask the auditor to put his or her questions in writing then have counsel review them. Treat questionnaires presented by the auditor the same way.
- Request that the auditor provide you with an exit conference. This is not the time to "plead your case," but to just listen to the auditor's remarks. A staff member should be present to document the information provided by the auditor.

The Findings

Within months -- or sometimes years -- the provider will receive a letter that sets forth the findings. In addition to setting forth the amount of overpayment, the letter usually contains an overview of the payor's rationale. Typically, the payor will demand a refund of the amount within 30 days. The audit packet should also include a listing of services the auditor reviewed and his or her decision on each service. If the audit does not result in an overpayment, the provider may never receive any communication from the third party payor. Correspondence that indicates a finding of no overpayment whatsoever is extremely rare.

The Appeal

Generally, private payors offer an appeal process. And generally, they will not demand immediate payment if the providers appeal. For example, BCBSM has agreed in the Provider Participation

Agreement that it "will defer deduction of overpayments until the arbitration determination, or the last un-appealed determination, whichever occurs first."

Provider appeal rights of BCBSM overpayment demands are set forth in Public Act 350 of 1980, and in the provider Participation Agreement. Generally the first steps in this appeal process are the Step One Level Appeal, which is a written appeal, followed by the Informal Managerial Level Conference (IMLC). There are tight timelines for requesting these appeals. Generally, the initial appeal must be requested within 30 days of the demand.

Most appeals will involve participation in an IMLC, an informal meeting with representatives of BCBSM, including the medical consultants involved in denying the claims, the provider and provider's counsel. BCBSM is required to submit a proposed resolution following this informal conference. Unfortunately, audits are rarely resolved at this level, due in large part to the absence of an objective third party. The IMLC, however, can be useful in narrowing the issues to be discussed at the next level.

If the parties are unable to resolve the matter following the IMLC, providers can request a Review and Determination (R&D) before the Insurance Commissioner's Designee. Providers must request this appeal within 120 days of BCBSM's proposed resolution following the IMLC. The R&D is an impartial and informal proceeding that gives the provider his or her first opportunity to have the matter heard by an objective third party.

Providers not satisfied with the results following the R&D can request a Contested Case Hearing Before the Insurance Commissioner within 60 days. This appeal is conducted pursuant to the Administrative Procedures Act, and is decided by an Administrative Law Judge. Finally, provider's can request Judicial Review in Ingham County Circuit Court or the Circuit Court where the provider is located. It is rare that an appeal makes it to this level.

Alternatives to this process include Binding Arbitration, Peer Review or Circuit Court. Decisions about which appeal process to choose should be made with counsel

Challenges to Overpayment Demands

There are many effective ways to appeal a demand for overpayment. Depending on the issues and forum, it may be beneficial to hire medical and statistical experts. Some examples include:

- Challenging a statistical sampling and extrapolation
- Asserting relevant Statutes of Limitations
- Demonstrating lack of notice of guidelines, or estoppel
- Arguing presumptions that favor the treating physician, as opposed to consultants paid to deny claims, and
- Offsetting any alleged overpayment with the existence of underpayments during the audit period

BCBSM's participation agreement puts limits on how far back it can go in demanding overpayments. Specifically, Addendum H of its Participation Agreement states:

BCBSM shall have the right to initiate recovery of amounts paid for services up to 18 months from the date of payment or up to 24 months from the date of payment as required by a (a) self-insured plan or (b) state or federal government plan. In instances of fraud, there will be no time limit on recoveries.

It is important that providers consult with attorneys experienced in audit defense in order to fully avail themselves of these and other defenses to overpayment demands.

Conclusion

Although the prospect of being audited is not a pleasant one, it is a part of the business of health care. Understanding your rights and working with experienced counsel can greatly improve your chances of decreasing a demand. Health care providers should consult with counsel as soon as they are notified of an audit. If you have questions about audits or have been notified of one, Warner Norcross & Judd can help. Feel free to contact Deborah Williamson (dwilliamson@wnj.com or 248.784.5056) or another attorney in the Health Law Practice Group.