

Audits: Ready or Not, They are Here to Stay



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Hospitals, physician groups and other health care providers

who provide services to Medicare beneficiaries (“Providers”) are at significant risk for increased scrutiny, auditing activity, and, most importantly, demands for refunds of claimed overpayments from Medicare, Medicaid and even private insurance companies. The Federal Government has indicated that billions of dollars in savings from existing provider payments will be required in order for the federal health care system to deliver health care services to a broader base of health care consumers on a more cost effective basis, and the Federal Government believes that increased audit activity will achieve this end. Private managed care organizations are following suit and are racing to establish increased examinations of payments made in an effort to recover revenue from health care providers.

Many auditors are paid a percentage of overpayments discovered by an audit, so the incentives for auditors to perform audits and demand refunds of claimed overpayments from Providers are clear and substantial. Audits are sprouting up all over the country, and, as medical providers in a state that has become infamous for allegations of health care fraud, Florida Providers big and small who provide services for Medicare,

Medicaid and patients covered by private insurance companies are particularly at risk.

The result of these developments is an increased scrutiny of Provider billing practices and an increase in the volume of demand letters asserting claims of overpayment that are received by Providers from Medicare, Medicaid or private plan payors. The increased pressure that these payors are under, and that these payors will continue to be under, to identify fraud and overpayment is likely to lead not only to increased audits for those who may have abused the system, but also increased audits for other Providers who have not abused the system at all.

Adopting and implementing a written compliance program is an appropriate first step to prepare for increased payor audit scrutiny. Unfortunately, even with appropriate compliance programs in place, Providers still may experience overpayment allegations, claim denials, and claims for recoupments. However, defense strategies exist for those who find themselves the subject of an audit. Many of these denials can be successfully appealed through each payor’s respective appeals process.

How Do Auditors Identify Improper Payments?

Although most auditors are tasked with identifying underpayments in addition to overpayments, the vast majority of improper payments identified by auditors are, unsurprisingly,

overpayments. Accordingly, the process of identifying, demanding repayment for and recouping alleged overpayments is of particular significance to Providers. Most auditors identify improper payments resulting from error, non-covered services (including services defined as not “medically necessary”), incorrectly coded services and duplicate services. Put simply, every aspect of a Provider’s Medicare, Medicaid and private insurance company billing is at risk for an audit and subsequent demand for refunds of claimed overpayments.

Auditors typically engage in two kinds of claims reviews to identify improper payments: (1) “automated review” and (2) “complex review.” An automated review is a review of claims data without a review of records supporting the claim. A complex review consists of a review of medical or other records, and is used in situations where there is a high probability that a claim may have resulted in an overpayment.

What Do I Do if I Am the Subject of an Audit?

If a Provider or supplier receives a claim denial, or a finding of overpayment is made as a result of a records review, this denial or finding will be subject to the payor’s appeals process. The rules governing this process for Medicare claims are contained in the Federal Register, and the rules governing the process for Medicaid claims are contained in the Florida Statutes, the Florida Administrative Code and applicable

Medicaid Handbooks. Private insurance company appeals rules are typically contained in the Provider's managed care contract. Each level of the appeals processes identified above includes complicated rules and regulations, including specific response time frames, that Providers must adhere to or risk appeal denial. Similarly, each auditor must comply with its governing regulations, and a failure to do so provides an opportunity for a Provider's defense to an overpayment allegation. More recently, the agencies that oversee these programs (e.g. the Centers for Medicare and Medicaid Services for Medicare and Florida's Agency for Health Care Administration for the Medicaid program), as well as private insurance companies, have taken a more hard-line approach to the appeals process and are not as likely to settle cases at an early stage.

How Do I Minimize the Chances of an Audit?

Although Providers cannot prevent an audit, they can immediately get

systems in place for tracking record requests and timely responding, and they can implement appropriate compliance programs and make efforts to understand available audit defenses. Specifically, Providers and suppliers can begin to prepare for audits by dedicating resources to the following:

- Responding promptly and properly to any auditor's records request;
- Upon receipt of a records request, properly notifying the Provider's counsel that the beginning stages of an audit are taking place;
- Implementing written compliance plans and providing billing and coding training to staff members;
- Consistently monitoring areas that may be subject to auditor review; and
- Timely putting together the appropriate team needed to pursue the appeals process and challenge denials and overpayment allegations.

Increased audit activity is unavoidable. Providers and suppliers subject to Medicare, Medicaid and other audits and claim denials should understand that many strategies exist that can be successfully employed in the appeals process to achieve meaningful results. These strategies involve effectively advocating the merits of the underlying services as well as employing legal defenses, including an auditor's failure to abide by proper procedure and/or exceeding its statutorily-granted authority.

Understanding the entire audit process, including deadlines for appeals, is critical to navigating this new compliance landscape. The multi-level appeals process that is part of most audit programs, and the auditing agency's often uncompromising approach to appeal negotiation, sets up an additional set of hurdles for Providers who find grounds for an appeal once an audit has commenced. Nevertheless, a successful audit defense is attainable.

Please contact us at your convenience and we can arrange a time to discuss how the new level of potential audits may affect your practice or business.

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