Got an audit letter? Don't panic

William H. Maruca, Esq.

***First in a series**

Few pieces of mail cause as much heartburn among physicians as the dreaded audit letter from a third-party payor. Your first reaction may be a vision of a six-figure refund demand. Worse yet, you may treat the letter as a nuisance and not give it the attention it deserves. Post-payment review audits are a fact of life in medical practice, and with the proper preparation and response, they do not have to be disruptive or catastrophically expensive.

Each payor has its own audit, refund and appeal mechanism. This series will focus on the protocols currently in place by the major payors in Western Pennsylvania. The first installment will look at Highmark Blue Cross Blue Shield.

The provider agreement

If you are a participating provider in Highmark's plans, you will have signed a participation agreement that addresses how overpayments are determined and sets out your rights if you disagree with a refund determination. "Overpayment" is defined as any payment greater than the amount actually due under the provider agreement regardless of the reason, and also includes any payment during any period in which a provider failed to satisfy any applicable participation criteria. If you receive what Highmark determines to be an overpayment, the plan can set off any overpayment against any future payments in addition to other rights under the agreement. If no future payments are due, you are required to reimburse the plan within 30 days of demand. If you request a Medical Review Committee (MRC) hearing, interest is charged beginning 30 days after the overpayment is determined by the MRC. If you have entered into a group account, each member physician agrees to be jointly and severally liable for overpayments and misreporting by any and all partners to the account.

The agreement authorizes the plan to perform reviews (on-site or otherwise), audits and statistically valid sampling techniques that are deemed necessary to include, but not be limited to, credentialing (for credentialed networks) and peer review program activities, medical practice audits, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits and quality improvement audits.

The document request

Typically, the first letter you receive will be from the Financial Investigations and Provider Review (FIPR) section and will request copies of complete patient files for the dates of service and patients listed (generally about 20 claims). Although you must provide notes from the specific dates of service they request, they will consider documentation from outside the review period that could assist in determining whether the claims were medically necessary and properly coded. You also are encouraged to include a typed transcript of any records which may be difficult to read, and a key of any abbreviations that are unique or created for your specific record keeping.

Tips

Your thorough and careful response to the first audit letter can be your best opportunity to minimize your liability under an audit. Reviewers often are under time pressure, and anything you can do to assist them in finding the information they need in your records will improve your outcome. The following tips are applicable to audits by Highmark and most other payors:

- Review each claim carefully before you submit the copies, and include any additional progress notes or information that may help a reviewer understand why you performed the service billed in each claim and why you coded it the way you did.
- If your notes are hard to read, include a transcript and explanation of your abbreviations.
- Also, consider including external records such as lab or other diagnostic test results, hospital records and notes from other physicians who have treated the patient during the time in question to assist in building a case for medical necessity.
- I generally recommend that you dictate a brief paragraph for each patient with a short summary of your treatment history of each patient,

including the patient's various diagnoses and all their medications. This note should be dated on the date you dictate it.

You may want to consider having your charts reviewed by an outside consultant before you send them in. This should always be done through counsel so that the consultant's report, if unfavorable, would be protected as privileged to the extent possible. If the audit is focusing on evaluation and management (E&M) visits, a consultant may find that you have undercoded some visits even if you have upcoded others, and this information may be helpful when finalizing the audit results.

NEVER alter or backdate a medical record. If you discover errors in your records, such as a transposed or incorrect date, attach a currently dated explanation.

Remember that each dollar saved in the review of the initial sample will be multiplied many times over if the plan extrapolates the results over a large group of claims, as is often the case.

Note that Highmark, like most plans, is usually flexible about the deadline when large quantities of records are requested, and you can often get an extension if necessary.

The demand letter

After Highmark reviews all the information you submit, they will send you a letter with the results of the review and instructions about your options for responding. If you agree with the results, you will be given the choice to repay the amount in a lump sum, have it offset against future payments, or pay it in installments. Installment payments will bear interest and generally not exceed six months without a compelling reason. Most practices have told me that offsetting payments creates accounting problems as well as interrupting cash flow, so if you agree with the amount but do not have the immediately available funds, it is sometimes beneficial to use a line of credit or other source of financing to pay the refund in a single payment.

The demand letter will generally set forth the basis for the audit determination, including copies of any relevant payment policies, notices from Highmark publications such as *PRN Policy Review and News*, and other supporting documentation.

The letter also will describe your rights to challenge the results of the audit. You are permitted to send additional information that may help justify or explain any services that were

Continued on Page 441

Gov. Corbett proposes Medicaid Expansion alternative

By William H. Maruca, Esq.

In March of this year, we reported that Pennsylvania Gov. Tom Corbett had rejected the option to expand Medicaid eligibility under the Affordable Care Act. In his announcement, he asked the Obama administration to consider approving state-specific alternatives.

On September 16, Gov. Corbett announced his proposal to reform Medicaid and increase access to health care in Pennsylvania, under a comprehensive plan entitled "Healthy Pennsylvania."

If accepted by the Obama administration, the plan would establish a hybrid system under which certain low-income individuals who do not currently qualify for Medicaid would be offered access to private insurance coverage using federal funds otherwise earmarked for state Medicaid expansion.

The Medicaid reforms proposed include:

- Simplification of 14 outdated, complex benefit designs;
- Improving personal accountability by eliminating most copays and replacing them with an income-based premium subject to credits for participating in wellness programs;
- Applying work search requirements and a link to job training opportunities;
- Providing a safety net for the critical care for children, older Pennsylvanians and persons with disabilities;
- Improving access and quality of care; and
- Continually emphasizing the reduction of waste, fraud and abuse in all facets of service delivery.

Access would be increased by implementation of a private option program for uninsured individuals currently not eligible for Medicaid with incomes between 0 and 133 percent of the federal poverty level. Coverage would be offered through the federal health insurance exchange.

The program has been compared to proposals on the table from Iowa and Arkansas. The plan will need to be approved by both the Pennsylvania General Assembly and the CMS. CMS has promised to work with Pennsylvania to get the proposal turned around as quickly as possible. The first meeting with CMS was to be held September 23, 2013.

From Page 439

determined to be discrepant. During this time, it may be possible to negotiate a mutually acceptable resolution. If so, you will want to make sure to get a full release protecting you from further liability for the claims or issues involved during the audit period.

If you are unable to resolve the dispute by agreement, you may request a hearing in front of Highmark's Medical Review Committee.

The MRC hearing

You have the right to submit any outstanding dispute to Highmark's Medical Review Committee (MRC), which currently consists of ten allopathic physicians, one osteopathic physician, two chiropractors, one physical therapist and two consumer representatives. All of the members attend the hearings and participate in the discussions, but only the practitioner members have a vote.

The hearings are conducted in two locations simultaneously, linked by video conferencing. About half the committee members are present at Highmark's Pittsburgh headquarters at Fifth Avenue Place, and the others are at their site in Camp Hill, Pa.; you can appear at either location. Prior to the hearing, each committee member receives a CD-ROM containing the entire file including any additional information you submit for their consideration, and these documents are displayed at the hearing on a second video screen.

You may be represented by an attorney at the hearing, and you also may present witnesses. If you have engaged a consultant to review your charts, you may want to have your consultant appear as a witness to describe his or her analysis supporting your coding decisions. You also may want to bring a medical expert witness to address issues of medical necessity.

In the hearing, one of the medical directors will briefly present the basis for the overpayment determination, and then you present your case. The committee members may ask you or your witnesses questions during the hearing.

After the testimony, the committee members will deliberate and reach a decision which is communicated to you some time after the meeting. They usually schedule multiple hearings on the same day and do not always make their decisions immediately, so you may not get the results for a while.

The MRC is considered to be contractually binding arbitration, which means it is generally not subject to challenge in court unless you can show some misconduct or fraud on the part of the committee.

The hearing determination

The MRC will report its findings to you after the hearing. In most situations, this is the end of the process and you must either pay the amount determined or it will be withheld from future payments. If you have been thorough and attentive to detail in your responses, it is hoped that this will be a resolution you can live with.

Mr. Maruca is a health care partner of the law firm Fox Rothschild LLP, which serves as counsel to the Allegheny County Medical Society. He can be reached at 412-394-5575 or wmaruca@foxrothschild.com.