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SURVIVING PAYER DISPUTES, AUDITS AND RECOUPMENT ACTIONS

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CURRENT TRENDS

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- Audits are increasing in frequency.
  - Unprecedented level.
  - Both governmental and private/commercial payers.
  - For government plans largely due to RAC audits and accountability requirements for payers—Affordable Care Act, for example.
  - For private payers, follow government actions, increased audit staffs.
- Payers are using more aggressive tactics.
- Amounts sought in recoupment actions are increasing significantly.

PRINCIPAL TYPES OF MEDICARE AUDITS

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1. **CERT Audits** (Comprehensive Error Rate Testing). Usually focuses on providers that provide high cost items or services and/or have high volume and/or have atypical billing/coding practices.

2. **RAC Audits** (Recovery Audit Contractor's Program). Uses private contractors. Paid on a percentage basis.

3. **ZPIC Audits** (Zone Program Integrity Contacts). Contractors to CMS. Data mining for compliance with Medicare coverage and coding policies. Can investigate fraud as well. Most serious of the audits. Can prepare cases for civil or criminal referral to CMS or law enforcement agencies.

TYPES OF PRIVATE/COMMERCIAL PAYER AUDITS

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- Informal (review) vs. formal (audit).
- Random vs. focused.
- Pre- or post-payment.
- Procedure usually determined by contract or Provider Handbook and applicable state law.

CURRENT TRENDS

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- Key areas of focus for audits include:
  - Medical necessity.
    - General.
    - Studies and registries.
    - Documentation of special stains.
    - Use of panels for toxicology and molecular/genetic testing.
      - Are unnecessary tests being ordered?
      - Does requisition form give doctors a choice?
      - Are doctors being otherwise "steered" to order more tests?
  - Coding/billing—often triggered by atypical billing or coding practices.
    - Incorrect code.
    - Duplicate billing.
    - Non-covered services.
    - Fraud (improper upcoding, billing for services not rendered).

CURRENT TRENDS

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- Key areas of focus for audits include: (cont.)
  - Patient balance billing by out-of-network providers.
    - Waivers of co-pays, deductibles and co-insurance.
    - Documentation of patient payment as pre-condition to payment by payer—Cigna.

CURRENT TRENDS

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- Special Fraud Alert — 6-25-14 activities:
  - Provision of benefits or payments to referring physicians.
    - Payment for collection and handling services.
    - Payments to physicians for participation in studies or registries.
    - Supplies/equipment.

MEDICAL NECESSITY

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- Definition can vary by payer.
  - Read payer contract carefully.
  - May vary for same payer depending on underlying plan.
  - Best to confirm specifics with payer.
    - Attach a list of covered tests/services that is as specific as possible.
- Pre-condition to coverage.

MEDICAL NECESSITY

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- Three core elements:
  - First core element: Evidence of documentation of medical necessity by ordering physician.
    - Required documentation can vary by payer and type of test/service. Medicare does not require signed order or requisition form for clinical laboratory tests. A signed written order is required for anatomic tests.
    - Documentation could include:
      - Signed requisition.
      - Electronic signature through e-mail.
      - Signed documentation in patient chart.

MEDICAL NECESSITY

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- Where the above does not exist, after the fact obtain a signed attestation—may suffice in an audit but it is not nearly as good as the above.
- This requirement extends to special stains—must be signed written order by pathologists.

MEDICAL NECESSITY

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- Second core element: Documentation:
  - Documentation of medical necessity of the test ordered in medical record.
  - For each test in a panel:
    - OIG views automatic prepackaged panels as fraud and abuse.
- Third core element: Usage of Test Results:
  - Increasingly, payers want to see documentation of review and/or use of the information by the ordering physician.
    - Palmetto MAC is leader in this, but others MACs are following.

WHAT YOU SHOULD DO

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- Educate your ordering physician as to what is required.
- Audit their adherence to the requirements.
- Assist, but don't steer them, in documenting medical necessity.

PATIENT BALANCE BILLING BY OUT-OF-NETWORK PROVIDERS

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- Overview:
  - Across the board full waivers are improper.
  - Exception is often recognized for patients with inability to pay.
  - General practice should be to make good faith effort to collect—send multiple bills.

PATIENT BALANCE BILLING BY OUT-OF-NETWORK PROVIDERS

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- Some payers (Cigna, for example) are taking the position that its obligation to pay does not commence until the patient pays his/her share—legally flawed on a number of levels.
- What you should do:
  - Learn what is and what is not proper.
  - Never advertise maximum out-of-pockets or full waivers.
  - Have a written policy regarding billing patient co-pays, coinsurance, deductibles and educate personnel including sales and marketing personnel on requirements.
  - Periodically audit billing to confirm compliance.
  - Review marketing items.

WORDS OF CAUTION

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- Take all audits seriously.
  - Extrapolation can lead to very large recoupment actions. Need to try to reverse audit findings, in whole or in part, before pre-payment review, extrapolation and recoupment occurs. RIGHT OF OFFSET!
  - Payers follow what other payers are doing. A problem audit with one payer can cause other payers to initiate their own audits.

WORDS OF CAUTION

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- Often difficult to reverse using payer/contractor internal process (police, prosecutor, judge). May need to resort to ALJ, Department of Insurance complaint, litigation or lobbying efforts. Consider ERISA rights and cause of actions.

ERISA ACTIONS

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- Not frequently utilized.
- ERISA applies to payers serving as service providers and fiduciaries for employer health plans.
- Payers that administer health benefits provided under an employee welfare benefit plan are subject to ERISA obligations and liabilities—payers process claims and make coverage and payment determinations.

ERISA ACTIONS

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- Provider should have patients assign their claims under ERISA to them.
- As an assignee, a provider has standing to bring an ERISA claim—"adverse benefit determination."

ACTION STEPS

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- HAVE A COMPLIANCE PLAN!
- Be prepared:
  - Know focus of audits—will vary over time and vary by payer.
    - Contractor (MAC) website.
    - Association information.
    - Advisers.
  - Conduct self-audits or independent audits (self reporting!)—best to find the problem yourself and mitigate its impact.
  - Ability to data mine for audit response is crucial.
  - Have solid recordkeeping system.
  - Conduct training and education regarding audit response obligations and responsibilities.
  - Have audit response process in place—don't miss key deadlines or not give yourself enough time for a comprehensive, thoughtful response.

ACTION STEPS

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- Audit response process elements:
  - Situation specific deadline and responsible party chart.
  - Known guidelines for each participant.
  - Centralized location and custodian for audit-related materials.
  - Permits input from all appropriate sources—multidisciplinary.
  - Corrective action plan.

ACTION STEPS

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- An effective audit response:
  - Recognizes the timelines and understands a missed deadline can mean fines, the inability to challenge or the inability to introduce evidence or arguments. The Medicare appeal process generally includes: redetermination, reconsideration, ALJ review, Medicare Appeals Council, and judicial review. Each level has different time periods and procedural requirements.
  - Includes a validation audit (before records sent in).
  - Immediately flags and stops problems in systematic way to prevent ongoing exposure.
  - Is thorough, clear and concise; includes all necessary/required information. Don't make the payer/contractor have to work too hard to decipher your information and arguments.

ACTION STEPS

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- An effective audit response (continued):
  - Looks for procedural, legal and factual flows in the auditor's position.
    - Auditor applied wrong rules or standards, misinterpreted CPT manual.
    - Auditor failed to consider or missed certain information.
    - Challenges to extrapolations.
      - Sample not representative.
      - Extrapolation done incorrectly.
    - Introduces all new facts and evidence when required.
  - Is professional and non-confrontational.
  - Employs an effective risk vs. cost/benefit analysis not driven by emotion.