RETROSPECTIVE AUDITS & HOW TO AVOID THEM

There is perhaps no more frustrating moment in a physicians career than when a health plan or managed care company notifies him or her that, after the physician has spent countless hours and expended endless efforts to get paid fifty or sixty cents on the dollar, the payor is now suddenly demanding that some exorbitant amount of money be "repaid" to the payor. The basis for such a demand? The payor has reviewed as few as six charts, isolated what it interprets as a pattern of inappropriate billing, takes the amount involved and *extrapolates* that amount to extend over a randomly selected number of past years. The result? A "discrepancy" of several dollars quickly becomes a demand for several hundred thousand dollars. While couched as a "retrospective audit" or a "probe review," many physicians have simply termed it as legalized extortion.

Understanding how these audits come about is a key first step in avoiding their potential wrath. The triggering event in most cases is a simple computer analysis that identifies those physicians who are billing and/or coding differently than their supposed peers, labels those physicians as "outliers" and refers them for additional scrutiny. To avoid these initial steps, physicians must first come to realize that just as accountants are needed to manage the complexities of the Tax Code, today's billing and coding systems dictate the need for specialized assistance. The traditional model of relying exclusively on staff who bill and/or code in a certain fashion because "we've always done it this way" or because "this is how other practices are doing it" is outdated, risky and self-defeating. Even a simple "snap-shot" review of current billing practices, done on an annual basis by a certified coder, can provide valuable insight into what methods are current areas of scrutiny, what trends are developing with ones peers and/or what can be done to keep the practice in the mainstream. Advice from any billing resource should be provided verbally (any written reports could be discoverable in any future proceedings) and should be provided directly to the physicians involved.

Physicians must also understand that even the smallest of amounts in dispute can generate extremely large demands for repayment. If a discrepancy is noted by the computer review, that notation triggers "additional scrutiny" of the practice. While neither statistically valid nor based upon a truly random sample, even the smallest of discrepancies provides the reviewer with a simple method to demand exorbitant monies be "repaid" to the payor. The basic "repayment formula":

Claimed Overpayment
X
Rate of Code Usage
X
Number Of Years Enrolled
DEMAND

Using this formula, even a billing discrepancy of only $2.00 can bring about an enormous demand

Claimed Overpayment - $2.00
X
Rate of Code Usage – eight per day, 40 per week, 2000 per year
X
Number of Years Enrolled – 12
DEMAND - $48,000.00

In consideration of such a potentially draconian impact, the need to secure expert, up to date advice has never been more paramount. For the very reason physicians rely upon an accountant to understand and keep abreast of the ever changing tax laws, they can no longer expect their staff to hold sufficient expertise to properly conduct their billing and coding. From Medicare's Fraud and Abuse Bulletins to the never ending stream of Policy and Procedure Manual updates of every health plan and managed care company, the amount of information to be digested is simply overwhelming. To expect general office staff to properly manage that information is both unrealistic and extremely risky. Just as accountants steer taxpayers away from IRS "red-flags" and identify inappropriate deductions, a certified coder focuses on what each payor's particular demands are and what issues might trigger (and thereby avoid) an audit or targeted review.

Moreover, just as every taxpayer understands the need to obtain (and retain) receipts in order to support their tax deductions, today's physician must understand the critical need to create (and retain) a medical record which adequately supports their billing claims. There are ample "short-cuts" to creating a record that will not only withstand audit scrutiny but will also deny payors the ability to reject future, individual claims for payment. From simple pre-printed forms, through digital transcription to an electronic medical record, ample resources exist that can document the level of services rendered, confirm the medical necessity for those services and bar both retrospective repayment demands and prospective denials of payment.

Physicians who are willing to realize that billing and coding in today's medical practice management environment are so obscenely complex that they require ongoing advice from expert specialists will have taken an enormous first step in avoiding coming under review and the potentially devastating impact of a retrospective audit.

Michael J. Schoppmann, Esq.

Michael J. Schoppmann, Esq., is a principal of Kern Augustine Conroy & Schoppmann, P.C., a healthcare law firm concentrating on representation of physicians and other healthcare professionals. Kern Augustine maintains offices in New Jersey, New York, Pennsylvania and Illinois. Mr. Schoppmann can be reached via email at schoppmann@drlaw.com or by phone at 1-800-445-0954.