The Physicians Advocacy Institute: Helping Physicians Face Medical Audits

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Introduction

The Physicians Advocacy Institute (PAI) is a not-for-profit 501(c)(6) advocacy organization established in 2006 with funds from settlement agreements in the Multidistrict Litigation (MDL) class action against major national for-profit health insurers. PAI's Board of Directors is comprised of CEOs of medical societies involved in the MDL and a physician who was a named plaintiff in that litigation. Likewise, its Physicians Advocacy Liaison Committee is comprised of legal counsel to these medical societies. CSMS was a named plaintiff and critical player in the MDL litigation. As a result, CSMS Executive Vice President/CEO Matthew Katz serves on PAI's Board of Directors and CSMS General Counsel Layne Gakos serves on PAI's Physicians' Advocacy Liaison Committee.

When it was formed, PAI's mission was twofold: 1) to monitor and attempt to assure compliance with the MDL Settlement Agreements and 2) to identify and address future health-plan practices that burden the ability of physicians to be fairly paid for their services. With the expiration of the last MDL Settlement Agreement, PAI has now focused all of its attention towards the second part of its mission: ensuring the viability of physician practices. In all of its projects, PAI calls on the expertise of its Board and Physicians Advocacy Liaison Committee and endeavors to respond to physician needs not currently met by other organizations.

This article will focus on PAI projects geared towards ensuring that Recovery Audit Contractors (RAC),* other governmental, and private payer audits are as transparent and fair as possible and providing physicians with the tools they need to prepare for and defend these audits.

Identifying Physician Practices Issues with Medical Audits

PAI decided to focus its efforts on medical audits after informal surveys conducted of physician practices, attorneys representing physicians, and state medical society managed care staff, identified medical audits as the most pressing issue facing physicians in private practice in today's health-care environment.

Private payer medical audits: In 2011, Frank Cohen, principal of the Frank Cohen Group, LLC, conducted an informational survey of physician practices regarding payer audits that he presented to PAI. Based on the survey responses, 82% of physician practices reported an increase in the number or frequency of repayment demands based on audits. Of those receiving repayment demand letters, 63% reported not having received a clear explanation of the reason for the repayment request. Similarly, approximately 40% of respondents indicated that the letters did not provide adequate information on how to appeal. In addition, although 85% reported having appealed at least one recoupment demand, over half of the respondents reported that their appeals were successful less than 25% of the time. This percentage was much lower than the percentage of successful RAC appeals and successful appeals of general payment denials, which in Mr. Cohen's view could be due to the lack

*Recovery Audit Contractors (RAC) is an audit program designed to identify and correct improper Medicare payments and to collect identified overpayments. The RAC program started as a demonstration project under §306 of the Medicare Modernization Act of 2003, was made into a permanent nationwide program under §302 of the Tax Relief and Healthcare Act of 2006 and was subsequently expanded to include Medicaid audits.

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of clear information in the initial demand letters both as to the reason for the demand and as to the process for appealing the demand for repayment.

After reviewing the data, Mr. Cohen concluded:

> It goes without saying that recoupment is more than just a problem for medical practices. The uncertainty alone of not knowing how much of what you receive you will be able to keep is a very disruptive interference in the business cycle. Most respondents reported that the recoupment letters were absent of adequate information on why the recoupment was occurring and did not contain proper or adequate instructions on how to appeal. Combine this with the huge lag time between the claim and the recoupment letter along with a lack of information identifying the original payment information and you have a situation that is unfair to the provider.[1]

Mr. Cohen added his voice to those asking PAI to address the issue.

RAC and other governmental audits: At the same that Mr. Cohen was conducting his survey, PAI was receiving a lot of anecdotal information regarding serious issues with RACs and other governmental audits. Some of the problems identified in the anecdotal situations presented to PAI were: lack of opportunity for the physician practice to interact with the auditors; sloppy audit processes promoted in part by RAC auditor compensation set at a contingency of monies repaid; problems with the use of extrapolation; and difficulties in obtaining repayments after overturn of audit findings.

PAI President and Executive Vice President/CEO of the North Carolina Medical Society, Robert W. Seligson, created a video depicting the frustrating experience of an internal medicine practice from a small town in eastern North Carolina that was subject to a faulty Zone Integrity Program Contractors (ZPIC)† audit entitled “Guilty Until Proven Innocent: When Medical Audits Cause Casualties.”[2]

That physician practice’s problems began when a ZPIC auditor, who had had no previous interactions with the practice, sought medical records for approximately 200 patients. Based on the review of these records, it was determined that the medical records did not adequately document certain services provided to Medicare patients, for which the practice had collected approximately $40,000 from the Medicare program. The ZPIC auditor then used extrapolation to the practice’s entire Medicare population to calculate that the practice had overbilled Medicare $1,032,287 and demanded repayment of this amount. Although the practice strongly disagreed with these findings, when the Medicare program started recouping from its current payments, it was forced to seek loans and enter into an agreement to repay Medicare over time. The video details the impact on the practice, its patients, and the community as it appealed the audit findings through the multilevel appeal process.

Because the practice had retained consultants before the audit to review its billing, it was convinced that the audit was faulty. Ultimately, the Administrative Law Judge hearing the third-level appeal agreed, overturning most of the audits findings and determining that the practice only owed approximately $4,000. Unfortunately, by this time, the practice had repaid the Medicare program over $700,000 and it had to seek the intervention of its US Senator to have those monies repaid.

PAI Projects and Tools to Address Physician Issues with Medical Audits

To address the issues facing physician practices identified above, PAI has undertaken a series of projects and made resources and tools available so that physicians are equipped to both prepare for and defend medical audits. Other projects are geared to remedying problems in the audit process itself.

Medical Audits: What Physicians Need to Know: To provide physicians with a comprehensive discussion of the issues surrounding medical audits, PAI published a white paper entitled “Medical Audits: What Physicians Need to Know.”[3] This white paper pointed out that medical audits have become part of the regular course of business for governmental and private payers and that therefore, physicians needed to regularly assess their risk of being audited and review their coding and documentation practices both to mitigate the risk of being audited and to be prepared to respond to audit requests and adverse audit findings. The white paper described the various types of audits and audit processes; provided tips on how to assess the risk of being audited; made recommendations on how to respond to an audit; provided tips to analyze audit findings; and discussed appealing adverse audit determinations. Thereafter, PAI broadcast a series of webinars with information from the white paper, presented by the paper’s principal author, Frank Cohen.

Among the paper’s most important recommendations were the following:

- Physicians should assess their risk of being audited by benchmarking their utilization of procedure codes and modifiers in comparison with other physicians of their specialty. This can be done on-line at www.cms.gov.

†The primary goal of the Zone Integrity Program Contractors (ZPIC) is to find and pursue cases of suspected Medicare fraud and take immediate action.

- Physicians should assess their risk of being audited by reviewing Medicare's Comprehensive Error Rate Testing ("CERT") report findings of improper Medicare payments to determine if they bill any of the codes subject to frequent error. If so, records should be analyzed to ensure accurate coding and documentation, correcting any identified issues.
- Physicians should conduct periodic claims and chart reviews to ensure accurate coding and documentation. Any issues identified in these reviews should be corrected.
- When physicians are audited, they should designate a person in the office to handle all correspondence, date stamp and scan all records provided, and send all documents by certified mail or another mechanism allowing tracking and verification of receipt.
- Physicians should ensure that the audit is as accurate as possible by providing complete medical records.
- Physicians should appeal any audit findings with which they disagree.

Fair Medical Audit Principles: PAI has also been endeavoring to ensure that payers conducting audits do so in as fair and transparent a manner as possible and that the process respect the need for physician practices to primarily focus on patient care. Towards that end, PAI has prepared a comprehensive list of Fair Medical Audit Principles, which it is urging all payers to adopt. In addition, PAI believes it may take federal legislation to eliminate some of the problems with the RAC audit process and ensure that RAC and other governmental audits are conducted in accordance with the Fair Medical Audit Principles.

The Fair Medical Audit Principles (hereinafter "the Principles") were developed by PAI's Physician Advocacy Liaison Committee in consultation with attorneys and other professionals who advise physicians during medical audits, and were approved by the PAI Board of Directors in 2012. The Principles promote transparency by specifying the information which should be included in audit notices, audit reports, and notifications regarding appellate rights and specifying the format in which audit findings should be provided. The Principles promote fairness by specifying minimum qualifications for auditors, by requiring that any extrapolation formula be developed based on sound statistical methods, and by requiring that auditors identify any underpayments as well as any overpayments. Lastly, the Principles promote respect for patient care by specifying parameters for the conduct of the audit.

CSMS used these Principles in making its suggestions to the Connecticut program review and investigations committee and in making suggestions to the Connecticut legislature on Medicaid audits. CSMS and other state medical societies have also used the Principles in meeting with private payers regarding their conduct of audits of physicians in their states.

Possible federal legislation: PAI also used the Principles to inform Congress on changes that could be made to the RAC program to improve the transparency and fairness of RAC audits and to remedy certain problems with the current audit process.

One of the most problematic aspects of the RAC audit process is the inaccuracy of the audits. In its most recent report, CMS stated that 43.4% of audit findings appealed to the Department of Health and Human Services (the third appellate level) were overturned in favor of providers. By any measure, this is an astounding number. Taking into consideration the time and expense — both to providers and to taxpayers — of such appeals, it is a number which must be reduced. PAI believes that the accuracy of RAC audits could be improved by eliminating the current compensation system which pays RAC contractors on a contingent basis, thereby incenting the contractors to inflate their audit findings, by imposing penalties on RAC contractors for incorrect audit findings and by ensuring that overpayment amounts calculated through extrapolation are computed using a statistically sound formula.

Another problem with the RAC audits which could be addressed by federal legislation concerns recoupments. Specifically, federal legislation could prohibit recoupment of any identified overpayment amounts until after appeal to the Health and Human Services Appeals Board, the third level of the five level RAC appeal process and require the return of any previously recouped amounts within 30 business days of reversal of an audit finding on appeal. Currently, the Medicare program may recoup funds after identification of an overpayment if the provider does not appeal within 30 days.

In working with Congress, PAI will continue to stress that improving the RAC program would not just eliminate the problems discussed in this article but would also protect the Medicare Trust Fund and mitigate physicians leaving the Medicare program at a time when seniors are increasingly reporting problems with finding physicians who accept Medicare.

Comments to CMS on proposed overpayment rules: PAI has also attempted to shape federal policy in the regulatory arena. On April 12, 2012, PAI filed comments with CMS on its proposed rules for reporting and returning of overpayments.

The rules would implement §6402(a) of the Patient Protection and Affordable Care Act, which requires the reporting and return of any identified overpayments. PAI's comments were geared towards making the rules more practical for physician offices. Specifically, PAI recommended that the look-back period be shortened from 10 years to three years to correspond to the RAC audit look-back period, that the use of the False Claims Act's definitions of "know" and "knowingly" be eliminated, that the rule be amended to clarify that the 60 day period for reporting overpayments begin after the provider has sufficient information to accurately calculate the amount of an overpayment, and that the reporting requirements be more narrowly tailored to include only essential information.

Conclusion

PAI continues to develop tools and projects designed to assist physicians facing medical audits. Projects under development include a Tool Kit and a list of attorneys and other professionals who advise physicians on medical audit issues.

Because PAI's mission is focused on ensuring the viability of physician practices and because its Board and Physicians Advocacy Liaison Committee have expertise gleaned from years of experience in working with physicians, PAI believes it can fill an essential role in providing physicians with the tools and information necessary to address the most pressing problems they face today. PAI welcomes any suggestions on issues it should address and/or tools it could develop to further assist physicians. Physicians with such suggestions should contact PAI's Executive Vice President/CEO Mary Jo Malone at maryjomalone@sbcglobal.net.

REFERENCES

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