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Heightened Peril from Physician Audits[1]

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Failure to Return Improperly Received Monies in a Timely Manner Can Result in False Claims

The voluntary repayment rules published in February 2016[2] created a new burden on those paid by Medicare Parts A and B to continually surveil and monitor their paid claims to unearth potential errors to be repaid. The overpayments required to be returned can emanate from all kinds of problems: duplicate claims, claims where another payer is primary, payments as a result of upcoding or under-documenting, and even claims in violation of Stark or the anti-kickback statute.

The challenges presented by the rules are substantial for all recipients of Part A and Part B monies, but they are particularly problematic for physician practices which frequently do not have the in-house resources to conduct the types of internal audits that hospitals can. Failure to return improperly received monies within 60 days of identifying the error can convert the claims to false claims—eligible for prosecution as well as whistleblowing.

The rules allow six months to "identify" the scope of the problem and quantify it, requiring a look back over six years to calculate the amount of the overpayment. The regulations themselves are less than one page in the *Federal Register*. The commentary explaining them is more than 25 pages long.

Under the rules, physician practices are expected to be exercising "reasonable diligence" in:

> both proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayment and investigations conducted in good faith and in a timely manner by qualified individuals in response to obtaining credible information of a potential overpayment.[3]

A good number of potential sources of such credible information are listed by the regulators, but they are not the only sources of information. They have offered at least eight examples of credible evidence that should trigger quantification of the overpayment: 1) complaints received on a compliance hotline; 2) in reviewing explanations of benefits, over-coding is found; 3) the provider learns a patient death occurred before the date of service; 4) a provider learns services were provided by an unlicensed individual; 5) internal audit suggests an overpayment; 6) a government agency, presumably including the Office of Inspector General (OIG) or a Medicare administrative contractor (MAC), says there has been a potential overpayment in alerts, newsletters, or other notices;[4] 7) profits from a practice or physician are unusually high in relation to the hours worked or the relative value units (RVUs) associated with the work; 8) an audit by a contractor or federal agency finds overpayments; in which case there must be reasonable inquiry to confirm the findings or contest them.[5] Still further, if a contractor determines an overpayment has been made, that is stated to be "always" credible information on which to look for other potential overpayments.[6] And so, we arrive at the now far graver significance of the results of an external audit by a MAC or the myriad other investigatory entities that conduct audits on physician practices.

While the best tactic to avoid bad audit results is to practice aggressive self-management to comply with billing and documentation rules, there are other techniques that can be used to prevent an audit in the first place. Many physician-practice audits are triggered by aberrant billing patterns by comparison with the peers with whom the MACs are constantly comparing physicians normatively. Assuring that each physician in the practice has the appropriate specialty designation in the Medicare system can be critical to assuring the physician is measured against his practicing peers. The earliest audit I worked on in my practice more than 30 years ago involved a family physician, who had moved to a fast-growing suburb. When asked by the then carrier his specialty interest, he listed allergy, which, in fact, was a clinical interest of his. When his claims submissions did not conform with what the allergists to whom he was being compared billed, he "kicked out of the computer," so to speak, for an audit. He ended up repaying money, paying my legal fees, and spending time he wouldn't have if he had been compared with family physicians.

Once the specialty designation has been assured, another technique to maximize position is to seek, under the Freedom of Information Act, the top 20 Current Procedural Terminology (CPT)® codes billed by physicians of the indicated specialty in the geographic area. This is easily done by merely writing a letter to the MAC asking for the data. Sometimes, they are slow to respond. Sometimes, they charge a nominal fee. It, however, is worth it for a practice to learn if the distribution of their services conforms with what their peers are doing.

Even having taken precautions though, if an audit notice is received, the most essential aspect of maximizing the practice's position begins with identifying and reading all the records that are requested. Making sure they are complete, all diagnostic information is present, and everything that substantiates the medical necessity of the services is documented are all vital steps.

It is legitimate to augment information in the records by explanation in a separate document, especially if there are any idiosyncratic documentation approaches; although the records themselves should never be altered. If, in reading the documents, the dates of service for which records are requested do not include essential prior information which substantiates why the course of

treatment was provided, I recommend including the additional records with a cover letter explaining everything that is submitted. If it is clear from the audit request that a particular service is under scrutiny, it is worth focusing attention around explaining why the services were rendered to each patient on each date of service—not in a summary format. Every single date of service should be addressed in explanation directing the auditor to the specific documentation that supports what was done. The point is to make it as difficult as possible for the reviewer to not see the precise documentation that substantiates the appropriateness of the services. On the other hand, even if the auditors are focused on one particular issue, they do have the authority to deny or reverse payment on other services as well.

Before the voluntary repayment rules were published, where records were sub-optimal and it was obvious on initial review before they were submitted, it was my standard advice to repay those claims before the audit and not dispute them in the audit. The new rules, however, confound this advice because once the practice repays any of those claims, that triggers an entirely new and separate obligation to look back six years to evaluate claim submission for the same types of services. Today, my advice is to wait for the results of the audit.

We now come finally to the real implications of an audit with a result that finds monies are owed; it is certainly legitimate to appeal that determination. Once the appeals process is concluded, even if the audit was for the previous two years, the repayment rules would, however, require the audit subject to look back to include a full six years of evaluation, based on the evidence that the audit produced, which as noted above, is always considered credible. There are many challenges in the voluntary repayment rules, including how to identify the size of the overpayment, how and whether to extrapolate, how to use legal counsel, how and to whom to report, and more. There, however, has been little appreciation of the new perils that arise from audits, given those rules.

Endnotes

1. For a deeper consideration of voluntary repayments by physicians generally, *see* Gosfield, "The Oxymoronic Landscape of Voluntary Repayments," HEALTH LAW HANDBOOK, (2017 edition) WestGroup a Thomson Company, pp. 71-99, *www.gosfield.com/images/Publication_Files/AGG.TheOxymoronicLandscape.Final.122116.pdf*.
2. 42 CFR 401.303 et seq.
3. 81 *Fed Register* 7661 (2/12/16).
4. See 81 *Federal Register* 7659, (Feb 12, 2016).
5. 81 *Federal Register* 7667, (February 12, 2016).
6. *Id.*

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