BRACH | EICHLER LLC

NJ HMR
HEALTHCARE MARKET REVIEW

The Payor Audit: How to Manage Your Successful Resolution

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PRESENTERS

Mitchell Brie, CHC
VP of Performance, Healthcare Compliance Network, LLC

Mitch has been an industry expert and trusted advisor in the Healthcare industry for the last 2 decades relating to payment care and revenue models, as well as the optimization of practice software. He is proficient in over a dozen EMR/PM systems and has worked with thousands of providers helping them attest for multiple programs, including MU/PQRS compliance. He works with practices to facilitate the transition from fee-for-service to value-based reimbursements, as well with Independent Physician practices to advise them on how to stay profitable. He has had tremendous success putting companies together in partnership so that they can thrive in the changing landscape of healthcare.

Riza I. Dagli, Esq.
Member & Chair, Criminal Defense & Government Investigations
Brach Eichler LLC

Riza Dagli is an experienced litigator and criminal defense attorney covering a broad array of matters including healthcare and insurance fraud, labor and unemployment fraud, racketeering and money laundering, and environmental crimes. A former prosecutor with the Office of the Attorney General of New Jersey, he aggressively defends clients in all stages of state and federal criminal investigations as well as trials and appeals. In his representation of both high-profile defendants charged with significant first-degree charges, as well as individuals merely being investigated by government agencies, he strives for the best outcome for his clients, their assets, and their businesses.

Prior to joining Brach Eichler, Riz held several key posts within the Office of the Attorney General of New Jersey including Director of the Medicaid Fraud Control Unit, where he prosecuted Medicaid and Medicare fraud, patient abuse and neglect, off-label marketing, and kickback litigation. He also served as Deputy Director of the Division of Criminal Justice, where he prosecuted organized crime, labor, casino, and environmental crimes. Additionally, Riz served as Acting Insurance Fraud Prosecutor (OIFP) for the State of New Jersey.

Keith J. Roberts, Esq.
Member & Co-Chair, Litigation, Brach Eichler LLC

Keith Roberts practices with emphasis in the healthcare and litigation fields. He is a certified civil trial attorney by the New Jersey Supreme Court, a distinction awarded to less than two percent of the lawyers in the state. Keith is an experienced and formidable advocate for his clients with extensive jury trial and administrative hearing experience in complex matters.

Keith has extensive litigation experience representing clients in healthcare and related business matters. He is frequently sought out by healthcare professionals to tackle complex litigation involving insurance fraud, RICO, False Claims Act, and disciplinary proceedings before state licensing boards. He also litigates commercial contract and restrictive covenant disputes for professionals in healthcare.

Keith is an expert in No Fault Insurance, as well as reimbursement litigation, where he commonly represents medical providers against insurance carriers in coding and fraud disputes. He previously served as a member of the Technical Advisory Committee to the New Jersey Department of Banking and Insurance. Keith was named to New Jersey Super Lawyers from 2017 through 2021.

AGENDA

Payor Audits – Basic Topics

- Government Payors
- Commercial Payors
- Auditing Principles

Government Payors – Who Are They?

- Medicare directly
- Medicare indirectly through Medicare Advantage Plans
- Medicaid directly
- Medicaid indirectly through Managed Care Organizations

Who might request audit or records?

- NJ Office of the State Comptroller / Medicaid Fraud Division
- NJ Attorney General / MFCU / DCJ / OIFP
- NJ Office of the Ombudsman for the Institutionalized Elderly
- US HHS / OIG
- US Attorney Office
- FBI
- DEA
- CMS and vendors working for CMS

What are the types of requests?

- SDT – Subpoena Duces Tecum
- STT – Subpoena to Testify
- CID – Civil Investigative Demand
- Request for Records

Why must you respond?

- It may be required by court order.
- It may be required as part of your provider agreement.
- It may be required as part of your professional license.
- Most importantly, you MUST respond to properly defend yourself.

Why were you targeted for an audit?

- Data mining shows an anomaly.
- Volume is higher than peers.
- Third-party (patient, employee, competitor) complained.
- Another agency took some action.
- Random.

How might the agency use the records?

- Sampling for use in extrapolation
- Overpayment demand
- Civil action
- Criminal action

What are important first steps?

- Your lawyer will contact agency.
- Your lawyer will request additional time.
- You will identify an employee or individual to gather records.

What is correct attitude

- An audit doesn't mean someone is "out to get you".
- Producing documents is labor-intensive and expensive, but cost is not normally a defense not to produce.
- Business should continue uninterrupted during the audit process.
- Only requested records will be produced.
- The agency drafted the subpoena, not you. It's not your job to fix the subpoena or guess.
- Your response to the audit demonstrates your attention to detail, organization and accountability.

CIVIL PAYORS

Audit Demand Types

- Types of Audit
  - In network v. out of network
- Timing
  - Pre-payment
  - Post-payment
- Demand Types
  - Information
  - Overpayment demand
  - Recoupment Notification

Immediate Considerations

- What are the key deadlines?
- Why are you being audited?
- What is the audit focused on?
    - Coding (levels, modifiers, unspecified codes)
    - Medical Necessity
    - Experimental Treatment
    - Fee Forgiveness
    - Fraud and Abuse

Action Plan

- Consult with Counsel
- Identify Key Issues
- Incorporate Key Team Members
  - IT Coordinator
  - Billing Manager
  - EMR vendor
- Gather Documents based on Audit Type
  - Medical Records
  - Billing Records
  - Administrative File

Consultant

- Identify the Right Experts
  - Billing
  - Medical
  - Compliance
  - Statistician (sample issues)
- Initial Expert Call
  - Discovery Process
    - Identify Issues and Gather Information
    - Exchange Information through Counsel

Reverse Audit

- Mini Audit
  - Small representative sample
  - Discuss preliminary findings with client
  - Decide whether to get a larger sample
  - Identify areas for education
- Expert Report
  - Addressing coding standards/guidance
    - CMS
    - CPT
    - Carrier Guidance/Policies

Final Issues to Consider

- Consider coding/documentation weaknesses
- Sample
  - Size of sample
  - Sample timeline v. demand timeline
  - Extrapolation issues
- Statute of Limitations v. Recoupment Demands
  - Fraud and pattern of inappropriate billing – 6 years
  - Standard overpayment – 18 months

Conclusion

- Negotiate Resolution with Carrier
  - Payment
  - Release
  - Billing protocols
- Put in Protocols to Avoid Future Issues
  - EMR issues
  - Documentation
  - Coding
  - Billing

AUDIT PROTOCOLS AND PROCEDURES

AGENDA

KNOWN TRIGGERS

- High Level Visit Codes
- Peer Comparison
- Unbundling
- ‘Incident To’
- Policy Violations (LCD, NCD, etc.)
- EMR Issues
- Whistleblowers

HOW TO RESPOND

- Review & Appeal Process
- Self-auditing
- Provider and staff education
- EMR modifications

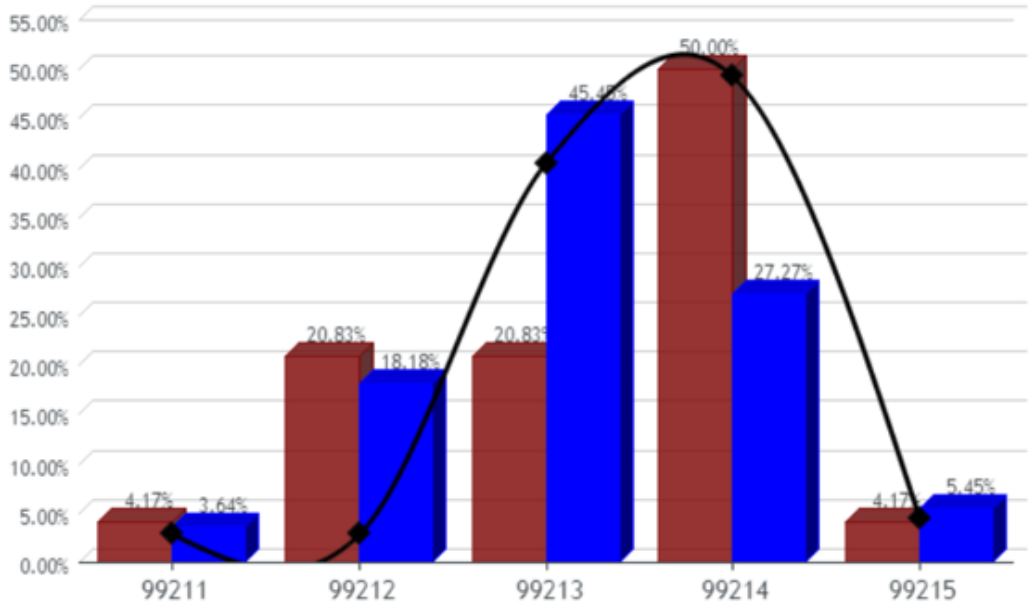
WHAT TRIGGERS AN AUDIT?

High Level Visits

- In the physician's office, the two highest code levels get the most attention
  - New patient 99204-99205
  - Established patient 99214-99215
  - Consultation 99244-99245
- Prolonged care 99354-99359
- Pitfalls
  - Not meeting comprehensive criteria
  - Suboptimal documentation of medical decision-making elements
  - Failure to effectively document time-based scenarios

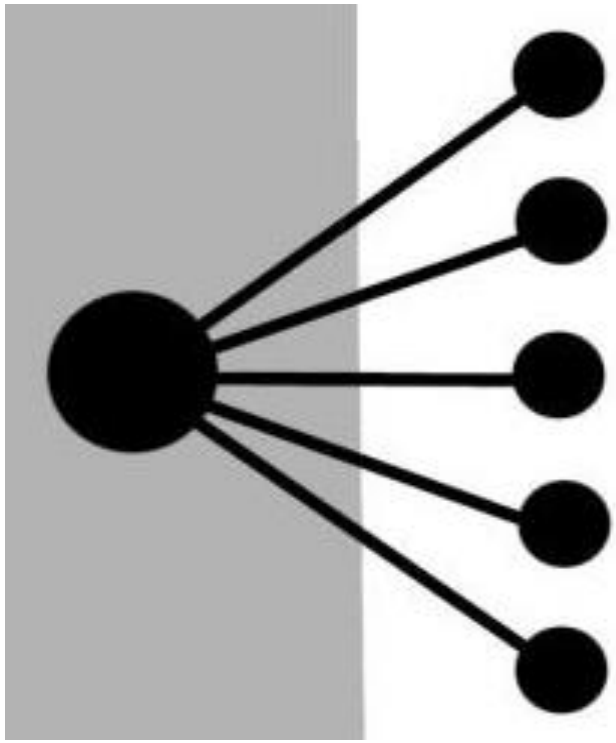
Peer Comparison

- Code volume
- Excessive use of modifiers
- Number of units
- Site of service
- Deleted codes
- Impossible days



Unbundling

- Fragmentation of billing into separate codes when a single comprehensive code exists
- National Correct Coding Edits (NCCI) & Modifier 59
- CPT nomenclature



Incident-To

- Guidelines related to billing for non-physician practitioners (NP, PA, CNM, CNW, etc.)
- Supervision and site of service considerations
- Medicare vs other payers

Medical Policies

- Sets forth the terms and conditions upon which certain types of services are payable under the plan
- Local Coverage Determinations (LCD)
- Common violations
  - Services too frequent
  - Incorrect coding
  - Medical necessity

EMR Issues

- Fragmentation of documents which support coding
- Cloning and conflicting documentation
- Inappropriate use of templates
- Coding ‘calculators’

Whistleblowers

- Staff members, competitors, patients
- Receive between 15-30% of recoupments
- Reportable violations typically include
  - Billing for services not rendered
  - Upcoding/Unbundling
  - Medically unnecessary services
  - Improper cost reporting
  - Kickbacks/Self-Referrals

WHAT SHOULD YOU DO?

Appeals

- Follow all directions given in related correspondences
- Self-audit/research
- Adhere to all timelines
- State your case

If you choose not to appeal, or your appeal is denied, there are various methods to repay:

- Offset against future claims
- Lump sum
- Installments

Self-Auditing

- Billing validation process
  - Periodic documentation reviews
  - Provider/staff education
  - Charge capture processes
- Establish policies and procedures
- Stay current on coding
- EMR modifications

Q & A

THANK YOU!

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