

What To Do When Your Medical Practice Is Facing A Post-Payment Audit

Paul W. Shaw
Partner
K&L Gates LLP

www.klgates.com

INTRODUCTION

LAYING THE FOUNDATION FOR ACCURATE BILLING

DOCUMENTING THE SERVICES RENDERED

AUDITING GENERATING CONDUCT

- Random audits.
- Complaints.
- Computer-generated audits.

INITIATION OF AN AUDIT

- Steps to Take Upon Receipt of a Request for Records.

WHAT NOT TO DO

- Do NOT create a “missing” document.
- Do NOT alter/amend an existing document.

SUPPLEMENTAL REQUESTS FOR RECORDS AND INFORMATION

NOTIFICATION OF THE RESULTS OF THE POSTPAYMENT REVIEW

- Submitting a Rebuttal Statement

THE USE OF STATISTICAL SAMPLING DURING CIVIL AUDITS

PRACTICAL SUGGESTIONS FOR CONFRONTING A STATISTICAL SAMPLING STUDY

- Re-Examination of the Audited Cases
- Review by a Medical Consultant
- Retaining an Expert Statistician

CONCLUSION

CONTACT INFORMATION



BOSTON OFFICE

617-261-3111 TEL

617.261.3175 FAX

paul.shaw@klgates.com

Confronting a Post-Payment Audit

Paul W. Shaw
K&L Gates LLP
Boston, MA
617-261-3111
paul.shaw@klgates.com

LAYING THE FOUNDATION FOR ACCURATE BILLING

Accurate billing is dependent upon compliance with the terms and conditions of the Medicare, Medicaid and insurance programs, which are most often found in the contract, enrollment material, handbooks, rules, regulations and coding books. This material is updated and periodically changed. Therefore, it is critical that the staff of a medical practice be vigilant in complying with any coding and billing amendments. It is recommended that all medical practices:

- Obtain yearly, by written request, all updates and amendments applicable to each insurance program in which the medical practice participates as a provider.
- Have key staff attend any seminars for participating providers sponsored by the Medicare contractor or other insurer.
- Document in writing, certified mail return receipt requested, any confusion over billing codes and the appropriate method for billing. Ask Medicare or the insurer for appropriate information and instructions.
- If the medical practice is not sure how to bill a certain procedure, ask the insurer. Do not rely on telephone advice. There is no substitute for a letter, sent certified mail return receipt requested. Keep all billing correspondence together with any billing information updates sent by Medicare or other insurers in a separate file. Review these periodically.
- Document in writing, certified mail return receipt requested, the oral instructions of the contractor or insurer, or the contractor/insurer's refusal to provide accurate oral and written instructions.
- Periodically review the practice's "superbill" form for changes and modifications. Compare the superbill to the updates received from the insurer.

STEPS TO TAKE UPON RECEIPT OF A POST-PAYMENT REQUEST FOR RECORDS

The following are suggestions for responding to an initial post-payment request for medical records and documents.

- Establish an office procedure where all requests for information are placed in a file for prompt review by the compliance officer, physician, or other person in charge of the practice.
- Do not let the Medicare contractor or auditor determine by its request what information is relevant to the claims being reviewed. Frequently, when an auditor asks for information about a patient's treatment on a specific date, the medical practice sends only the medical record for that date of service. The compliance officer or physician should review the patient's entire medical record (including x-rays, lab test results, surgery reports and other dates of service) to determine if those records contain information pertinent and relevant to the medical care on the specific date requested. If so, send those records to the auditor as well. Similarly, if the medical record for the particular date of service refers to other records, these records should also be provided.
- The compliance officer or physician should review all the documentation copied by the office staff before it is submitted to the auditors to ensure that it is complete and supports the services provided and the medical necessity of those services.
- If the medical records are not entirely legible or are difficult to read, it is perfectly appropriate to attach a handwritten or typed statement that is clearly marked as being a transcription of the original record. *However, do not alter the original record in any manner.*
- Send all information to the Medicare contractor or other insurers with a cover letter by certified mail, return receipt requested. This letter should identify the patients, the information sought, and the information provided. It should be addressed to a particular person at the Medicare contractor. Never send this information without directing it to a contact person and never send it by regular mail.
- Maintain copies of everything sent to Medicare until the audit is resolved.

WHAT NOT TO DO

The biggest mistake a medical practice can make when confronted with a request for records is to either create a “missing” document or alter/amend an existing document. Such conduct will result in a referral for criminal prosecution for obstruction of justice.

While medical records should not be changed under any circumstances, it is perfectly appropriate to add an addendum to include any relevant information about the patient encounter, such as the patient's condition and treatment, which may not have been in the contemporaneous record. *If this is done, however, the addendum must be identified as such and dated as of the date it was created.* Similarly, if the medical records are not entirely legible, it is permissible to attach a written or typed transcription of the record. *However, under no circumstances should the original medical record be altered in any way in an effort to make it legible.*

SUBMITTING A REBUTTAL STATEMENT TO THE INITIAL OVERPAYMENT DETERMINATION

Both Medicare and state Medicaid programs, as well as private insurers, give the medical practice the right to submit additional documentation and other information concerning the claims that were subject to review for the purpose of having Medicare/Medicaid re-determine the potential overpayment. It is critical that the compliance officer or physician review each and every overpayment determination made by the auditors.

First, each sampled case must be re-examined to determine if the results reached by the contractor are correct.

- If it is alleged that the medical records did not disclose the medical necessity of the services rendered, the physician can provide a written justification for the services.
- If it is alleged that an improper billing code was used, the physician again can justify the use of the billing code based upon the overall condition of the patient or inadequate billing instructions from the insurer. In some instances, either the billing instructions or billing codes may have changed during the time period encompassed by the audit.

If the denial was based on an alleged lack of medical necessity for the services, consider responding with more than “medical records.” Quite often, Medicare's physician consultants or internal medical review staff substitute their own personal views of the efficacy of a particular procedure as the final word on “the professionally recognized standards of the profession.” Consider submitting the following:

- Texts, articles, and other professional publications supporting the physician's choice of treatment.
- Written expert opinions from a medical specialist supporting the physician's choice of treatment. It is important to ensure that the expert has reviewed the same records as the consultant for Medicare or the insurance company.
- Affidavits or letters from the patient(s) confirming that the treatment was performed, the patient's satisfaction with the treatment, and the fact that no one from Medicare examined the patient.

CHALLENGING STATISTICAL SAMPLING

Medical practices need to understand the appropriate bases for challenging statistical samples. The following is a listing of factors to consider:

- **Statistical Significance:** Each statistical sample must involve a large enough number of claims to generate statistically valid results.

- Universe Stratification: Stratification involves insurers splitting the universe population into sub-populations for the purposes of conducting a sampling. The use or lack of stratification can lead to improper statistical results. The medical practice should analyze the appropriateness of the insurer's stratification techniques and challenge these techniques when appropriate.
- Outliers: Unrepresentative sample claims, known as outliers, can significantly bias the results of a statistical sample. The medical practice should review the sampled claims to determine whether any such outliers exist.
- Extrapolation Techniques: The manner in which insurers extrapolate sampling results may be inappropriate. Extrapolation that fails to take sampling errors and other variables into account may result in overinflated overpayment demands. The medical practice should request information regarding how an insurer's extrapolation was conducted.
- Documentation: Insurers conducting statistical studies must maintain detailed documentation throughout the sampling process so that the medical practice can evaluate and challenge the validity of the sampling techniques. Lack of such documentation can be the basis for invalidation of a sampling.

PRACTICAL SUGGESTIONS FOR CONFRONTING A STATISTICAL SAMPLING STUDY

When confronting the results of a statistical sampling, the medical practice must evaluate the study to determine if either the factual findings derived from the sampled cases are in error or if the statistical sampling methodology was flawed.

- Re-Examination of the Audited Cases

First, it is essential that each of the sampled cases be re-examined to determine if the results reached by the auditor are correct. Pursuant to Medicare's *Program Memorandum on the Use of Statistical Sampling*, all findings with respect to each case involved in the sample must be documented as to why the original claim was changed and how the overpayment was determined.

- Having a Medical Consultant Review the Medical Findings

Through counsel, the medical practice should also consider retaining a medical consultant for the purpose of rebutting the findings made by the auditor/insurer. Experience with Medicare and other insurers has shown that the insurer will exclude from the sampling well-documented case evaluations that demonstrate the propriety of the services rendered. If the medical practice can persuade Medicare that a number of the claims involved in the actual sampling were in fact correctly submitted for payment, the resulting percentage of error on which the extrapolation is based will also be reduced, resulting in a much-reduced projected claim for reimbursement from what the insurer initially sought.

- Retaining an Expert Statistician

Additionally, it is vital to retain an experienced statistician to examine the methodology on which the statistical sampling and the resulting projection was conducted. A statistician will understand the process of challenging samplings on the basis of statistical validity, improper stratification, improper presence of outliers, improper extrapolation techniques, insufficient documentation, and other improper non-sampling errors.



Paul W. Shaw

BOSTON OFFICE

617-261-3111 TEL

617.261.3175 FAX

paul.shaw@klgates.com

AREAS OF PRACTICE

Paul W. Shaw is a partner in the litigation department of K&L Gates. Mr. Shaw has a national health care fraud and abuse practice, and has represented numerous health care clients involved in criminal and civil fraud and abuse investigations by the federal government and state Medicaid Fraud Control Units in Massachusetts and elsewhere in the United States. These clients include pharmaceutical service providers, hospitals, physicians, medical practice groups, behavioral health providers, clinical laboratories, durable medical equipment suppliers, home health agencies and other health care providers. He has acted as counsel to a number of organizations, including the Massachusetts Medical Society, *The New England Journal of Medicine*, the New England Medical Equipment Dealers Association, and the Home & Health Care Association of Massachusetts. Mr. Shaw was recently recognized for his work in the healthcare fraud and compliance area as one of the top ten healthcare fraud and compliance lawyers by *Nightingale's Healthcare News* in 2010.

Mr. Shaw also has an active government investigations, civil litigation and white collar criminal defense practice, having successfully tried numerous cases in state and federal court involving healthcare, securities and insurance fraud, product liability, breach of contract and personal injury claims. Additionally, he has argued in excess of 18 cases to appellate courts.

PROFESSIONAL BACKGROUND

After graduating from Georgetown University Law School in 1975, Mr. Shaw served an Assistant Attorney General in the Criminal Bureau of the Massachusetts Department of the Attorney General from 1975 to 1982, where he was Chief of the Regulatory Crimes Unit that prosecuted economic crimes and offenses affecting state administrative agencies, including insurance, banking and tax fraud as well as hazardous waste prosecutions.

SPEAKING ENGAGEMENTS

Mr. Shaw regularly speaks on the topic of healthcare fraud and abuse to the American Health Lawyers Association and various bar and trade associations.

PUBLICATIONS

- Co-author, *Avoiding Fraud and Abuse in the Medical Office* (AMA/AHLA)
- Co-author, *Fraud & Abuse Investigations Handbook for the Healthcare Industry* (American Health Lawyers Association)
- Co-author, "Business Valuation Damages" in *Massachusetts Expert Witnesses*, (MCLE)
- Co-author, "Proceedings Before the Office of Campaign and Political Finance," in *Massachusetts Election Administration, Campaign Finance and Lobbying Law*, (MCLE)
- Numerous health care articles in various professional journals and trade association publications

Paul W. Shaw

PROFESSIONAL/CIVIC ACTIVITIES

- Adjunct Professor, Suffolk University Law School, where he has taught a course on Healthcare Fraud and Abuse since 1999
- Member, American, Massachusetts and Boston Bar Associations
- Member, American Health Lawyers Association
- Former Vice-Chair, Medicine and Law Committee of the Tort and Insurance Section of the ABA
- Former Chair, Health Law Section Council of the Massachusetts Bar Association
- Active rower in the Cambridge Boat Club, and has participated as an umpire and rower in the annual "Head of the Charles" regatta for a number of years

BAR MEMBERSHIPS

Massachusetts

COURT ADMISSIONS

U.S. Supreme Court

First Court of Appeals

U.S. District Court for the District of Massachusetts

EDUCATION

J.D., Georgetown University, (1975)

B.A., University of Massachusetts, (1972)(*magna cum laude*)

ACHIEVEMENTS

Consistently listed by *Chambers USA America's Leading Lawyers for Business* for regulatory healthcare litigation

REPRESENTATIVE EXPERIENCE

- Successfully resolved a number of qui tam False Claims Act cases brought against a national pharmaceutical service company following criminal and civil investigations by the Department of Justice and state Medicaid Fraud Control Units.
- Represents a major academic medical center during government investigations for alleged False Claims Act and regulatory violations.
- Represents *The New England Journal of Medicine* in a variety of mass tort litigations where the parties seek materials relating to scientific studies and articles published in the Journal. See, e.g., *In Re Bextra And Celebrex Marketing Sales Practices And Product Liability Litigation*, 249 F.R.D. 8 (D. Mass. 2008).
- In a case of first impression with significant potential ramifications, representing a neurologist sued by a consortium of health insurance companies for engaging in alleged illegal marketing practices on behalf of a national pharmaceutical manufacturer by promoting the off-label use of a major drug at medical education conferences.
- Successfully defended at trial a multi-specialty medical group practice in a state

Paul W. Shaw

court lawsuit against claims by a competitor for unfair competition and violation of the federal "Stark" law.

- Lead attorney for national stored-value card issuer in challenging the authority of states to regulate gift cards issued by federally chartered banks, resulting in a ruling of first impression that such gift cards are pre-empted by federal law from state regulation. *SPGGC, LLC, et al v. Kelly Ayotte, Attorney General*, 488 F. 3d 525 (1st Cir. 2007).
- Lead trial counsel with Brown Rudnick banking attorneys for the Ad Hoc Committee of Trade Creditors in the MCI/World Com Chapter 11 cases in the Bankruptcy Court for the Southern District of New York, in which the clients successfully increased their plan recoveries by 50%.
- Successfully tried on behalf of the country's largest baking company a \$3.4 million contract dispute in Massachusetts federal district court.
- Successfully represented a national chain of restaurants in class action litigations in federal court in Boston and Philadelphia for violation of the Fair Credit Reporting Act.
- Obtained an acquittal on state criminal securities fraud and related charges for an individual involved in a foreign currency trading operation.
- Developed a model fraud and abuse compliance program for the Massachusetts Medical Society and implemented numerous compliance programs for hospitals, medical practices, home health agencies and durable medical equipment suppliers. Mr. Shaw also acts as compliance counsel to these entities.