T. Legal and Practical Considerations for Internal Payment Audits

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LEGAL AND PRACTICAL CONSIDERATIONS FOR INTERNAL PAYMENT AUDITS

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Overview of Discussion

• Deciding What to Audit and Defining It
• Approaches to Structuring Audits
• Repayment and Reporting Implications
• Politics, Practicalities and the Real World
Deciding What to Audit and Defining It

- Clearly Define the Scope of Audit at Outset
  - What is the issue (potential problem)?
  - What items and/or services are involved?
  - What personnel are involved?
  - Are multiple locations, providers, and/or Places of Service involved?
  - What standards apply? What are you auditing against?
    - Stark and/or AKS rules
    - Documentation/coding conventions and guidelines
    - Conditions of Participation, licensing rules, Standards of Practice

Types of Audits

- Why is the audit being done?
  - Proactive audit (i.e., part of annual audit plan)
    - Routine billing reviews (coding, medical necessity)
    - Denials management
  - Internal review in conjunction with an external review
    - In response to RAC reviews
    - OIG self-audits
  - Reported or suspected compliance concerns
Proactive Audits

• Part of Annual Audit Plan
  • Issue raised in OIG Workplan or similar
  • Identified ongoing potential risk (e.g., physician coding and documentation)
  • New or “clarified” regulations or billing “rules”
  • New processes or systems
  • Creation, merger or acquisition of groups, businesses, provider locations, service lines, etc.
  • Follow-up review of past issues

Internal Review with External Review

• Who is performing the external review?
  • MAC, RAC, ZPIC, OIG, State Medicaid Agency
• Who is/are the external review target(s)?
  • Department, group, individual physicians/practitioners, entire organization/system
  • Are other parts of the organization/system potentially subject to the same issues?

• “Shadow audit” vs. “self-audit” for reviewers
• What are the issues?
  • Overpayments only? Fraud? Criminal violations?
Reported or Suspected Concerns

• Potential overpayments
• Integrity of billing or documentation systems
• Fraud and Abuse issues (AKS/Stark)
• COPs, payer contracts, licensing regulations
• Etc., etc., etc. . . .

• Before performing the audit, verify the potential validity and scope of the expressed concern.
  • Get the facts.
  • How broad or specific is concern?
  • Get legal and/or professional coding advice early.

Designing Internal Compliance Audits

• Focus
  • Organization-wide, departmental, individual (physician, practitioner, biller)
  • Consider:
    • Probe audits
    • Profiling providers/billers

• Timing
  • Pre-billing vs. post-payment
  • Contract relationship reviews
  • Provider revalidation
Designing Internal Compliance Audits

- **Unit of review**
  - “Claims,” services, admissions, encounters, transactions, payments
- **Availability and integrity of data**
  - Data systems issues, changes in billing systems, partial EHR integration, data loss, destruction
- **Approach**
  - 100% claim-by-claim vs. random sampling or hybrid approaches

Designing Internal Compliance Audits

- **Look-back period**
  - Reopening periods (e.g., 4 years on claims)
    - absent “fraud or similar fault”
  - Proposed 10 years, but not finalized
  - Period of disallowance (Stark)
  - Check state laws (e.g., 365 days)
  - Statutes of limitations
  - Error/issue defined (e.g., known start of error)
Managing Internal Audits

• Staffing
  • Consultants, internal resources or both?
    • Technical qualifications
    • Independence
    • Timeliness
  • Expert advice (e.g., physician reviewers)
    • Technical qualifications
    • Independence
  • Lawyers?

Managing the ACA 60-Day Deadline

• ACA requires not just a refund OR report
  • Providers must REPORT and RETURN and NOTIFY (of the cause) of overpayments within 60 days of “identification.”
    • 42 U.S.C. §§ 1320a-7k(d), 1320a–7a(a)(10)
  • Failure to meet the deadline renders the overpayment an FCA “obligation”
    • FCA violation only if “knowingly and improperly” avoided or reduced.
      • 31 U.S.C. §§ 3729(a)(1)(G); (b)(3)
Legal Counsel for Internal Audits

• When to use legal counsel
  • Reason for audit
  • AKS/Stark vs. routine payment audits
  • Risks associated with findings
  • Patient harm/substandard care/alleged malpractice
  • Patient abuse
  • Alleged criminal conduct
  • Pending or anticipated private litigation
  • Potential conflicts of interest

• Attorney-Client Privilege
  • Establish from the beginning
  • Correspondence directing the review
  • Documents labeled
  • Distribution of findings and advice controlled

Documenting Internal Audits

• Often not done --or not done well
• To support potential validation reviews
• To show compliance program effectiveness
• Important to document your:
  • Process (key decisions and rationale)
  • Findings (clinical and calculations)
  • Follow-through (refunds/corrective action)
  • Follow-up (monitoring/risk assessment)
Documenting Overpayment Refunds

- Cover Letters
  - Identification of provider(s)
  - Nature of issue
  - Summary of the investigation undertaken
  - Summary of calculation methodology
  - Overpayment refund form (?)
  - Additional corrective action/commitments(?)
  - Request for recording voluntary refund (to avert duplicate RAC demands)
- Corrected Claims

Repayment and Reporting Implications

- What was the audit about?
  - Intent to defraud (including AKS violations)
  - Stark violations
  - Routine claims (coding and documentation)
  - Conditions of Participation deficiencies
- Was it negligence or “reckless disregard”?  
- Was there patient abuse or neglect?  
- Conditions of Participation vs. conditions for payment
Evaluating Repayment Obligations

• Were claims inaccurate (i.e., did they misrepresent services provided or the circumstances of the claims)?
• Were inaccuracies material to payer determinations?
• Can claims be corrected by submitting corrected claims?
• Does provider concede claims were not payable, payment amounts were incorrect, and that refunds are due?
  • Waiver of liability (medical necessity)
  • “Without fault”
  • Reopening period has passed
• Payments were correct or not greater than due
• Providers are not required to forfeit appeal rights

AKS Overpayment Implications

• Effective March 23, 2010: “a claim that includes items or services resulting from a violation of [AKS] constitutes a false or fraudulent claim for purposes [of FCA].”
  • 42 U.S.C. § 1320a-7b(g)
  • Still, are all AKS-tainted payments “overpayments”?
  • Court looked to certifications in provider agreements, CMS 855 forms and cost reports
  • Creates potential mandatory refund exposure for providers, potentially for even unknown acts of third parties
Repayment/Reporting Stark Issues

- Are you sure you have a violation?
- When did the “period of disallowance” begin?
- Has the violation been cured?
- Calculation of overpayment exposure?
- Who to report/refund to?
  - OIG Self-Disclosure Protocol (if also AKS issue)
  - CMS Self Referral Disclosure Protocol (SRDP)
  - US Attorney or DOJ
  - Refund to Medicare Payment Contractor

Sources of Duty to Repay Overpayments

- ACA “Mandatory-Voluntary” Refunds
- FCA amendments
- Medicare Secondary Payer (MSP) rules
- Stark law rules
- OIG Integrity/Compliance Agreements
- OIG Compliance Program Guidance
- Provider agreements and payer contracts
Strategic Reasons to Report/Refund

- Limiting per-claim penalties and multiplier
  - Heading off whistleblowers
- Avoiding prosecution/reducing penalties
  - Federal Sentencing Guidelines (§ 8C2.5(g))
- OIG Integrity/Compliance Agreements
- Clean representations/certifications
  - Cost reports, accounting and security filings
- Framing the issues / Demonstrating commitment to compliance

Calculating Overpayments

- Consider alternate theories/approaches
- Check quality of data
- Statistical extrapolation concepts
  - Net Financial Error Rate (NFER) recognizes underpayments
  - No extrapolation if NFER under 5% (based on CIAs)
- Use OIG’s RAT-STATS software
- Sample size for adequate precision (i.e., < 25%) for refund based on lower bound of 90% confidence interval
- Consider co-payments and deductibles
Politics, Practicalities and the Real World

• Getting management cooperation/support
• Organizational turf wars:
  • “Internal Audit” vs. Compliance Department
  • Billing/revenue cycle/unit clerks/clinical personnel
  • Utilization review staff/Discharge coordinators
• Doctors and Medical Staffs
• Ruffling feathers and herding sacred cows

Some Ammunition for Persuasion

• *East Tenn. Heart Consultants* Settlement (2007)
  • Failing to repay overpayments
  • Healthcare fraud charges (pretrial diversion)
  • $2.9 million in civil penalties/restitution
• *United States ex rel. Keltner v. Lakeshore Medical Clinic* (E.D. Wis. 2013)
  • Alleging FCA liability resulting from failure to refund and follow-up on probe audit findings
  • Survived motion to dismiss
Final Recommendations

• Try not to panic
• Don’t rush, but don’t delay
  • Document the plan and your intentions
• Don’t jump to conclusions
• Remember the big picture
• Follow up on corrective action/discipline
• Don’t waste “educational opportunities”
• Good luck!

Questions?

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