

## How to prepare for a health insurer retrospective audit

A retrospective audit is a cost containment mechanism that health insurers use to determine whether overpayments on claims have been made to a particular physician practice. Though some attempts to recoup overpayments may be appropriate, such as when honest health insurer payment mistakes are made, retrospective audits are burdensome and add to administrative expenses of the physician practice. If a health insurer determines, through a retrospective audit, that overpayments have been made because the documentation does not support billed charges, physicians may be asked to make repayments for services and procedures already provided or unwillingly accept automatic reductions in future reimbursements. Because health insurers are using retrospective audits to recoup suspected overpayments more frequently and because of the attention retrospective audits and recoupments have garnered in connection with recent litigation, the American Medical Association's (AMA) Practice Management Center along with the American Academy of Neurology (AAN) have developed this resource to help physicians understand the retrospective audit process, their contractual rights under the law, the options available to them and the necessary resources needed to determine the appropriateness of a retrospective audit finding.

### **What is a retrospective audit?**

In a retrospective audit, health insurers review claims that have been paid to a particular physician practice. The review of claims and ensuing request for repayment often dates back several years. The initial stage of the audit is typically conducted without notice to the physician. If the health insurer determines, based on its own medical payment policies, that an overpayment was made, the health insurer will typically notify the physician in writing. Practice managers, administrators and physicians should be alerted immediately upon receipt of these notices. Such notices from health insurers informing physicians of suspected overpayments should not be overlooked.

These notices usually include the reasons for the suspected overpayments, such as lack of medical necessity, patient eligibility or medical record documentation. If the health insurer disputes the medical necessity or eligibility for reimbursement of services or procedures, the health insurer will usually request additional information, medical records and documentation, which the health insurer may feel will assist it in making a determination.

### **Are retrospective audits like the medical peer review process?**

Medical peer review, unlike retrospective audits, generally serves educational or other constructive functions. Its emphasis is on improving patient care. Retrospective audits are conducted to recoup payments that health insurers have determined were made inappropriately. Generally, medical peer review sessions that fall within the scope of specific laws are confidential and any records, transcripts or individuals participating in the process are shielded from any subsequent litigation. All aspects of a retrospective audit, however, can be made part of any litigation. Physicians should respond to health insurer inquiries very carefully to avoid jeopardizing or eliminating any possible defenses should the matter lead to litigation. Most physicians, in responding to health insurer inquiries about retrospective

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audits, should consider involving legal counsel to ensure their rights are protected. It also may be prudent to alert state and local medical societies.

## **Why was I selected for a retrospective audit?**

Health insurers may choose to audit physicians' claims for the reasons below, among others. Be aware that the 1995 and 1997 Centers for Medicare and Medicaid Services (CMS) Evaluation and Management (E/M) guidelines still are enforced.

### **High service volume**

Health insurers may suspect that high service volumes indicate over-utilization of reimbursable health care services or procedures. Physicians may substantiate high volume or frequency of services by citing the size, specialty, local disease prevalence, patient case-mix and other factors that affect a physician practice's billing patterns.

### **Coding issues**

Health insurers may view repeated use of the same evaluation and management (E/M) Current Procedural Terminology (CPT<sup>®</sup>) \* code as inaccurate reporting of E/M services. Because patient encounters vary in complexity, health insurers expect that coding for such encounters will also vary. Physicians with high usage patterns of a single level of complexity may be more likely to be audited. It is critical that physicians bill each service case by case rather than employing "generic" billing practices, as well as ensure that either internal billing staff or third-party billing companies report services and procedures in accordance with CPT coding, guidelines and conventions.

Certain physician specialties, like neurology, may be more likely to bill for higher level E/M services because of the potential for increased frequency of complicated cases. Physicians that accept more cases with increased complexity may fall outside the normal range of higher level E/M billing volume as compared to physicians that accept less complex cases. Health insurers may suspect that the physician's elevated frequency of high level E/M billing indicates a pattern of overcoding, leading to a greater likelihood of being selected for a retrospective audit.

### **Modifiers**

The reporting of a high volume of CPT modifiers, such as modifier 25, may prompt a retrospective audit. According to AMA CPT codes, guidelines and conventions, "the CPT modifier 25 is appended to the CPT code to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable E/M service, above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed." A high reporting volume of E/M services with the CPT modifier 25 appended may prompt a retrospective audit so that health insurers can determine whether the additionally reported services were, indeed, above and beyond the service performed during the E/M service based on the health insurer's medical payment policies.

### **Recovery Audit Contractors (RACs)**

Section 302 of the Tax Relief and Health Care Act of 2006 makes the Recovery Audit Contractor (RAC) Program permanent and requires the Secretary to expand the program to all 50 states by 2010. There are

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\*\* This document contains links to non-AMA Web sites. The AMA is not responsible for the content of other Web sites.

four RACs, each responsible for identifying overpayment and underpayments in approximately ¼ of the country. Physicians are encouraged to monitor their RAC's Web site, as RACs are required to post publically the issues on which they are focusing their audits. Visit the AMA's RAC Web page at [www.ama-assn.org/go/regrelief](http://www.ama-assn.org/go/regrelief) and select "Recovery Audit Contractors" to learn more.

### **Other reasons**

Physicians may be selected for retrospective audits for previous nonconformity with health insurer coding guidelines. Further, health insurers may conduct retrospective audits randomly.

### **What should I do when I learn that I have been selected for a retrospective audit?**

Adequate preparation is key in substantiating claims under a retrospective audit. Part of the preparation involves gathering as much information as possible about the health insurer conducting the audit, the process involved and any current industry trends. Inquiries can be made to organizations such as state and county medical associations, national medical specialty societies, the AMA and possibly any government agencies that regulate insurance (e.g., state departments of insurance). These organizations may have valuable information for physicians and may be able to provide referrals to consultants. Such inquiries may also alert these medical associations and government agencies to unfair health insurer practices currently affecting physicians. A developing pattern may bring about initiatives to address the issues on a larger scale through advocacy efforts or regulatory oversight.

### **Make inquiries**

Physicians should try to determine whether medical associations or government agencies are aware of any "hot button" issues involving the health insurer, such as coding complexities, specific services and certain procedures or CPT modifiers. Physicians can also request information about the health insurer's auditing history such as which services and procedures or medical specialties have been recently audited by the same health insurer. Further, physicians should try to determine whether the health insurer has been compliant with state laws pertaining to insurance transactions and specifically to retrospective audits. A pattern of noncompliance may indicate that legal counsel may be necessary to address the health insurer's noncompliance.

### **Review compliance guidance**

Physicians should review any pertinent documents related to billing and coding. This includes items such as a physician practice's internal compliance program, the CPT coding manual and associated coding resources, any government guidance such as through CMS and any billing guidelines the health insurer has provided to the practice. Physicians can compare their billing and coding practices with the requirements of such guidelines. A high rate of compliance can prove very helpful in substantiating claims billed to the health insurer.

### **Review health insurer contract**

The basis for virtually all health insurer requests is the underlying contract between the health insurer and physician. The contract imposes both rights and obligations but may also provide important substantive or procedural protections for the physician. Physicians should aggressively pursue their rights and understand their limitations under their contracts. Therefore, physicians and/or their legal counsel should review their contracts to determine whether the health insurer's actions are consistent with contract provisions addressing retrospective audits. If retrospective audits are not specifically addressed in the contract, physicians should look to general provisions addressing offsets or adjustments. These types of provisions discuss the health insurer's ability to deduct payments otherwise due to physicians or the health insurer's ability to retrospectively adjust contract payments. Physicians and/or their legal counsel should ensure health insurers comply with contract provisions and note any health insurer noncompliance.

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Physicians and/or their legal counsel should also review contract provisions that address medical necessity. Medical necessity, as defined in the contract, may greatly impact the audit results. If the contract allows for the health insurer to have full discretion in determining the medical necessity of a particular service, physicians may face a bigger hurdle compared to a contract that uses the AMA's "prudent physician" standard in defining medical necessity. The AMA defines medical necessity as:

"Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health insurers and purchasers or for the convenience of the patient, treating physician, or other health care provider."

Provisions dealing with access to medical records should also be reviewed. These provisions may either protect physicians from inappropriate health insurer requests for access to records or give health insurers free access to the requested health records. In any event, physicians should be aware of and comply with contract provisions and, with the aid of legal counsel as necessary, ensure that the health insurer does as well.

Lastly, some state laws exist that regulate the health insurer retrospective audit process. Physicians and/or their legal counsel should check to see if any laws exist in their state that address retrospective audits.

### **How do I prepare for a retrospective audit?**

Physicians can take additional measures to prepare for a retrospective audit. Physicians who have not contacted legal counsel at this point should consider conferring with legal counsel, accountants or coding consultants. These professionals can aid physicians in determining and limiting any potential liability exposures. Additionally, physicians should take careful measures to ensure patient privacy. While the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require patients to authorize the release of private health information for purposes of conducting a retrospective audit, both physicians and health insurers are responsible for ensuring that only the "minimum necessary" information is made available. Some state laws, however, may impose more stringent requirements. A designated practice staff person may be responsible for the audit process or physicians may consider hiring a consultant specializing in billing and collections to assist in specified audit tasks.

### **Contact the health insurer**

Physicians should review the notice that details the suspected overpayments and contact the health insurer for any needed clarification. Inquiries to the health insurer at this point should be mostly procedural, since the retrospective audit is still in its initial phase—that is, the health insurer may have determined that a billing or payment error has been made, but the extent or breadth of such occurrences may not have yet been determined.

Physicians may also attempt to obtain the health insurer's medical payment policies to determine whether the services and procedures in question were eligible for reimbursement under the health insurer's medical payment policies. Physicians should be aware, however, that many health insurers do not release these policies citing legal proprietary rights.

### **Documentation review**

Substantiating charges under a retrospective audit means presenting detailed documentation as evidence that services and procedures were performed as billed and were medically necessary. Physicians should review medical records and gather all available documentation such as referrals from colleague physicians, handwritten notes from patients or patients' families, notes of phone contacts, template patient

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questionnaires, and laboratory or radiology reports. Physicians should provide copies of such records to the health insurer and retain the originals for their records.

Physicians should prepare a letter to accompany each medical record that the health insurer requested. The letter, signed by the attending physician, should expand on any missing or ambiguous information and should also articulate on the appropriateness of the coding methodology used to report the services provided.

### **Monitor RAC Web sites**

Each RAC is mandated to post current approved issues under review to their Web site. Physicians may direct billing staff to monitor their RAC's list in preparation for potential requests for review. Visit the AMA's RAC Web page at [www.ama-assn.org/go/regrelief](http://www.ama-assn.org/go/regrelief) and select "Recovery Audit Contractors" to learn more.

### **What should I expect during the audit process?**

Once all requested information is received, the health insurer will begin its audit, likely to take place in one of the health insurer's offices. Physicians are generally not required to be present. If given the option, however, physicians should be present to facilitate better communication and allow immediate access to the auditors. Physicians may also consider having the audit conducted in their office, but on-site audits can be intrusive.

### **Audit findings**

If the health insurer determines that the physician's documentation substantiates the billed charges, the health insurer may not send notice of this finding. If the submitted records do not substantiate all billed charges, however, the health insurer will likely send notice to the physician practice or initiate refund procedures.

Sometimes the health insurer will request refund amounts from the overpayments discovered from the audited claims only. However, especially for overpayments resulting from overcoding, some health insurers may extrapolate the discovered overpaid amount or percentage to apply across all claims submitted during a specified time period. For example, if 50 percent of the services on the audited claims were determined to be overcoded, the health insurer may request repayment for 50 percent of the services performed by a physician over several years.

In cases where overpayments are not promptly refunded, the health insurer may elect to deduct amounts otherwise due to physicians from future payments, often without warning. Physicians and/or their legal counsel should review their health insurer contracts and state law to determine whether this practice is allowed.

Audit findings may also result in health insurers requesting physicians to alter their standard of patient care to meet the health insurers' treatment guidelines. Physicians that health insurers deem as over-utilizers or having a pattern of prescribing or providing more costly treatments are typically targets for these types of requests.

### **Contesting the audit finding**

If the retrospective audit results in an adverse finding, despite presenting sufficient documentation, physicians, with the aid of legal counsel and other consultants as necessary, should investigate the appropriateness of the finding. Since random coding errors may occur, physicians may consider having the same charts (claims) that were reviewed by the health insurer reviewed by an independent coding professional to verify and validate the physician practice's reporting of services and procedures. Retaining an independent coding professional may help to correct the random coding errors that are present in any

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coding review. This verification will assist physicians in substantiating the physician practice's otherwise accurate reporting of the services and procedures provided, as well as help to disprove, invalidate, or even mitigate the penalties associated with the health insurer audit results. The independent coding professional's findings can be presented through any internal appeals process that the health insurer and/or underlying contract affords physicians. Physicians should be sure to appeal within the time frame specified in the agreement with the health insurer. Though time-consuming, many appeals are eventually successful.

**Note:** The AMA has extensive policy regarding retrospective audits and recoupment that physicians may find useful in contesting retrospective audit findings (see additional resources at the end of this document). Additional AMA policy can be found on the PolicyFinder page on the AMA Web site at [www.ama-assn.org/go/policyfinder](http://www.ama-assn.org/go/policyfinder).

## Reporting unfair health insurer business practices

Physicians should consider contacting their state medical associations and national medical specialty societies to alert them to any unfair health insurer practices. Physicians can also file a complaint through the [AMA's Health Insurer Complaint Form \(HPCF\)](#). While the AMA may pursue compliance activities with health insurers or payers where a pattern of complaints warrant, the information gathered from the HPCF will be used primarily to further shape AMA advocacy agendas. Visit [www.ama-assn.org/go/clickandcomplain](http://www.ama-assn.org/go/clickandcomplain) to access this form.

Physicians may also want to alert the government agency that regulates insurance in their state. These agencies may provide remedies that benefit physicians. The National Association of Insurance Commissioners' Web site, [www.naic.org](http://www.naic.org), provides links to each state's insurance regulatory agency.

## How to avoid another health insurer retrospective audit

Education and re-education of physicians and practice staff on the importance of consistently providing clear, accurate and detailed documentation for every patient encounter is essential. Stressing such a basic component of record keeping is necessary because once a physician is notified that a retrospective audit has been initiated, it is usually too late to improve the documentation for the medical records in question.

Internal self-audits conducted periodically allow physicians to identify specific deficiencies in their billing practices before claims are denied or a health insurer retrospective audit is initiated. Deficiencies should be corrected, and the processes taken to correct the deficiencies should be documented. For more information on internal self-audits, see "[How to perform a physician practice internal billing audit](#)," available on the AAN Web site at [www.aan.com/professionals/coding/index.cfm](http://www.aan.com/professionals/coding/index.cfm) or on the AMA's Practice Management Center Web site at [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc).

Physicians and/or legal counsel should review their health insurer contracts, with specific attention to retrospective audit provisions. Where needed, physicians should attempt to renegotiate their contracts to facilitate a fair retrospective audit process. Physicians can reference the [National Managed Care Contract Database](#) to address issues regarding retrospective audits generally and to help identify and avoid contract language that unfairly allows health insurers to offset payments to physicians. Visit [www.ama-assn.org/go/nationalcontract](http://www.ama-assn.org/go/nationalcontract) to access the [National Managed Care Contract Database](#).

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## Additional resources

**AMA PATH™**, the Practice Analysis Tools for Healthcare from the AMA, offers three modules that work as an “online consultant” for your practice, helping you set your fees with confidence and identify coding and billing risk areas. You can even benchmark your practice against physicians in the same specialty and locality for a practical comparison. Use AMA PATH to help make process improvement in your practice more efficient and affordable. Visit [www.ama-assn.org/go/amapath](http://www.ama-assn.org/go/amapath) to learn more about AMA PATH™.

### **Existing AMA policy on retrospective audits:**

**Physicians’ Experiences with Retrospective Denial of Payment and Down-Coding:** This AMA policy states that the retrospective denial of payment should be opposed for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained. (D-320.995)

### **Reasonable Time Limitations on Post-Payment Audits and Recoupment by Third Party Payors:**

This AMA policy allows health insurers up to one year after the claim has been submitted or equal to the time physicians are permitted to submit claims, whichever is less, to initiate recoupment efforts. (H-70.926)

### **Physicians’ Experiences with Retrospective Denial of Payment and Downcoding by Managed Care Plan:**

This AMA policy requires health insurers to issue written notification in a timely manner to both physician and patient of its determination to retrospectively deny payment of claims or downcode claims. The notice shall include the principal reasons for the determination, the clinical rationale and a statement describing the process for appeal. (H-320.948)

**Preauthorization for Payment of Services:** This AMA policy states that the retrospective denial of payment should be opposed for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained. (H-320.961)

**Postpayment Review and Recoupment Specific to Medicare:** This AMA policy calls on the AMA to seek specific clarification from CMS on the process, procedures, and criteria of physician office postpayment review and recoupment; oppose the concept and application of extrapolation; oppose arbitrary, erratic, or inappropriate components of postpayment review and recoupment; and seek appropriate relief to achieve equitable treatment of physicians in office postpayment review and recoupment situations. (H-335.981)

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### **Questions or concerns about practice management issues?**

AMA members and their practice staff can e-mail the AMA Practice Management Center at [practicemanagementcenter@ama-assn.org](mailto:practicemanagementcenter@ama-assn.org) for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 621-8335** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**. To help us address your issue with an insurer, the AMA Practice Management Center may ask you to provide supporting documentation. If these materials contain protected health information (PHI)—defined as individually identifiable health information—please transmit the PHI to the AMA Practice Management Center through our secure FAX number: (312) 464-5468. By sharing PHI with the AMA, you agree to accept our **business associate agreement**.
- Visit [www.ama-assn.org/go/pmc](http://www.ama-assn.org/go/pmc) to access the AMA Practice Management Center Web site.

Physicians and their practice staff can also visit [www.ama-assn.org/go/pmalerts](http://www.ama-assn.org/go/pmalerts) to sign up for free Practice Management Alerts, which help you stay up to date on unfair payer practices, ways to counter these practices, and practice management resources and tools.

### **Resources from the American Academy of Neurology**

AAN members can visit AAN's Public and Private Insurer Web page at [www.aan.com/go/practice/paymentpolicy](http://www.aan.com/go/practice/paymentpolicy) to find additional resources.

The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.