

How to prepare for a health plan retrospective audit

A retrospective audit is a cost containment mechanism that health plans 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 plan payment mistakes are made, retrospective audits are burdensome and add to administrative expenses of the physician practice. If a health plan 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 plans 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) Private Sector Advocacy (PSA) unit along with the American Academy of Neurology (AAN) have developed this brochure 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 plans 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 plan determines, based on its own medical payment policies, that an overpayment was made, the health plan will typically notify the physician in writing. Practice managers, administrators or physicians should be alerted immediately upon receipt of these notices. Such notices from health plans 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 plan disputes the medical necessity or eligibility for reimbursement of services or procedures, the health plan will usually request additional information, medical records and documentation, which the health plan 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 plans 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 plan inquiries very carefully to avoid jeopardizing or eliminating any possible defenses should the matter lead to litigation. Most physicians, in responding to health plan inquiries about retrospective 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 plans may choose to audit physicians' claims for the reasons below, among others.

High service volume

Health plans 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 plans may view repeated use of the same evaluation and management (E/M) *Current Procedural Terminology* (CPT®)* code as inaccurate reporting of E/M services. Because patient encounters vary in complexity, health plans 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 plans 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.

*CPT is a registered trademark of the American Medical Association.

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 plans can determine whether the additionally reported services were, indeed, above and beyond the service performed during the E/M service based on the health plan’s medical payment policies.

Other reasons

Physicians may be selected for retrospective audits for previous nonconformity with health plan coding guidelines. Further, health plans 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 plan 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 plan 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 plan, such as coding complexities, specific services and certain procedures or CPT modifiers. Physicians can also request information about the health plan’s auditing history such as which services and procedures or medical specialties have been recently audited by the same health plan. Further, physicians should try to determine whether the health plan 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 plan’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 plan 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 plan.

Review health plan contract

The basis for virtually all health plan requests is the underlying contract between the health plan 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 plan’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 plan’s ability to deduct payments otherwise due to physicians or the health plan’s ability to retrospectively adjust contract payments. Physicians and/or their legal counsel should ensure health plans comply with contract provisions and note any health plan noncompliance.

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 plan 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 plans 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 plan requests for access to records or give health plans 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 plan does as well.

Lastly, some state laws exist that regulate the health plan 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 plans are responsible for ensuring that only the “minimum necessary” information is made available. Some state laws, however, may impose more stringent requirements.

Contact the health plan

Physicians should review the notice that details the suspected overpayments and contact the health plan for any needed clarification. Inquiries to the health plan at this point should be mostly procedural, since the retrospective audit is still in its initial phase—that is, the health plan 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 plan’s medical payment policies to determine whether the services and procedures in question were eligible for reimbursement under the health plan’s medical payment policies. Physicians should be aware, however, that many health plans 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 questionnaires, and laboratory or radiology reports. Physicians should provide copies of such records to the health plan and retain the originals for their records.

Physicians should prepare a letter to accompany each medical record that the health plan 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.

What should I expect during the audit process?

Once all requested information is received, the health plan will begin its audit, likely to take place in one of the health plan’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 plan determines that the physician’s documentation substantiates the billed charges, the health plan may not send notice of this finding. If the submitted records do not substantiate all billed charges, however, the health plan will likely send notice to the physician practice or initiate refund procedures.

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

In cases where overpayments are not promptly refunded, the health plan 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 plan contracts and state law to determine whether this practice is allowed.

Audit findings may also result in health plans requesting physicians to alter their standard of patient care to meet the health plans’ treatment guidelines. Physicians that health plans 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 plan 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 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 plan audit results. The independent coding professional’s findings can be presented through any internal appeals process that the health plan and/or underlying contract affords physicians.

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

Reporting unfair health plan business practices

Physicians should consider contacting their state medical associations and national medical specialty societies to alert them to any unfair health plan practices. Physicians can also file a complaint through the AMA's Health Plan Complaint Form (HPCF). While the AMA may pursue compliance activities with health plans or payers where a pattern of complaints warrant, the information gathered from the HPCF will be used primarily to further shape AMA advocacy agendas. Physicians can go to www.ama-assn.org/go/psa 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 at www.naic.org/state_contacts/sid_websites.htm provides links to each state's insurance regulatory agency.

How to avoid another health plan 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 plan 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 <http://aan.com/professionals/coding/index.cfm> or from the AMA's PSA Web site at www.ama-assn.org/go/psa.

Physicians and/or legal counsel should review their health plan 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 *AMA Model Managed Care Contract* to address issues regarding retrospective audits generally and to help identify and avoid contract language that unfairly allows health plans to offset payments to physicians. The *AMA Model Managed Care Contract* can be accessed from www.ama-assn.org/go/psa.

For additional information, go to the American Medical Association's Private Sector Advocacy Web site at www.ama-assn.org/go/psa.

For more information, you may also visit the American Academy of Neurology's Web site at www.aan.com.

Additional resources

Existing AMA policy on retrospective audits and federal legislation:

- **Reasonable Time Limitations on Post-Payment Audits and Recoupment by Third Party Payors:** This AMA policy allows health plans 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 plans 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)
- **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)
- **The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003:** Includes provisions designed to make auditing of physicians more fair. The MMA also requires the Centers for Medicare and Medicaid Services (CMS) to establish auditing standards for physicians within the Medicare program. Physicians should check with MMA and CMS guidelines as they become available to see if health plans are complying with federally mandated requirements. More information is available on the CMS Web site at www.cms.hhs.gov.

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