Understanding & Responding to Third-Party-Payer Audits

- Focus on *Insurance Carrier* Audits (*i.e.*, Non-Government Audits).
- Type of Payer Audits
- Applicable State Statutes & Federal Regulations
- Managed Care Contract Language
- Improper Payer Audit Tactics
- National Audit Guidelines
- Strategies to Resolve Audit Issues
Types of Audits

- Pre-Payment Audit vs. Post-Payment Audit (i.e., Retrospective)

- Medical Necessity Audits
  - Patient Status (Inpatient vs. Outpatient)
  - Level of Care (Intensive Care vs. Telemetry)
  - Length of Stay

- DRG Downgrade Audit vs. DRG Validation Audit

- Desk Audit (i.e., Charge Audit)

- Itemized Bill Review Audit (i.e., Forensic Audit)
  - Bundling
  - Implants
Resources

- Legal Principals & Concepts
- Florida State Statutes
- Federal Regulations
- Contract Provisions
- Payer “Provider Manual” Language
- Medical Records
- Hospital Internal Policies & Procedures
- Hospital System Notes
- Summary Plan Description
- Industry Guidelines
Florida State Statutes


- No later than 20 days after receiving an electronic claim (or 40 days for a paper claim), an insurer must pay the contracted amount, or
  - Pay portion of claim not in dispute, or
  - Notify provider, in writing, why claim will not be paid.
    - Notification must be accompanied by an itemized list of additional information the insurer can reasonably determine is required to process the claim.
  - Providers must submit additional information within 35 days after receipt.
  - The insurer may not request duplicate documents.
Failure pay or deny a claim within 120 days for electronic claims (or 140 days for paper claims), creates an “uncontestable obligation” for the insurer to pay the claim.

Penalty is interest at 12% per year on unpaid amount, payable with payment of claim.
Florida Case Law


Supreme Court of Florida held that a provider can bring a cause of action against an HMO for failure to comply with the prompt payment provisions of the Florida Statute.
Florida State Statutes


- Committing or performing with such frequency as to indicate a general business practice any of the following:
  - Failing to adopt and implement standards for the proper investigation of claims;
  - Failing to acknowledge and act promptly upon communications with respect to claims;
  - Denying claims without conducting reasonable investigations based upon available information;
  - Failing to promptly notify the insured of any additional information necessary for the processing of a claim; or
  - Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.
If an overpayment determination is the result of retroactive review or audit not related to fraud, a carrier must adhere to the following policies:

- All claims for overpayment must be submitted to a provider within 30 months after the carrier’s payment of the claim.
- A provider must pay, deny, or contest the carrier’s claim for overpayment within 35 days after the receipt of the claim.
- Failure to pay or deny overpayment and claim within 120 days after receipt creates an uncontestable obligation to pay the claim.
- The carrier may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the carrier’s overpayment claim as required.

All claims for overpayment submitted to a physician must be submitted within 12 months after the health maintenance organization's payment of the claim.
Florida State Statutes

Potential Provider Defenses:

- The audit does not conform to the audit parameters set forth in the managed care contract.
- The audit is beyond the applicable time frame.
  - Was the claim paid within 30 months for hospitals / 12 months for physicians?
  - Does the contract between the hospital and the payer contain a time period shorter than the Florida statute?
  - Is the payer governed by Florida law?
    - ERISA Self-Funded Payer
    - Out-of-State Payer
Potential Provider Defenses:

- The Florida statute indicates that if a claim is not paid or denied within 120 days after receipt, the claim is considered as an “uncontestable” obligation to pay. Based on this provision, providers can argue that such a claim is *not* eligible for audit.

- The Florida statute provides payers with a means to contest or deny claims, or portions of claims, during the adjudication process. Unless a payer can furnish the provider with a reasonable explanation as to why the bill was not examined during adjudication, the audit request should be denied.
Managed Care Contract Language

- Plan agrees that only Plan and its employees may conduct an audit. Third-parties (i.e. audit companies) are not entitled to conduct audits.

- If Plan’s accounts receivable over 60 days exceeds “X,” Plan shall forfeit its right to audit until such time as the A/R is at or below “X”.

- Plan agrees that Payer’s audit requests cannot exceed “X” Members for any given month.

- Plan shall not conduct an audit of a Member’s medical and billing records unless payment of the entire amount due on the claim is made to Hospital.

- Accounts that have not been paid in accordance with Fla. Stat. s. 641.3155 or 627.3155 are not entitled to be audited.

- All audits must be conducted within 6 months of the date of service for outpatient services and date of discharge for inpatient services.
PAYER will conduct audits in accordance with the following guidelines:

- Provision of documentation of audit company relationship with payer and copy of business associate agreement;
- Provision of information to identify the claim (date of service, account number, patient name);
- Provision of patient’s authorization to release PHI to third-party;
- Payment to Hospital for copies of medical records;
- Audit personnel will identify to HOSPITAL any underpayments that are discovered during the audit.
- Final letter documenting agreed upon audit results, terms for collections for overpayments, and action to be taken by PAYER or HOSPITAL for underpayments.
Healthcare Carrier Claim Audit Guidelines

- Drafted by the National Association of Insurance Commissioners.
- State and Federal Regulations and Managed Care Contract Language *preempt* these Guidelines.
- Carrier shall provide notice of audit within 6 months of receipt of claim and complete the audit within 12 months.
- Carriers shall make prompt payment of a bill and shall not delay payment for an audit process.
- Payment of 95% of the insurance liability shall be an acceptable payment amount prior to scheduling the audit.
- The medical record documents clinical data on diagnoses, treatments, and outcomes; it is not designed to be a billing document. Other documentation for services may exist.
- Once both Parties agree to the audit findings, *audit results are final*. 
Hall v. Humana Hosp. Daytona Beach, 686 So.2d 653, 657 n. 1 (Fla. 5th DCA 1996)

- Insurance carrier alleged a provider charged unreasonable fees for medical services received which the carrier paid and brought suit seeking a refund of such overpayment.

- Court held no overpayment occurred. Florida law recognizes the “voluntary payment” doctrine, where money paid voluntarily “with full knowledge of all the facts, cannot be recovered back merely because the party, at the time of payment,” mistook their liability.
An HMO must pay any hospital service which was authorized by a provider empowered by contract with the HMO to authorize, unless the hospital provided information to the HMO with the willful intention to misinform the HMO.

A claim may not be denied if a provider follows the HMO’s authorization procedures and receives authorization for a covered service for an eligible subscriber unless there was a willful intention to misinform the HMO.
Managed Care Contract Provisions

Payor A

- PAYER shall not deny or reduce payment to Provider for any services provided by Provider to PAYER Beneficiaries once initially pre-certified or authorized provided that there was no material misrepresentation or fraud in the request for authorization.

Payor B

- Payor may deny payment of claims which have not been approved by its utilization review program. However, there shall be no retroactive denial of claims on the basis of medical necessity for claims which have been approved by the utilization review program.

Payor C

- Provider may *conclusively* rely on authorization obtained from plan or plan’s agent for medically necessary covered services pursuant to Florida Statute 641.3156.
If the Medicare Advantage Plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity. *Program Integrity Manual, Chapter 6, Section 6.1.3(A)*
Promissory Estoppel

- Occurs when Payer makes a promise to Hospital and Hospital reasonably relies on that promise to its detriment.
- Hospital is entitled to rely on superior knowledge of the payer and cannot be faulted for payer’s error in verifying coverage.
- In other words, payer is in the best position to know who is covered and what is covered under their policies.

*Humana v. CAC-Ramsay, 714 So.2d 1025 (3rd DCA 1997)*
Inappropriate Audit Tactics

Payer A – Third-Party Audits – Claims Previously Authorized

- Payer A certified the inpatient admissions during the preauthorization process and issued authorization numbers.
- Payer A’s Audit Company ("Affiliate") included the claims in an audit and requested medical records to review level of care. Affiliate determined the admissions didn’t meet inpatient level of care.
- Internal Payer A system notes indicate Payer A was aware admissions were pre-certified.

Recovery Notes: Provider Billing Error
Credit Notes: Please rekey claim to deny with Not Covered Reason D1142 - Services not covered in an inpatient setting. See CSB 171-11. Clinical Operations has entered into a partnership with HealthDataInsights (HDI) to perform Retrospective Utilization Review Audits of inpatient admissions. While precerts may exist for these claims, it has been determined that they do not meet criteria for an inpatient admission. Claims should not be repaid or adjusted without approval from Audit Services. For
Inappropriate Audit Tactics

Payer A Affiliate Audit – Claims Previously Authorized

- Hospital Appeal Cited:
  - Contract language which stated that “there shall be no retroactive denial of claims on the basis of medical necessity for claims which have been approved by the utilization review program.”
  - Florida state statute that provides “a claim may not be denied if a provider follows the HMO’s authorization procedures and receives authorization for a covered service for an eligible subscriber.”
  - For Medicare Advantage claims, the Medicare Managed Care Manual which indicates “if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage later on the basis of a lack of medical necessity.”
Inappropriate Audit Tactics

Payer A Affiliate Audits — Claims Previously Authorized

- Payer A argued that “authorization is not a guarantee of payment.”
- Disclaimer is not supported by CMS policy or Florida law and is not entirely applicable to the issue at hand.
- Hospital understood that an authorized claim may later be validly denied for a variety of reasons such as eligibility and coordination of benefits.
- Hospital’s position is that an admission that is subject to a concurrent utilization review process and approved under such process should not, months/years later, be subject to a second retrospective utilization review.
Inappropriate Audit Tactics

Payer B Audit – Claims Previously Adjudicated

- Payer B denied an inpatient claim prior to payment for lack of authorization. Hospital submitted an appeal and Payer B overturned the denial and issued payment.

- Payer B’s Audit Division included the claim in an audit and requested medical records to review level of care. Hospital submitted medical records and Payer B’s Audit Division determined the admission didn’t meet inpatient level of care. Payer B recouped payment.

- Accounts that are reviewed and adjudicated through the payer’s appeals process should not be subject to a later retrospective audit.
  - Florida statute prohibits a payer’s duplicate request for information.
  - Federal regulations do not allow multiple audits of a single account.
  - National Association of Insurance Commissioner’s Audit Guidelines indicate audit results are “final.”
Inappropriate Audit Tactics

**Payer C Audit – Improper Notice**

- Payer C’s Affiliated Audit Company sent notice of audit, including medical record request, to wrong hospital address (i.e., hospital’s physical address as opposed to the address specified in the contract for audit notice).

- Payer C recouped payment because of failure to provide medical records / untimely medical record submission.

- Hospital overturned denial based on (i.) contract language which designated address for audit correspondence and (ii.) multiple letters from Hospital to Payer C regarding the audit company’s use of an incorrect address for audit correspondence.

- Hospital aggregated all audit claims and directed “Notice of Dispute” to Payer C directly (not the affiliated audit company).
Inappropriate Audit Tactics

Payer D Audit – Failure to Forward Appeals to Maximus

- Payer D is non-participating with the hospital. Payer D failed to forward Medicare Advantage Plan audit appeals to Maximus after denial of second level appeal. Maximus refused to accept appeals directly from the hospital.

- Hospital aggregated claims and sent Notice of Dispute to Payer D’s Medicare Advantage Department. Hospital demanded that (i) claims be forwarded to Maximus with no timely filing implications and (ii) Payer D correct its appeal process.

- Hospital cited 42 CFR § 422.590(b): “If the Medicare Advantage Organization affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by CMS no later than 60 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.”

- Hospital also cited Payer D’s own website which indicated that if it upholds an initial determination, it will forward the case to Maximus.
Inappropriate Audit Tactics

Payer D Audit – Failure to Forward Appeals to Maximus

- Instead of reprocessing the claims, Payer D and Hospital agreed upon a settlement amount. Payer D corrected internal appeals process and assigned a representative for hospital to contact with future issues.

- Hospital made changes to its appeals processes;
  - Hospital ensured Medicare Advantage appeals submitted (i) to appropriate Payer D address (ii) without Payer D’s *commercial* appeal cover form.
  - Hospital included the executed Waiver of Liability Form with every appeal.
Court Ruling – Exhaustion of Administrative Remedies in Medicare Advantage Disputes

- Non-contracted Medicare Advantage Plan initially paid the hospital’s bills, but later "unilaterally recouped substantial sums" from hospital on post-payment audits.
- The plan refused to return the payments, and the hospitals sued for unjust enrichment and quantum meruit.
- The plan argued the claims should be dismissed because the hospital failed to exhaust their administrative remedies under the Medicare Act – the case was dismissed.
- Court held that hospitals must exhaust their administrative remedies before bringing their payment dispute with a Medicare Advantage Organization to court.
Inappropriate Audit Tactics

Payer E Audit – Use of Incorrect Clinical Criteria

- Payer E performs patient status audit of Medicare Advantage Plan claims and uses Milliman Care Guidelines ("MCG") or InterQual to deny admissions as not meeting inpatient level of care.

- Inpatient admissions for Medicare Advantage beneficiaries must be reviewed under the two-midnight rule with deference to the physician’s complex medical judgement.

- Furthermore, inpatient admissions are based on an expectation that a patient will require two midnights of inpatient care. CMS requires that reviewers evaluate the appropriateness of an admission based solely upon the information available at the time of admission.

- Hospital argued that use of MCG was inappropriate and demanded that payer cease use of MCG in audit of Medicare Advantage claims.
Inappropriate Audit Tactics

**Payer F Audit – Incorrect Application of Coding Criteria**

- Payer F performs DRG downgrade audit and removes a secondary diagnosis citing documentation “did not support that the condition significantly increased resources or the length of stay.”

- ICD-10 Official Guidelines for Coding & Reporting defines “other diagnoses” as additional conditions that affect patient care in terms of requiring:
  - Clinical evaluation; or
  - Therapeutic treatment; or
  - Diagnostic procedures; or
  - Extended length of hospital stay; or
  - Increased nursing care and/or monitoring; or
  - Has implications for future health care needs.

- Payer F’s criteria only considers *two* of the six factors.

- The guidelines contain the word “or” denoting that only *one* factor must be met.

- Payer F’s use of the word “Significant” is out of context – “Clinically Significant” is different from “Significantly Increased Resources.”
Several payers request itemized statements on high-dollar claims that meet an outlier threshold and deny certain charges as “Routine,” “Redundant,” “Included in Room & Board,” or “Not Separately Payable.”

The review is used to re-characterize properly-billed services and supplies as not separately billable.

Guidelines cited by payer as justification for non-payment of the supplies and services are irrelevant to the reviews performed.

- Guidelines applicable to physician services.
- Coding Edits used are only applicable to outpatient charges.
- Medicare guidelines are used on *commercial* claims.
- Drugs and IV Fluids denied without consideration of the patient’s condition.
Review managed care contracts for provisions which allow payers to “rebundle.”

- e.g., “Hospital agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding.”

- If payer requires such contract provision, be sure to review the software and industry standards used in the payer’s rebundling logic during the negotiation process. Try to negotiate a framework around the software and edits that will be used.

- Negotiate with the payer that hospital is excluded from the enhanced bill review audits.
Non-Emergent Denials

- Payers implementing policies to (i) deny emergency department ("ED") claims as "non-emergent" and (ii) reduce reimbursement for Evaluation and Management ("E/M") Services.
- Denials are based on the **coding of the claim**; not on the medical record.
- UHC utilizes Optum’s tool; EDC Analyzer.
Impact on the Revenue Cycle

- Retrospective reviews will, inevitably, lead to an increase in denials for ED services.

- **High** volume of **low** dollar denials.

- Denials will require an individual appeal with medical records.

- Cite Federal & Florida Regulations – “Prudent Layperson Standard” – Medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson who possess an average knowledge of health and medicine . . .” AHCA Medicaid Model Contract

- Increase in patient responsibility allotments.
Managing Third-Party Audits

- Consolidate all audits under single department or employee.
  - Able to coordinate review and appeal efforts with other departments;
  - Ensures timely filing deadlines are monitored and met;
  - Allows for identification of trends and recurring payer issues;
  - Aggregate claims with common “inappropriate” audit issue.
  - Direct recurring, improper audit issues to high level payer representative.
  - Create appeal letter templates by denial issue and by hospital defenses.
Managing Third-Party Audits

- Assemble an “Audit Task Force” with stakeholders from hospital departments (HIM, Case Management, Managed Care . . .).
  - Meet regularly to develop best practices & proactive steps.
- Develop a written Hospital Audit Policy.
  - Refer to slides 12-14 for provisions to include in policy.
  - Provide policy to payers to deny or manage audits.
  - Include protocol for rebilling inpatient claims as outpatient when hospital agrees the admission did not meet criteria.
- Engage Managed Care Team regarding contract language to reduce the number of audits or mitigate impact of the audit.
- Object to the payer’s application of an audit policy to hospital because of the “Materially Impact.”
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