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OUTSIDE COUNSEL

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Defending Physicians in Billing Audits

In a healthcare environment where effective control of costs can mean the difference between success and failure, some HMOs have become aggressive in their attempts to control fees to physicians.

Health insurance companies and HMOs have embarked on an aggressive campaign of auditing past, paid billings submitted by physicians believed to have engaged in "upcoding" of evaluation and management services for in-office sick patient visits, new patient visits, established patient visits and office consultations (CPT codes 99201-99205, 99211-99215 and 99241-99245).

One approach that has gained popularity is the use of statistical techniques to "prove" that physicians systematically "upcode" patient visits to higher levels of treatment than were actually provided, in order to bill higher fees to the HMOs. To support their contention, HMO statisticians retrospectively allege "upcoding" by comparing actual numbers of patient visits in different categories (e.g., new versus established or consult patients) with "expected" numbers based on national "benchmarks".

Typically, the HMO begins an audit by requesting a "random" sample of up to 25 chart entries for in-office patient visits (usually chart entries for which the highest code levels, and therefore the highest reimbursement rates, were assigned by the physician). Once received, the HMO submits the charts to an outside coding company specializing in focused reviews of physician documentation to determine whether the medical record information supports the CPT codes assigned.

Invariably, the coding company will find that the medical records do not support the CPT codes assigned, and will "downcode" the claim by one, two or three levels.

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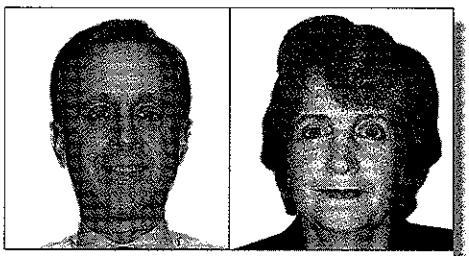

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Thereafter, the HMO will perform a "statistical extrapolation" of the percentage of "upcodes" in the sample as compared to the total universe of the physician's claims during the relevant time period, and will assign an "estimated" amount of total "overpayments" (i.e. the difference between the payments made by the HMO at the "upcoded" rate and the payments which would have been made at the "downcoded" rate) over the relevant period.

One of the most egregious flaws that appear in HMO analyses involves inappropriate statistical sampling.

The HMO will then send a demand letter to the physician seeking repayment of this amount, the refusal of which would result in the HMO commencing arbitration or litigation against the physician to recover the "overpayment." Often this number can run into six figures.

Many of the techniques used by the HMOs, however, are scientifically unreliable and lack probative value. Yet these methodologies put individual physicians at risk unless they can develop empirical challenges to the HMO's analysis, or their own statistical analysis that validates the appropriateness of their own coding assessments.

Given the observation that "statistics will prove anything, even the truth," physicians and the attorneys who represent them need to be aware of common techniques employed by these HMO statisticians to "prove" that a doctor has inappropriately upcoded classifications of visits. Many of them employ invalid and scientifically unreliable assumptions, methods, and analyses.

One of the most egregious flaws that appear in HMO analyses involves inappropriate statistical sampling.

Insurers may conduct a non-random review of a physician's claims and then extrapolate coding errors to the population at large. They may also draw samples that are too small to make statistically valid inferences about a non-independent, heterogeneous population of patient visits. Or they may simply fail to sufficiently specify how a sample was selected, rendering it unreliable.

Another basis to attack such statistical analyses is careless definition and use of data. This may include the failure to analyze variables that define a particular doctor's uniqueness, such as case mix, demographic variability, and geographic practice variations, when comparing the physician with a national benchmark.

Often HMOs look only at the final codes for patient visits without also evaluating the variables from which these codes are developed: patient histories, physical examination, medical decision making, medical complexity and total time.

Another variable is the particular characteristics of a medical practice that determine how cost data are adjusted, particularly in expensive, complicated cases. HMOs often perform chart reviews to determine data quality, yet these are notoriously unreliable, since there is no way to accurately assess inter-rate reliability.

Other problems that often undermine data validity are the use of a fee-schedule rather than actual fees paid; analysis of a particular time period without comparing it to other time periods; the use of invalid data containing errors; and omitting unpaid visits when evaluating the appropriateness of data coding.

The benchmarks employed by HMOs are often undefined, undocumented, or, in the worst case, non-existent. In fact, using national "benchmarks"

to profile physician practice patterns has been shown to be inaccurate because healthcare practices in neighboring towns vary as much as 33-fold. Another significant difficulty with benchmarks is that the guidelines for coding are not stable, having changed several times in the past 10 years.

A final issue is that insurance companies may not use statistical methods that are appropriate for the data and type of analysis they are performing. For example, some have used outlier analysis, which is primarily used for cutting costs and reducing losses in manufacturing companies. This sampling method is now being applied to detect improper coding among physician practices. Since medical care is not a production line, outlier analysis is not a meaningful way to establish coding errors among physicians who treat unique patients with atypical collections of symptoms or categories of disease.

Help Required

Navigating the waters of medical billing audits by financially stressed HMOs requires help. When faced with statistical claims audits from health insurance companies, attorneys representing physicians should consult with a statistical expert who can evaluate the data presented, the samples drawn, and offer experienced opinions on the inferences made.

The authors have worked together to identify numerous methodological flaws in these statistical extrapolations. Included among the methodological flaws that we have found are that the statistical extrapolation methodology:

- Does not reflect or correspond to the actual distribution of visits among the provider's patients;
- Uses a Centers for Medicare and Medicaid Services (CMS) distribution "benchmark" that does not, in fact, exist;
- Uses undocumented standards to make an "overpayment" determination;
- Uses biased standards to construct its "random" sample of patient charts;
- Uses an inappropriate statistical average as a standard to "benchmark" claims;
- Unfairly provides patient charts for "upcoding" overpayments, without similarly adjusting for those visits for which payments have not been made, or for which providers have been underpaid;
- Performs a methodologically flawed statistical analysis using data that has no official source, that contains coding errors, that is ill defined in terms of population and geographical parameters and that leads to conclusions that have no basis in reality and that are of no statistical or methodological relevance.

New York Public Health Law Section 4406-d(4) sets forth requirements for health plans with respect to profiling methodologies used to evaluate the performance or practice of healthcare professionals. Specifically, it requires that:

- Plans have a process to regularly inform healthcare professionals of information that will be maintained to evaluate performance;
- Plans consult with healthcare professionals in developing methodologies to collect and analyze data;
- Plans provide such information, data and analysis to healthcare professionals on periodic basis in an appropriate manner;
- Any profiling data used to evaluate performance or practice be measured in stated criteria and an appropriate group of healthcare professionals using similar treatment modalities serving a comparable patient population; and
- Plans to give healthcare professions the opportunity to discuss the unique nature of their practices and to work cooperatively with plans to improve performance.

A statistical expert can help prove that the audit does not conform to the requirements of Section 4406-d(4).

The New York State Department of Health has received provider complaints and has reviewed a number of plan practices for the purposes of determining compliance with Section 4406-d (4). It has determined that any plan initiative in which any aspect of a healthcare professional's performance or practice is evaluated is subject to the requirements of Section 4406-d(4). This includes plan initiatives related to evaluating provider billing/coding patterns, including "upcoding" claims.

Thus, the HMO must follow all of the requirements of Section 4406 d(4) in its "upcoding" reviews, including the requirement that it uses profiling data that is measured against stated criteria and an appropriate group of healthcare professionals using similar treatment modalities serving a comparable patient population. In some cases, the provider can distinguish herself from the "benchmark" group of healthcare providers against whom it measures the provider's performance.

If the physician can demonstrate that her treatment modalities or patient population do not compare to the HMO's "benchmark", the HMO audit does not satisfy the requirements of Section 4406-d(4), and the provider can challenge the audit based upon its violation of that provision. A statistical expert can help prove that the audit does not conform to the requirements of Section 4406-d(4).

Asserting a Counterclaim

Providers may, themselves, have been unpaid or underpaid by the HMO over the same time frame, and we encourage those physicians to search their records to identify unpaid, or underpaid, claims.

Often, it is a difficult and time consuming process for the physician and her billing staff to identify such underpayments. However, we have found that identifying unpaid or underpaid claims can have a positive effect in negotiating a favorable resolution to an HMO audit.

It is important that the claimed underpayments represent legitimate claims by the provider, as opposed to claims where the HMO properly denied payment for reasons such as lack of authorization for the procedure, absence of documentation, or other reasons for denial that fall within the HMO's authority.

Conclusion

An "upcoding" audit and resultant demand for payment presents the physician with many difficult choices. If the sums demanded are on the lower end of the spectrum, the physician should seriously consider paying a portion of the claim to settle the matter, rather than incurring large expenses in defending herself.

However, where the HMO has made a payment demand for a significant amount of money, the physician may have no choice but to actively defend against the audit.

Such a defense should include hiring experts to challenge the coding analysis and statistical extrapolation methodology. In addition, it should focus on New York Public Health Law Section 4406-d(4), with which the HMO must be in strict compliance in order to seek reimbursement for alleged billing or coding violations.

The audit process is very coercive. Many physicians, when faced with the prospect of defending an upcoding audit, feel compelled to "cave-in" and pay a negotiated settlement, even though the physician believes she did not code improperly, simply because it would be economically unreasonable to wage a full-scale fight with an insurance carrier with deep pockets and resources. This often results in settlements borne out of economic duress rather than merit.

The utilization of knowledgeable and experienced counsel and experts should, in all cases, be standard practice for physicians undergoing such an audit.