Can an Audit or Regulatory Proceeding Really Happen to You? Yes it can.

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Regulation of the healthcare industry is increasing. Almost every aspect of a medical practice is now regulated, including interactions with patients, employees, vendors, and even how you bill for your services.

Though the headlines are filled with articles about million dollar settlements between the government and providers, hospitals, or pharmaceutical companies, no one thinks it will happen to him or her.

What if it does? Do you have a plan in place for when you receive a large audit demand, subpoena or civil investigative demand (CID)? What will you do if you receive a six-figure recoupment demand for billing errors from a government auditor?

Don’t wait until it happens to have a plan in place.

You’re Being Audited…Now What?

Understanding how the audit process works and having a knowledgeable person guide you through it is essential. The government and its audit contractors do not discriminate on specialty, size or location when mining your billing data for possible errors. The auditors are looking for a wide variety of mistakes or intentional deceit. These items include things like upcoding, (using a higher paid code in place of a lower code), incorrect or inadvertent mistakes in coding, or lack of

documentation.

Routine audits can quickly turn into large repayment demands from payers. These demands should *not* be paid automatically. You may want to consider the appeals process.

There are five steps in the appeals process:

1. **Redetermination** – Typically, this can be done in-house if the organization or provider has trained personnel to prepare the appeal; however, it's recommended that you engage counsel as soon as you get the audit.
2. **Reconsideration** – This is a request by the organization or provider to have the data reviewed by a Qualified Independent Contractor who was not involved in the redetermination. It is advisable at this stage to obtain the help of an experienced healthcare attorney. The reason for the appeal and all supporting data should be presented.
3. **Administrative Law Judge (ALJ) Hearing** – At this level, the case will be heard by an administrative law judge. There are significant delays at this level due to the backlog of cases. It could take two to three years for the case to be to be heard. Only certain cases which meet the dollar amount threshold can be appealed at this level.
4. **Appeals Council Review** – At this level a Medicare appeal council will review the ALJ decision and make a decision.
5. **Judicial Review in Federal Court** – Only certain cases with a minimum dollar amount make it to this level, the court will review the Appeals Council's Review and make a determination.

The appeal process can be timely and costly and there are time constraints involved in each step. These steps must be followed or you could inadvertently lose the ability to appeal to the next level. Be prepared and have a team in place that is ready to respond should you receive a demand for repayment.

What to do When You Receive a CID

A subpoena or CID typically comes from the US Department of Justice or HHS-OIG and is a formal legal inquiry that must be responded to appropriately and timely. These are typically related to allegations pertaining to the False Claims Act, Stark Law, or Anti-Kickback Statute. Your organization should immediately contact legal counsel and your insurance carrier upon receipt of a subpoena or CID. If you receive a CID or subpoena you must preserve all data and documents or your defense could be jeopardized.

If documents or data are destroyed, additional penalties may apply.

Having a knowledgeable attorney is key to a successful response to a subpoena or CID.

Staying Ahead of a False Claims Act Investigation

Many times a False Claims Act (FCA) investigation may have already begun by the government long before you become aware. If there is a whistleblower, (also known as a Relator), then the case must be kept confidential for a set time to allow the government time to investigate before you are notified.

Some of the common types of FCA cases in the healthcare industry involve:

- Billing for items or services not provided
- Billing for items or services (not medically necessary)
- Inflated billing (upcoding)
- Stark Law or Anti-Kickback Statute violations

These matters can result in significant recoupment amounts and fines and penalties imposed by the government. Penalties can range from $11,181 to $22,363 for each false claim plus three times the amount of damages because of

the false claims.

There are some steps you can take to minimize your risk for an audits or regulatory proceedings:

1. Have a billing and coding compliance program that is continually reviewed
2. Provide yearly coding education
3. Hire properly trained and certified billing and coding staff and ensure that they have access to continuing education
4. Have open communication with staff and a process for reporting any improper billing
5. Engage a consultant to do an audit of the billing and address any deficiencies that are found
6. Work with legal counsel to prepare a voluntary self-disclosure if errors are found
7. Have all contracts reviewed by an experienced healthcare attorney to ensure compliance with all laws and regulations, including the Stark Law and Anti-Kickback Statute
8. Consider purchasing insurance to transfer some of the financial risk for billing errors proceedings and other regulatory proceedings

Visit www.MagMutual.com [1] for more information about our Regulatory Defender insurance products or contact your agent who can answer questions related to your specific insurance needs.

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