

PHYSICIANS' RIGHTS ISSUES

THE MISREADING AND MISAPPLICATION OF

NEW YORK STATE INSURANCE LAW §3224-b

BY NEW YORK HEALTH PLANS

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## HEALTH PLAN ABUSES OF PHYSICIANS' RIGHTS PURSUANT TO NEW YORK STATE INSURANCE LAW §3224-b

### INTRODUCTION

Physicians today face unfair treatment in the health plan financial audit process due to health plans apparent disregard of the reforms to New York Insurance Law Section 3224-b which were instituted to even the playing field and ensure that audits are conducted in a fair and efficient manner. Today, physicians who receive a medical record request from a health plan routinely face a pre-designated, automatic labeling of their prior billing methods as “fraudulent” and/or “abusive”. Faced with such an undue characterization, physicians are forced to spend vast amounts of time and financial resources as they hire certified professional coders and healthcare counsel simply to ensure that health plans treat them fairly during the audit process. Physicians are often forced to retrieve, at great expense, medical records from storage in order to meet these labels and their attendant demands for billing and claims information that is six or more years old. Over the past several months, many of our efforts in defending physicians have been met with health plans becoming exponentially more aggressive in the scope, manner and mechanisms of their audit demands and much less willing to negotiate appropriate and reasonable settlements. These new tactics and methods by the health plans serve to undermine, if not obviate, the very intentions of the reforms gained under New York Insurance Law Section 3224-b.

We do not argue that health plans should not have the opportunity to review medical records to ensure that the claims have been appropriately paid to the providers. We simply argue that they must be required to comply with New York Insurance Law Section 3224-b and conduct audit claims within the boundaries of the law and the clear intention of the legislature in enacting the same. The health plans' interpretation of the meaning of “abusive billing practices” has become so broad that the effect is to allow them to routinely look back for claims paid within six years prior to the audit demand in almost every case. If left unchecked, health plans, mindful of the costs concomitant with defending such audits, will only continue their abusive auditing practices. Already financially strapped physicians will be left with little choice but to make unjustified payments to health plans - even in defensible cases. Clarifying the law to require that health plans must first establish clear evidence of an intent to bill incorrectly, or a willful disregard of accepted standards of billing and coding practices, in order to make any claim that a physician has been fraudulently or abusively billing, will end this practice and provide the physicians of the state of New York the rights intended, and originally afforded them, under the law.

## DISCUSSION

New York Insurance Law Section 3224-b(b)(2) states that:

“A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a physician. Provided, however, that no such time limit shall apply to overpayment recovery efforts which are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required by a state or federal government program. Notwithstanding the aforementioned time limitations, in the event that a physician asserts that a health care plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For purposes of this paragraph, “abusive billing” shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of conduct.”

The New York legislature has recently made revisions to this section of the Insurance Law. Accordingly, effective January 1, 2010, the relevant provision set forth above, now Insurance Law Section 3224-b(b)(3), will state:

“A health plan shall not initiate overpayment recovery efforts more than twenty-four months after the original payment was received by a health care provider. However, no such time limit shall apply to overpayment recovery efforts that are: (i) based on a reasonable belief of fraud or other intentional misconduct, or abusive billing, (ii) required by, or initiated at the request of, a self-insured plan, or (iii) required or authorized by a state or federal government program or coverage that is provided by this state or a municipality thereof to its respective employees, retirees or members. Notwithstanding the aforementioned time limitations, in the event that a health care provider asserts that a health plan has underpaid a claim or claims, the health plan may defend or set off such assertion of underpayment based on overpayments going back in time as far as the claimed underpayment. For purposes of this paragraph, “abusive billing” shall be defined as a billing practice which results in the submission of claims that are not consistent with sound fiscal, business, or medical practices and at such frequency and for such a period of time as to reflect a consistent course of action.”

Despite the express time limits set forth therein, health plans and managed care companies have recently acted, in concert and by clear design, to circumvent the law and extend the “look-back” period to six years in furtherance of their audits of health care providers. Specifically, managed care companies’ self-serving interpretation of the term “abusive billing practices” has essentially nullified the intent of the law. This tactic flies in the face of the efforts of the Medical Society of the State of New York and acts to circumvent the hard earned reforms that were implemented to guarantee fair results in managed care audits. As a result, the managed care companies’ interpretation of what constitutes “abusive billing practices” has become so broad that the effect is to allow them to routinely extend the “look back” period to include claims paid within six years prior to the audit demand in almost every case. In effect, the statutory two year “look back” period has become virtually irrelevant.

The following case study provides a perfect example of the tactics used by managed care companies to circumvent the law. In the fall of 2007, Dr. A. B. received a chart request from a third-party contractor that performs audits for Oxford Health Plans (“Oxford”). Prior to this request, Dr. A. B. never received a phone call or correspondence from any insurer indicating that his billing or documentation practices were deficient in any way. There was never a suggestion by any party that his billing or documentation practices were abusive or fraudulent.

In order to ensure that he and his office staff were complying with the relevant documentation and billing guidelines, Dr. A. B. immediately retained a certified professional coder to audit his practice, review his documentation practices and train his staff.

After reviewing the relevant records and speaking with the doctor’s staff, the certified coder rendered the opinion that Dr. A. B. provided the care and treatment that he billed for, however, noted a documentation error in that while Dr. A. B. documented the length of each patient encounter, he did not note how much of that time was spent counseling and coordinating the patient’s care and how much of that time was spent examining the patient. This inadvertent technical mistake was certainly not evidence of abusive billing. The certified coder educated all of the staff of the medical office, including the doctor, concerning relevant guidelines and appropriate documentation procedures.

Given the certified coder’s findings, Dr. A. B. was understandably shocked to receive Oxford’s subsequent overpayment demand of \$130,285.28. This demand was comprised almost exclusively of claims that were paid more than twenty-four months prior to the date of the demand. Tellingly, Oxford’s correspondence did not accuse Dr. A. B. of abusive billing or fraud but instead noted “incorrect Evaluation and Management (E&M) Current Procedural Terminology (CPT) codes submitted.” For the first time, Dr. A. B. was offered guidance from Oxford regarding the appropriate coding method (which he had already, on his own, obtained).

Prior to responding to Oxford’s demand, the certified coder was asked to review a sample of Dr. A.B.’s then-current charts and to analyze trends in the volume of each level of CPT code that the practice was billing. This time she found that in each instance the doctor’s

documentation comported with the relevant guidelines and gave him credit for 100% percent of what he billed. In comparing the two reviews that the certified coder performed, it was noted that:

- 1) Dr. A. B., at all times prior to and subsequent to the initial review, provided the care that he billed for;
- 2) There was no evidence of fraud or abusive billing practices at any time;
- 3) The physician had applied the knowledge gained during the in-service that had been conducted; and
- 4) Dr. A.B.'s patient population is unique. As a Reproductive Endocrinologist, he treats patients with complex medical problems and provides highly specialized medical care to them. Therefore, his utilization of Level 4 and Level 5 visits is appropriate and justified.

In response to Oxford's findings, Dr. A.B. filed a detailed submission, enclosing the certified coder's findings, and putting forth the evidence that all care billed for was in fact provided and articulating the unique aspects of Dr. A.B.'s patient population. Without addressing the specifics of the submission, Oxford responded by letter that cited an outdated New York State Insurance Department opinion letter and an erroneous interpretation of the definition of "abusive billing practices". The certified coder's unchallenged report was more than enough evidence to support the position that any alleged technical billing error made was clearly unintentional. Oxford's findings, citing its self serving interpretation of Insurance Law §3224 constitutes bad faith and a willful disregard of the law. In the face of Oxford's deplorable conduct, one would submit that a showing of united force is needed to make clear that Oxford's fiscal recovery efforts are egregious and unlawful.

Unfortunately, there is little or no guidance regarding what constitutes "abusive billing practice". This firm contacted an attorney at the Insurance Department and discussed the case with him. He opined that Oxford had erred in looking back beyond the twenty-four months allotted by statute. We also ordered, and reviewed, all New York State Insurance Department opinion letters, legislative history and other information made available to us in response to a Freedom of Information Law (FOIL) request.

Of note, this firm did not identify any Insurance Department opinion letter that adequately described the meaning of "abusive billing practice." However, a careful examination of the Legislative History pertaining to the January 1, 2007 Amendment to New York State Insurance Law § 3224-b reveals that the amendment was passed to address the inequities in the audit process. The following highlighted excerpts from a sample of the letters of support for the legislation, although authored by different individuals from different organizations, read as though penned by one hand.

New York State Senator Nick Spano wrote in support of the reform explaining that:

“This measure seeks to address some of the numerous difficulties faced by physicians and other providers in their dealings with health insurance plans. Inconsistent and cumbersome procedures cause physicians to waste valuable resources dealing with the administrative burdens of health plans, rather than treating patients. These problems include deviation from nationally accepted claims coding standards, confusing health plan rules used to adjudicate claims submitted by physicians, excessive demands for refunds of claims paid several years in the past, the lack of meaningful notice to physicians of refund claims... To address these issues, this legislation would enact much needed reforms by attempting to assure fairness, uniformity and consistency for physicians and health plans...”

Dennis Whalen, Executive Deputy Commissioner of the New York State Department of Health noted that “The legislative intent of this bill is to provide some uniformity and consistency in claims and payment...” and recommended the approval of the reforms.

The American College of Obstetricians and Gynecologists conveyed the following analysis:

“When insurers demand that physicians pay back large sums of money several years after the original claim was made, it puts a tremendous financial burden on the physicians and their respective practices. Contesting the demand is often difficult because so much time has passed between when the refund is demanded by the insurer [and notice of the dispute]... The aforementioned managed care reforms are necessary to correct abuses which have been employed by insurance companies in New York State.”

The letter of support of the amendment from the Medical Society of the State of New York also appears in the legislative history. Specifically, Gerard L. Conway, Esq. made several noteworthy points, as follows:

“[the proposed amendment would] begin to address some of the several contracting problems that health care providers have experienced with certain HMOs and other insurers in the processing of health insurance claims and the credentialing of physicians... It should be noted that several of the settlement agreements of lawsuits initiated by MSSNY against the managed care plans have resulted in provisions that have set forth time imitations on the ability of health plans to demand refunds from physicians of previously paid claims. It should also be noted that this issue has been debated extensively between MSSNY and the health plans for the past several years at the Insurance Department Health Care Roundtable. A major roadblock to a successful resolution of this issue in this forum has been the argument by the health plans that there is no language currently in statute that expressly limits the ability of health

plans to demand such refunds. We believe that this two-year “look back” limitation set forth in this bill, while not completely addressing the problem of unfair health plan refund demands, would at least narrow the scope of the problem.”

The legislative history cited above explains the difficulties faced by physicians defending audits and confirms that the intent of the amendment to the New York State Insurance Law § 3224-b was to require managed care companies to address any billing concerns soon enough for physicians to defend them properly and without undue hardship. Now, health plans and managed care companies, such as Oxford, disregard these reforms that the Medical Society of the State of New York and others fought hard for. The result is that thousands of physicians now face the very same burdens and uncertainty as they faced before the reforms were passed.

Therefore, it is our suggestion that substantive revisions be made to Insurance Law §3224-b to remove the current ambiguity in the law regarding the rights prescribed to both health plans and healthcare providers therein and to ensure fairness in the audit process overall.

First, it is our suggestion that health plans be limited to utilizing only universally accepted and standardized methods of reviewing the billing habits of health care providers. In the absence of such a standard, health plans will be permitted to continue to use their own self-serving proprietary standards and result oriented software. This change in the law would prevent such unfairness and instill confidence in health care providers that the audit process is both legitimate and objective.

Second, the “look back” period, currently set at twenty-four months, should be reduced to twelve months. As set forth above, the overpayment amounts determined by health plans are extremely substantial and can serve to financially devastate a practice if not render it insolvent altogether. The reduction of the retrospective “look back” period would remove the unfair practice of a health plan seeking repayment for a time period much longer than what is required by them to determine that billing irregularities may exist. In essence, the onus will be placed on the health plan to notify the health care provider within a reasonable period of time as to any billing concerns it may hold so as to reduce the amount in controversy and mitigate the repayment amount.

Third, in determining overpayment amounts, health plans should be limited in utilizing the application of “extrapolation” in only those cases where there is clear evidence of fraud or intentional misconduct. Extrapolation is the statistical method wherein a claim for a minimal amount can be multiplied over all claims and then the resulting, far higher amount is multiplied again over a period of years – bringing the original minimal claims amount to an exponentially higher level.

Fourth, in connection with those specific instances that are exempt from the current two year “look back” limitation, the term “abusive billing” should be removed altogether. As set forth

above, the term is ambiguous and is subject to self-serving interpretation which, when applied without appropriate basis, can result in an unjust windfall for a health plan. Even with the term's removal, the health plan is already sufficiently protected under the law as the exemptions to the two year "look back" period - fraud and intentional misconduct. Moreover, to prevent the future misapplication of this "false label", the law should provide that if a health plan alleges fraud or intentional misconduct and initiates overpayment recovery efforts for more than the two year "look back" period and it is subsequently determined that the payments in dispute are not a result of fraud or intentional misconduct, that health plan shall reimburse the falsely-accused health care provider for any and all reasonable legal fees, consulting fees and costs expended in connection its defense against such an action. To further prevent such abuse, a health plan found to have falsely accused a health care provider of fraud or intentional misconduct, shall be subject to a penalty of up to five thousand dollars per payment.

## CONCLUSIONS

There are several potential, and differing, approaches to address this problem. We have prepared this White Paper with the hope that we can coordinate a collective approach that garners the maximum amount of physician support and substantive impact in order to prevent future unfair and unlawful audits.

It has been our experience that far too few physicians are aware of the risk of an audit, the inherent unfairness of the audit process and/or the increasing likelihood that no physician or practice will be able to avoid facing such threats. However, through the issuance of this White Paper, we would hope to increase physician awareness of these issues and we firmly believe that increased awareness will result in increased involvement.

Combining that involvement with the support of organized medicine, we believe that physicians can take action toward restoring the health plan financial audit process to its intended methods and/or mechanisms, mindful of the rights of the physician community. To those who share such goals, we would hope that this White Paper will serve as a starting point toward developing a collective strategy and a unified attack against unlawful audits.

## ABOUT THE PAPER

This White Paper is published by Kern Augustine Conroy & Schoppmann, P.C., a law firm that has been dedicated to and exclusively representing physicians and other healthcare professionals for more than a quarter of a century. Kern Augustine Conroy & Schoppmann, in association with its affiliates, Augustine Kern & Levens, Ltd. and Physicians' Counsel, LLC, forms one of the nation's largest Healthcare Law Firms devoted predominantly to the needs of physicians and other healthcare professionals. Together they have defended physicians throughout the United States.

The author, Michael J. Schoppmann, Esq., has spent his career focusing on the defense of healthcare professionals in actions before state licensing authorities (OPMC), the Office of Inspector General (Medicare), hospital disciplinary actions and other state and federal authorities. Mr. Schoppmann has also served as a faculty member of the Cornell University, Johnson Graduate School of Management, Executive Program in Health Care Delivery Management. He is a past two-term Chairman of the State Bar Association's Administrative Law Section. For more information, please contact Mr. Schoppmann at (516) 294-5432 or [schoppmann@drlaw.com](mailto:schoppmann@drlaw.com).

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