

## DRAMATIC INCREASE IN NUMBERS OF MEDICARE AUDITS

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In the past few months the number of audits conducted by Xact Medicare has soared. Based upon the number of audits coming to the attention of our law firm, Kern Augustine, Conroy & Schoppmann, we estimate that many hundreds of audits of New Jersey physicians will be conducted this year. While conducted by Xact, the audit process is, by Xact's own admission, inexact. The results can be potentially devastating. Xact will ask the physician for a relatively small sample of patient charts (usually forty to fifty), corresponding, generally, to one or more CPT codes used in the physician's practice. The codes selected are often those which the physician uses with greater frequency than ordinarily expected in similar primary or specialty practices, based upon regional averages. Recently, Xact has even conducted random evaluations of billing patterns that fall within the norm, just to add an element of unpredictability as to which providers or services will be targeted.

Xact, using 1995 record-keeping criteria, will then downcode the claims associated with these charts, if its review of the charts indicates that the documentation does not meet the requirements of the submitted code. Xact then extrapolates its findings to the general population of Medicare patients in the physician's practice. For example, if a change in one code resulted in a \$40.00 reduction in fee in thirty of forty charts reviewed, Xact will assume that 75% of all claims submitted under that CPT code were overbilled by \$40.00. If the physician had billed the code at issue two thousand times, Xact would thereby conclude that fifteen hundred of these claims were overbilled by \$40.00 and demand repayment of \$60,000, plus interests and the costs associated with the audit.

Remarkably, in its letter demanding repayment, Xact advises the physician that the sample upon which it makes its initial demand is statistically invalid. Nonetheless, it provides the physician with only three alternatives, none of which is especially appealing. Alternative One is to accept the unscientific, invalid sample, as if it were valid, and repay the money. Alternative Two is to not contest Xact's findings, to waive the right to a statistically valid sampling, and to also waive the right to a hearing. In return for giving up these rights, Xact will allow the physician to offer any explanation he or she may wish to provide, in an attempt to convince Xact that its initial findings are incorrect. In so doing, the physician places himself at the mercy of Xact, since Xact has no obligation to accept the explanation, and since the physician has waived all rights to a hearing or appeal from the final determination. In short, by accepting Alternative Two, the physician places the burden upon himself to convince Xact that the original determinations it has made were wrong, while waiving any rights to any review of Xact's final decision.

Alternative Three is to demand a hearing. However, the right to a hearing does not come without substantial cost. Xact tells the physician that if he wants to exercise his right to demand a hearing, it will conduct a complete review of all of the physician's Medicare files, thus creating the possibility that the physician will expose himself to far greater liability than that which he might otherwise have.

Thus, Xact is telling the physician that he either pays them the amount they demand as a result of an admittedly statistically invalid sampling of charts; that he waive he waive his right to a hearing in the hope that Xact will listen to his explanation, with no right to appeal, if they do not; or that the physician open himself to a full-blown audit of his practice.

The amounts demanded by Xact, in our experience, have ranged from thirty to forty thousand dollars, to nearly one million dollars. Before making a determination as to which option to elect, a physician must conduct an internal review of his practice and an analysis of the potential risks and benefits associated with each option. That analysis is complicated by the fact that the State Board of Medical Examiners and Managed Care Companies are now asking physicians whether they have ever been required to return monies to third party payors, including Medicare. An affirmative response to the question can have significant repercussions to the physician.

Further complicating the problem is the real concern that the physician could be required to turn over all evidence of his internal evaluation to government agents, or third party payors, at a later time, since any review performed internally by the practice is not privileged.

To guard against the likelihood that an internal review and analysis may become "discoverable" and form the basis for more severe legal action, internal compliance reviews and practice audits must be conducted under the auspices of an attorney, so that the attorney client privilege can be used to help avoid disclosure of adverse findings to third parties. Otherwise, any discrepancies uncovered in the course of an internal review may have to be disclosed to the Board of Medical Examiners, a government or other third party payor, or other federal or state agency, at a later time. Evidence of prior inappropriate claims, or non-compliance with law, could form the basis for disciplinary action and claims of false or fraudulent billing which carry enormous financial penalties, the possibility of incarceration, and loss of medical license.

For these reasons, no physician should undertake any review of his billing or coding practices, nor engage in any internal compliance review, other than through legal counsel. Otherwise, the physician's affirmative efforts to achieve compliance could create the exact opposite result -- providing the very evidence which results in civil or criminal action against the physician who attempts to assure future compliance.

Though dangers exist for those attempting to assure their own compliance, the need for internal audits and compliance reviews has never been greater. Government regulations and laws, under which physicians are obligated to practice, are extraordinarily complex and easily overlooked. Billing and coding problems are not the only concern. Any physician whose income is based, even minimally, upon services provided by persons who are not his direct employees, may well be violating the law. A physician whose compensation is in any way determined by the nature or extent of referrals or by profits from ancillary services, even if those referrals or services are provided by other members of his group, is at risk of being in violating of the law. Given the myriad state and federal laws and regulations at issue, given the huge exposure physicians have, and given the risk of doing nothing, every physician must consider retaining health care counsel, working with management and coding specialists, to perform a compliance audit of his or her

practice.

In conclusion, Xact is performing large numbers of audits which place physicians at significant exposure. To reduce exposure, every practice should have a compliance review performed. To assure confidentiality of the results, and avoid creating evidence which could lead to indictment, this review should be conducted under the direct auspices of health care counsel.