Payer-Based Audits are Often a Waste of Time for Docs

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While some payer-based investigations into fraud might be based on actual patterns of abuse, most are just an attempt to recoup funds.

Source: Physicians Practice

An enormous amount of time and effort is spent by physicians and other providers attempting to comply with fraud and abuse mandates issued by private and federal payers. While some investigation/auditing may be based on true patterns of fraud and abuse, other audits are fishing expeditions that simply uncover errors and misunderstandings, or even nothing at all.

Regardless of the reason for an investigation/audit, physicians spend an inordinate amount of time responding to audit requests and fighting with payers regarding reimbursement issues. Too often, payers use the investigation/audit approach less as a means of ferreting out true fraud and abuse and more as a mechanism for filling their coffers. When an audit/ investigative agent or department is compensated based on recouped funds from physicians or rewarded monetarily for the amount of recoupment they are able to achieve, we should all be concerned about the mechanisms used by such parties, which are often unfair and abusive in themselves.

In my experience in dealing with payers in investigation/auditing efforts, I often find the following:
1. Unclear demands with incorrect references to providers, dates of service and codes;
2. The inability to communicate with a live person regarding questions and errors or to resolve simple issues quickly and inexpensively;
3. Recoupment by payers on the same claims for which providers are going through a hearing/mediation/legal process resulting in “double-dipping” by the payer (which is not revealed to the provider);
4. Uninformed auditors and medical staff used in the auditing process who are not familiar with the intricacies of the medical services/codes until educated by the physicians who they are auditing;
5. Making up rules or issuing retroactive mandates contrary to recommendations by the board/medical specialty on which physicians rely;
6. Randomly modifying a position on certain coding/billing/reimbursement rules, which are not specifically set out by statute or regulation;
7. Bullying providers to respond to requests in unreasonable amounts of time or face severe consequences; and
8. Disagreeing with a provider’s use of coding/modifiers and denying any reimbursement rather than an equitable adjustment for services rendered.

These are just a few examples from both the private and public sector. I am sure if I were to invite my fellow healthcare lawyers to submit their experiences, this list would be much longer. The bottom line is that there is a lack of equity in much of the investigation/auditing that occurs, and this is a direct result of the incentive investigators are given to recoup as much as possible from as many physicians as possible.

Further complicating an already untenable situation is the desire of states to jump on board with their own efforts to put an end healthcare waste, fraud, and abuse as well. For example, Governor Bruce Rauner of Illinois recently created a task force intended to find waste and fraud and abuse in tax payer-funded healthcare programs. The primary goal, of course, is to save money for tax payers in a state that has been unable to balance its budget and is scrambling to find other sources of income. Once again doctors are the primary target for these efforts, with other states expected to jump on board (if they have not already).

While I am all in favor of finding and preventing corruption and fraud and abuse within our healthcare system, there is currently an abundance of abuse and mistreatment by those tasked with routing out healthcare fraud and little to no regulation of the techniques being used by such parties. Moreover, the administrative and financial drain on physicians increases healthcare costs and lowers physician productivity, pushing even more physicians out of private practice or out of medicine entirely. Physicians went to medical school to become caregivers. While some physicians clearly
engage in fraud or show a total disregard for appropriate billing and coding, most physicians simply do their best. Physicians must take it upon themselves to be educated and informed about proper billing and coding within their specialty. You cannot rely on your billing company, your office-based coder, or any other third party. Every practice needs rigorous auditing and claim review and ongoing education for every physician. If your practice is targeting by a payer for investigation and auditing, be sure to consult legal counsel immediately.

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