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## A Prescription for the Medicare Audit

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The federal government estimates that Medicare paid out over \$29 billion for evaluation and management services for 2003. Accordingly, in its quest to ferret out what it characterizes as “fraud and abuse,” The Office of the Inspector General for the United States Department of Health and Human Services (“OIG”) recently issued its work plan for 2005 and identified, once again, the coding of evaluation and management (“E&M”) services as a prime target for investigation in

the upcoming year. Not surprisingly, OIG will attempt to balance Medicare’s book on the backs of the very physicians that make the program work by targeting family practitioners and other Medicare providers for audit and, ultimately, demands for repayment. While the battle lines have been drawn, physicians need not allow themselves to become the victim of government abuse or incompetence.

While it is about money, the Government has raised the stakes for participating physicians by conducting those audits under its “fraud and abuse” umbrella. An unfavorable audit, one that gives the Government grounds to claim fraud, may result not only in a substantial repayment, but your exclusion from the program (and concomitant report to the National Practitioner Databank) and parallel investigations by other third party payors, state Medical Boards and a referral to law enforcement authorities for an investigation of alleged criminal activity. However, demands for repayment and the audits upon which they are based are fraught with error and subject to very effective challenge.

With the advent of technology, Medicare has implemented complex software programs that quietly allow its auditors to gather data about the billing and coding practices of all participating physicians. From this vast databank, Medicare will compare literally every participating physician’s billing and coding practices to those of his or her peers. Those, for example, who consistently bill at

higher E&M code levels, make frequent house calls or perform a particular procedure more frequently than others will be targeted for audit.

### Identification as an Outlier

Normally, the process begins with some correspondence from Medicare notifying the physician that he or she is an outlier – a physician who allegedly bills and codes at a particular level more frequently than his peers. Experienced health care counsel should be consulted at the earliest possible moment, for such letters are the Government’s first “shot across your bow.” Experienced counsel will consider the advisability of retaining an outside billing and coding expert to undertake a review of a random sampling of the subject codes for the time frame in question. By having counsel retain the consultants, the audit work papers, findings and suggestions will be protected from any disclosure at a later time by virtue of the attorney client privilege. In the worst case, overpayments will be identified, arrangements for repayments will be made and the error that caused the overpayment will be identified and corrected. I suggest this course of action not simply for the sake of honesty, but because such actions allow you to show that the overpayments were simply errors and reduce the risk that the Government will later claim fraud.

Additionally, the failure to address such issues may cause Medicare to relegate the physician’s claims to “pre-payment review status,” which requires the submission of all records before claims will be paid. If a substantial part of a physician’s practice is comprised of Medicare patients, relegation of one’s claims to such status may cause cash flow problems so severe that many physicians faced with such action are forced to simply close up shop.

### Medicare Audits and Dealing with Repayment Demands

Typically, a Medicare audit begins with a request for production of a limited number of charts for the identified E&M Codes. The records are analyzed for the purpose of

determining whether the charting supports the level of care reflected by the E&M code submitted. If Medicare finds, for example, that a physician has inappropriately “upcoded” 99213 office visits to 99215, in five of the ten charts reviewed, it will then total up all of your 99215s for a given time frame and demand partial repayment on fifty-percent of those matters.

Demands for repayment should be immediately referred to experienced counsel who will determine whether a negotiation should be swiftly opened up or whether it is prudent to challenge the findings. If the random sampling analyzed by our own consultants demonstrates even greater problems than those identified by Medicare, a negotiation will be opened and the matter will be quickly settled.

In countless other circumstances, we have found serious flaws in the demands. For example, in some instances through our own investigation, we have found that Medicare has simply compared the physician to the wrong group of peers. For instance, a physician with a large homebound geriatric patient base should not be compared to other family practitioners in his or her area. In other cases, we have been able to prove that the demand is based upon a flawed review of records or that the records reviewed do not constitute a random sampling.

In one case, our investigation demonstrated that one Medicare program administrator had relied upon the opinion of a medical reviewer who had been convicted of conspiring to bribe public officials in an attempt to influence federally funded health care legislation. In that matter, the physician was quickly removed from repayment review and the matter quietly disappeared.

## Conclusions

- 1. Do Not Alter Records.** While one may suspect that his or her office records will not withstand audit scrutiny, the temptation to create or alter records in the face of an audit must be avoided. Such conduct is criminal and I have represented many physicians who face licensure proceedings and the possibility of jail simply because they did not realize that there was a copy of the original record floating that somehow came back to haunt them.
- 2. Review all correspondence from Medicare.** Be aware of the existence of claims that are routinely rejected and which may establish a pattern leading to an audit. Train your staff to bill properly (or hire a reputable billing company, one that does not charge on a percentage basis) and institute a compliance plan. By doing so, you can demonstrate a lack of fraudulent intent by showing the existence of a vital, ongoing and professional effort to identify and report erroneous claims.
- 3. Scrutinize Your Business Relationships.** The OIG Work Plan for 2005 has identified the relationships amongst physicians, billing companies and purveyors of durable medical equipment as investigatory targets for the upcoming year. Have your business relationships and agreements reviewed by a knowledgeable attorney.

**Protect Yourself.** If confronted with an audit, we recommend retaining an appropriately experienced health care attorney. If you do not know one, contact your specialty society or local medical society and request a recommendation. Remember, a find of fraud can also result in a physician's exclusion from Medicare (with the concomitant report to the National Practitioner Databank) and parallel investigations by other third party payers, state Medical Boards and law enforcement authorities for an investigation of alleged criminal activity

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