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# The Business of Health Care Provider Audits

How payers are getting away with practice murder.

By Brian Capra, D.C., Yuval Lirov, Ph.D. and Jeffrey Randolph, Esq.

In Illinois, a psychiatrist was sentenced to 23 months in prison over Medicaid bills that added up to \$75.25. In California, one doctor served five years in prison over \$65,000 in disputed Medicare bills [*Forbes*, 2005]. These are not isolated horror stories. Take a look at Table 1: Something has happened during the past decade in health care that has driven audit rates through the roof. Average judgments are also shockingly high when compared to years past, leaving everyone who cares to ask wondering—emphatically—why.

As any social scientist will tell you, the suggestion that the rise in audit rates is indicative of a concerted increase in fraudulent activity among providers is absurd. It is more likely that the payers have started doing something differently. Indeed, the “scene” in the title of this section alludes to a new payer strategy adopted a few years ago: large-scale claims monitoring, fine-tuned provider targeting, and merciless audit.

If payer audits seem like old news to you, take another look at the numbers in Table 1. This is a whole new ballgame. It might not be murder, or even criminal, but it is undeniably unscrupulous. And you should know about it, because

unless you are actively working to manage audit exposure, your practice is at risk.

**TABLE 1. FRAUD STATISTICS—HEALTH AND HUMAN SERVICES**  
Civil Division, U.S. Department of Justice

Year	New Matters	Judgments	Average Judgment
1993	61	\$155,323,165	\$2,546,281
1997	347	\$920,350,127	\$2,652,306
2000	260	\$912,388,758	\$3,509,188
2003	243	\$1,825,406,640	\$7,511,962

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**MOTIVE**

The motive in business is always profit, but insurance companies have it particularly rough. They play in a massively regulated, traditionally altruistic industry, where they are the only for-profit game in town.

Against all odds, they swashbuckled their way to the top.

But now, as Wall Street sweethearts, they have stepped through the looking glass into a world that seems to keep pace no matter how fast they run. The faster they grow profits, the higher they drive expectations, leaving them increasingly desperate for new ideas to generate revenue.

Worse, their top two revenue-boosting wells are drying up. Premium was preclude them from raising rates, and recently enacted timely payment laws limit how long they can withhold repayment to earn interest as they had in the

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past. To meet profit expectations and still play within the new rules, insurers have decided to go after the reimbursements after they are paid. If your skepticism has led you to the—rational—rebuttal that audits are expensive for everyone, rest assured that the invisible hand (gloved in technology) has helped insurers overcome this traditional obstacle.

**MEANS**

The central question is how insurers turned random, expensive audits into a cookie-cutter revenue stream. Audits used to be plenty painful for insurers too. After all, reviewing samples of random claims from random providers and cross-referencing for problems egregious enough to warrant follow-up is expensive business. How can you trust small samples enough to invest the resources to launch an audit that will probably turn up nothing? How do you detect subtle cases of fraud when you have to compare hundreds of three-foot tall stacks of paper?

**TABLE 3. SAMPLE BILLING VIOLATIONS**

1. "Phantom Billing"—Billing for services not rendered.
2. "Double Billing"—charging more than once for the same service, e.g., using an individual code again as part of an automated or bundled set of tests.
3. "Clustering"—Using only a few codes on the theory that it will average out.
4. "Upcoding"—Using a higher reimbursement code than the code reflecting the service rendered, e.g., billing for complex services when only simple services were performed, billing for brand-named drugs when generic drugs were provided, listing treatment as having been for a more complicated diagnosis than was actually the case.
5. "Unbundling"—Using two or more billing codes instead of one inclusive code where regulations require "bundling" of such claims. Submitting multiple bills, in order to obtain a higher reimbursement for tests and services that were performed within a specified time period and which should have been submitted as a single bill.
6. "Code Jamming"—Inserting or "jamming" fake diagnosis codes to get insurance coverage.
7. Billing for non-covered services
8. Billing for services that are not reasonable and necessary.
9. Inappropriate balance billing—billing Medicare beneficiaries for the difference between the total provider charges and the Medicare Part B allowable amount.
10. Routine waiver of co-payments and billing third-party insurance only.

**TABLE 2. AUDIT TRIGGERS**

Stage	Report
Prepayment Review	CCI and LMRP rules Inter-claim, intra-claim, cross-claim Lifetime duplicates Date range duplicates Re-bundling Modifier codes E&M crosswalk Visit level
Post-Payment Audit	Procedure repetition High payments per day Surge analysis Unusual modifiers Unusual procedure rates Geographic improbabilities 5/50 patterns
External Resources	Providers watch lists OIG sanctions databases High-risk address databases

Perhaps driven by the simple goal of reducing the cost of identifying audit targets, insurers began building claims databases. With the advent of electronic submission, this became almost costless. As with many purportedly win-win propositions we have seen from insurers, electronic submission has proven a wolf in sheep's

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clothing. As providers submit claims to be paid, insurers simply add each claim to their growing database, and their Computer Science geeks regularly crank out reports that give executives a bird's eye view of all their providers (see Table 2 for a short list of reports).

Health care finance insiders call this a "Big Brother" system and, setting aside the melodramatic implications of such a name, it is easy to see why. While executives have a soft spot for pretty charts, the true power of such a system is its ability to drill into the data and find outliers (when they talk about this type of tool, Information Systems specialists use jargon like data mining and On Line Analytical Processing, or OLAP for short). The system automatically pinpoints providers that are doing something differently from the pack, and you can bet the insurers are going after these guys one by one.

OPPORTUNITY

Invariably, providers are in denial about their exposure, and insurers are quick to comfort them. They will tell you that audits are an unfortunate, but necessary tactic for keeping fraud in check, implying that honest providers have nothing to worry about. But insurers are not crusaders for truth and justice. Providers need

**TABLE 4. AUDIT MANAGEMENT STRATEGY**

1. Document every patient encounter in SOAP notes. Note:
  - If you bill a five-region CMT code, make sure your SOAP notes support all five regions.
  - Make sure your notes support any extra-spinal manipulation.
2. Identify
  - 98941 or 98942 on every patient each visit because you are a full spine doctor
  - Full spine x-rays on each and every patient on initial exam and then again as a re-check
  - Billing and coding for cervical, thoracic and lumbar X-rays when meant a full spine performed
  - 97140 manual therapy in place of a manipulation code because it pays more
  - Billing for an E/M code on each visit: 99211-5.
  - Billing for all new patients as a 99204 or 99205
  - Billing for both a spinal and extremity adjustment on each patient
  - Billing insurance company when the patient wasn't even in the office
  - If you have seen a patient within the last 3 years, then you must bill the established patient E&M codes. This applies even if the patient has an auto accident, work injury, new insurance carrier, etc.
  - Missing co-payment collection
  - Separating the diagnostic global fee into professional and technical components
  - Same day billing for manual therapy, neuromuscular re-education, or massage in the same area as the spinal adjustment
  - Billing for services rendered beyond maximum therapeutic benefit or for maintenance/preventive care
  - 99201, 99211, 99241 more than 3 times per month on a single patient

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Some providers have already figured this out and have come up with clever coding strategies to fly under the radar (Table 3). But since insurers do not divulge their selection criteria, these providers are flying blind. In fact, sometimes

these maneuvers themselves identify providers as targets. After all, why fly so fancy unless there is something to hide. Other providers do not even consider audit a threat because they run a cash-only practice. Yet these providers are still exposed because patient submissions put them on the map. Furthermore, as astute providers know, malpractice and general liability insurance policies do not cover audit defense legal fees and costs, leaving the practice fully exposed to audit liability. The situation looks dire, but providers do not have to set up a desk in the office for the auditors just yet.

THE LAW OF THE JUNGLE

Providers should start seriously managing audit risk. All providers must calculate the likelihood a bull's-eye has been taped to their back. See Table 4 for questions your practice should be able to answer for any period of time, for each insurer with whom you work, for practices in your area, state, and nationally. Even if you run a tight ship, it is unlikely you can answer many of these questions, and there are two reasons for this: first, unless you happen to be a database expert, it is probably next to impossible to collect and aggregate this data for your own practice; second, you simply do not have access to your peer practices' data.

Here is the call-to-action: providers need a Big Brother system of our own (or perhaps a Big Sister system in the spirit of our egalitarian times). Such a system, modeled on the insurers' own, would store claims data and generate reports for the benefit of participating providers. Better yet, if the system was integrated into the billing process and monitored claims before submission, providers could actively manage their image in the hawklike eyes of insurers by adjusting their process before it draws much attention. However implemented, it is clear that audit risk must be actively managed.

Having acquired the means to cost-effectively target providers, insurers have begun the hunt. It behooves providers to arm well and fight back.

TCL

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