Retrospective Audits

What is a retrospective audit?

In a retrospective audit, managed care organizations (MCOs) review claims paid to a physician practice over a set period of time to determine whether there has been overpayments of claims. Retrospective audits are burdensome and add an administrative expense to the physician practice, particularly when they occur several years after a claim was paid. If a MCO determines through a retrospective audit that overpayments have been made, physicians may be asked to make repayments for services and procedures already provided or may be forced to accept automatic reductions or "offsets" to future reimbursements until the "overpayment" amount is satisfied.

In recent years, MCOs have become increasingly aggressive in using retrospective audits as a cost containment tool. Sometimes the MCO will request refunds from overpayments discovered in the audited claims only. However, MCOs also may extrapolate the findings from a sample review and apply them across all claims submitted during the time period of the audit, a practice that the American Medical Association (AMA) opposes. This can result in physician receiving a letter demanding repayment of significant sums of money in a short time frame.

How will I know if MCO is performing a retrospective audit?

Retrospective audits involve a multiphase process that will vary by MCO. The first phase is typically an internal audit of claims performed by the MCO. The audit looks for "red flags" that indicate an overpayment may have occurred. The MCO will provide written notice to the physician of the suspected overpayment. The notice usually includes the reason for the suspected overpayment and a request for medical records and other documentation to assist in performing the next phase of the audit. When a practice receives notice of an audit, it is important to be proactive in responding. In some cases, the MCO will refuse to pay pending claims until the audit is complete.

What are the reasons that MCOs audit?

There are a number of reasons that MCOs audit. In some cases, the MCO may "red flag" a physician practice because of high service volume that the MCO believes indicates overutilization of reimbursable health care services or procedures. In other cases, MCOs may "red flag" a practice that uses the same AMA Current Procedural Terminology (CPT®) code frequently. An audit may also be prompted by a practice's reporting a high volume of certain CPT modifiers or for nonconformity with health plan coding guidelines. And, MCOs can simply conduct random audits.

**CPT is a registered trademark of the American Medical Association.*

What should a practice do once it receive notice of an audit?

Quality medical record documentation is the key to successfully navigating a retrospective audit. For example, if the practice is audited because of high service volumes, the physician may substantiate high volume or frequency of services by providing documentation relating to the size, specialty, local disease prevalence, and other factors that affect the practices's service delivery and billing patterns. Likewise, if a practice is audited because of repeated use of the same E/M codes, the practice is much more likely to prevail in a retrospective audit if the medical record clearly supports the need for the level of service billed and the procedures or services required. It is critical that physicians bill each service or procedure case-by-case rather than employing "generic" billing practices. Without good documentation, it is very difficult to defend a retrospective audit.

Some physician practices perform an annual internal billing audits to assure that billing errors are not occurring and that billing is in compliance with CPT codes, guidelines and conventions, as well as billing guidelines MCOs provide to the practice. While this is a significant undertaking, it will typically yield improved claims management processes and cash flow and also will help the practice in the event of a retrospective audit.

Are there any legal limits to retrospective audits?

Physicians who receive notice of a retrospective audit should review their MCO contract to determine whether it addresses retrospective audits. Many MCO's include "offset" provisions in their contracts that are very broad and give the MCO wide berth to decrease future reimbursement based on alleged overpayments. See **AMA Model Managed Care Contract Addendum, Section 3.0**

However, six states prohibit automatic "offset" or recoupment of payment and require notice and some due process (Alaska, California, Florida, Kentucky, Ohio). A number of states also limit the time period for retrospective audits.

In addition, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires that physicians may only release the "minimum necessary" information for the intended purpose of a request. Therefore, if a physician practice believes that release of some or all of the information requested as part of the audit goes beyond the "minimum necessary" standard, it should not release the information and should inform the MCO of its position.

Finally, if a physician practice believes it has been singled out for a retrospective audit because of patient advocacy or other protected activity, it should seek legal counsel.

How does the AMA Model Managed Care Contract protect physicians from retrospective audits?

The AMA Model Managed Care Contract Section 3.10(d) specifically provides that all payments to physicians and physician groups/ networks will be final unless adjustments are requested in writing by the MCO within 180 days after receipt. It also requires the MCO to notify the physician within 15 days of a request for additional information if the claim is not considered "clean," and to provide the reason for the alleged deficiency. This eliminates the possibility of retrospective audits beyond the 180 day period.