Dealing with Managed Care Audits

Following these step-by-step pointers can help protect your practice and your patients.

Increasingly, managed care and other health insurance companies seem to be auditing psychologists’ client records, especially when the practitioner is an out-of-network provider. Psychologists facing such audits often have questions about how the audit process works and how the practitioner should respond. For example, they may be uncertain and concerned about their rights (see sidebar below) as well as patient privacy considerations.

This article lists steps to follow before and after a psychologist receives an audit notice. The sidebar on page 13 guides practitioners in handling a company’s demand for a refund.

Step 1: An ounce of prevention...
The best way to prepare for an audit is to understand the company’s requirements and expectations well in advance of an audit – before you start delivering services for patients insured by the company. This knowledge may reduce your chances of doing something that flags your practice for an audit and will make you better prepared in the event that you are audited. For example, you should understand the company’s:

- Preauthorization and billing requirements and procedures
- Coverage and treatment guidelines relevant to your patient’s diagnosis and condition
- Expectations about treatment plans and patient progress
- Recordkeeping requirements or expectations – for example, what details the company wants for each session, as well as in the overall record

This information should be available in the company’s provider manual or the provider section of the company’s website. If not, contact the company’s provider relations representative.

Step 2: Determine the purpose of the audit
Audits typically start with a letter from the company explaining the purpose of the audit. If not, you should ask the company to clarify the purpose. Common reasons for auditing are:

- To determine the quality and appropriateness of the care provided to the company’s policyholders
- To assess the adequacy of your recordkeeping
- To verify that there has been no billing fraud and abuse.

For many audit situations, the pointers in this article will be sufficient for a psychologist to deal with the audit himself.

I’m out-of-network with the company requesting an audit. What right does the company have to audit my records?

More and more audits seem to involve companies looking at psychologists who are out-of-network providers. Such psychologists may ask what gives the company the right to audit when they have no provider contract with the company. (Provider contracts typically require that you comply with the company’s audit requests.)

The answer is that while you may not have audit obligations to the company in this situation, the patient’s contract with the company may require the patient to allow that his or her care and records be audited in order for the patient to be reimbursed or to have further care authorized. The company might also claim that it has the right to determine if your out-of-network services met the medical necessity definition in the patient’s insurance plan. Generally, the patient’s best interest is served by complying with audit requests that are reasonably aimed at determining whether the patient received appropriate out-of-network services.

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What steps should I take if the audit results in the company demanding a refund?

In some cases, the audit may result in the company writing you a letter asking you to refund a portion of the money that they previously reimbursed you as an in-network provider. If that happens, take the following steps.

Determine the basis for the refund demand

Any demand letter from a managed care organization (MCO) should explain to you clearly the basis for the company’s refund demand. It should describe exactly how the MCO calculated the dollar amount, perhaps including a spreadsheet that details the individual claims that factored into the calculation. If these details are unclear, you should ask the company for clarification or documentation.

Assess demands based on allegedly inadequate record keeping

In the past, a common ground for demanding post-audit refunds was the assertion that the health care professional’s records were inadequate, such as the demands made by Oxford Health Plans in 2003. In this situation, the company does not dispute that you actually performed the services claimed; it simply contends that your record keeping for those services was inadequate. For example, the company may assert that you did not record sufficient details for certain sessions.

If the refund demand is based on charges of inadequate record keeping, you should review your provider contract, your provider manual and/or the provider section of the company website, and applicable state law for the following issues. If favorable in your case, you can use the following factors to argue against the refund demand:

- Does the company clearly state what type of records it expects psychologists to keep? In some cases, the record keeping guidelines are directed at physicians and may not apply to psychologists.
- If the company claims that notes from particular sessions were not sufficient, did the company make clear what it expected the psychologist to record for each session?
- If the company did not give clear record keeping guidance, what does your state law require? Do your records meet that standard?
- What does your provider contract or provider manual say will happen if records are not adequate? Does the contract specifically make your reimbursement dependent on adequate record keeping? (If not, you can argue that your reimbursement was not contingent on the content of your record keeping.) Does your provider contract allow the company to demand refunds for claims of record deficiencies?
- Remember that if you choose to keep detailed records in your psychotherapy notes, apart from your general clinical records, the MCO is not entitled to these notes. The company should not be able to penalize you for not having details in your clinical record that you have properly protected in your psychotherapy notes.

Determine if the company “extrapolated” to increase the refund demand

In Medicare and Medicaid, regulations often allow auditors to extrapolate from the audited sample of claims across a much larger volume of reimbursement payments. For example, if the auditors sample 10 claims and believe that two of the claims should not have been paid, they can then demand a refund for 20 percent of all prior payments over a certain period of time.

However, those regulations do not apply to the private sector. Therefore, a company dealing with private sector claims would have to rely on its provider contract for the right to extrapolate. Many provider contracts have no provision allowing the company to extrapolate.
or herself. However, you may want to consider retaining an attorney if the focus of the audit is potential fraud and abuse (which may be indicated by the involvement of the company’s special investigations unit), or if the company has demanded a very large refund.

The purpose of the audit may change once it is under way. To give a worst case example, auditors who are looking at quality-of-care issues may find that a provider’s records do not contain any entries for certain dates of service. This omission may shift the focus of the audit to whether services were actually provided on those dates – that is, a possible case of fraud and abuse.

**Step 3: Verify that you have appropriate patient consent**

The next question is whether you have adequate consent from the patient to release any records. This is generally a question of state law governing consent. Under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, release of records for most audit purposes does not require a HIPAA authorization, so state-level consent requirements apply. Under applicable state law, consent may be satisfied by the consent form that the psychologist had the patient signed when applying for or enrolling in health insurance. You should seek to verify that the provisions of the consent form you used are sufficient to cover the audit.

The company may claim that it cannot provide you with a copy of the patient’s application consent form. If so, you might respond by asking the company to represent in writing that it has adequate consent from the patient under state law. If you are uncertain about the adequacy of either your prior consent form or the company’s form, and you are able to contact the patient, you may wish to request the patient’s consent for releasing records for the audit. You should not release the records if you do not believe that you have adequate consent from the patient.

**Step 4: Determine what records you can release for the audit in light of privacy laws**

Other aspects of audits are governed by the HIPAA Privacy Rule. In particular, if you keep separate psychotherapy notes as defined by the Privacy Rule, the insurance company cannot ask for those notes without the patient’s HIPAA-compliant authorization, regardless of the state where you are located.

Further, the company cannot attempt to coerce your patient into providing an authorization to release psychotherapy notes by threatening to withhold treatment or payment. You are only required to give the auditors your separate clinical record containing basic information like diagnosis, symptoms and treatment plan. Practitioners who keep psychotherapy notes separate from the general clinical record report that it makes responding to an audit less burdensome because there are fewer records to provide.

Whether or not you keep psychotherapy notes, the company must follow the HIPAA “minimum necessary” rule and thereby seek only those records necessary to accomplish the purpose of the audit. For example, if the audit focuses on whether you actually saw a patient on particular dates for which you were paid, you could claim that the company does not need to see anything further than your records involving those specified dates. (Importantly, this rule is expected to change under forthcoming regulations governing the federal Health Information Technology for Economic and Clinical Health Act, or HITECH Act, which modifies portions of HIPAA.)

A few state laws, such as New Jersey’s Peer Review Statute and the District of Columbia’s privacy law, provide even stronger privacy protections than the HIPAA Privacy Rule that will further narrow the information you can release in situations where they apply.

For answers to further questions about audits, please contact our Office of Legal & Regulatory Affairs by phone at (202) 336-5886 or by email at praclegal@apa.org. We are particularly interested in hearing from you if you think a company auditing your practice is violating your provider contract, HIPAA or state law.

**PLEASE NOTE:** Legal issues are complex and highly fact-specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time. The information in this article should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.