Provider Audit Workgroup Public Hearing
Indianapolis, Indiana
July 11, 2016

Attendees:

1. Jim Skeel, Aspire Indiana
2. David Holwager, DDS, IDA
3. Linda Wehner, DDS
4. John Roberts, DDS, IDA
5. Jason Rogers, Director, Delaware County EMS
6. Jessica Sowers, Community Health Network
7. Connie Smith, CHN
8. Marie Weber, CHN
9. Alice Butterworth, DDS
10. Suzan Butterworth
11. Frank L. Butterworth III
12. Carmel Glass, ISDH
13. Leila Alter, IDA
14. Liz Elias, Hall Render
15. Matt Brooks, IACMHC
16. Jessica Kramer, Damar
17. Ed Rosenbaum
18. Doug Bush
19. Jyati Shah, DDS, The Smile Center
20. Rachel Allison, TSS Capitol Group
21. Brandy Campbell, CFO, Park Center
22. Stacy Mantooth, Comfort Dental
23. Maddie Gookins, IHA
24. Ron Gibson, Anthem
25. Gus Habig, FSSA
26. Shane Hatchett, OMPP
27. Tatum Miller, OMPP
28. Scott Gartenman, FSSA
29. Jim Waddick, PI
30. Ryan Torres, OGC
31. Becky Selig, PI
32. Ann Zerr, OMPP
33. Steve Towns, IDA, NDA, ISP
34. Ed Popcheff, IDA
35. Michelle Stein Ordonez, IAHHC
36. David Jose
37. Sunaina Menawat, Cognosante
38. Barbara Scott, Aspire Indiana

Dr. Alice Butterworth, DDS

Good morning to the Medicaid Officials and Staff, Medicaid Providers and other interested parties.

As one of the major Medicaid Dental Service Providers for Indiana, I hope to paint a picture of what these audits are doing to me and my fellow dentists. I received a Sagamore of the Wabash from Governor Kernan in 2004 in recognition for the great amount of charity dental care that I've provided over my 35 year career. Now, I'm in the middle of an audit in which FSSA is trying to recoup $4.56 million out of the $5.04 million I've billed to Medicaid in the last 7.5 years over a mere $5,124 worth of billing errors.

I am a sole practitioner, like many of my fellow dentists. All the risk is personal. We do not have a Big Daddy to fund the punishment. These current audit practices are unduly harming individuals who have been civic-minded and generous by accepting Medicaid patients. I've worked 35 years treating children in a low socioeconomic area; our office serves 87 zip codes. Central Indiana providers refer cases to me because I can safely sedate patients to overcome barriers of age, behavior, handicapped and rampant infection. Daily, we do 2, 3, 4 sedations because the Medicaid population often needs sedation because the teeth of these kids are often decayed to the point they need major work by the time they decide to seek treatment, find a dentist that will accept Medicaid, and find a way to get to my office.

At one time Marion General Hospital was utilized to treat such kids with general anesthetic in the operating room. When I discovered that a one-day hospital stay was about $5000, it seemed too pricey for Medicaid and for non-insured families. So I brought the expense and risk/responsibility back to my office where Medicaid now pays me $38.50 for that service. They pay me no further for drugs or supplies. But we keep doing it because there is such a need, and my sense of duty to the community and these children is so great. They have so few options for dental providers who will treat them. It has been my privilege to help these children when so few dentists will.

My dream was to partner with a larger health institution who could invest in space, facilities and personnel to carry on our services to the poor children of Central Indiana when I retire.

Dream is gone. Financial ruin. Broken heart. Instead, I'm now faced with a Medicaid audit that will break me financially if it is finalized at its current dollar amounts. My audit sample was 106 records, and errors were found that totaled $5,124. However, because the universe of claims in my audit is over 107,000 claims, that $5,124 is extrapolated to over $4.5 million that I might have to repay to FSSA. I do not have $4.5 million.

Because I am one of the few dentists still accepting Medicaid and doing sedation dentistry, my Medicaid volume is higher than most dentists. So the more generous a Provider is, the greater the pain and penalty. Yes, I was shocked and dismayed.

The audits are disappointing the provider base because we work hard for less money with a difficult and generally uneducated population but get penalized for more or less administrative or technical flaws such as "no signature" or "cannot read the initials."

These flaws are being addressed with punitive damages that threaten each dentist's persona in a life-changing or life-ruining manner. I will be forced to file bankruptcy if this penalty is assessed against me.

That said, I absolutely agree that we need an awakening as to what is expected. Surveillance has its function and responsibility. But the current audit procedures will decimate the provider base out of fear of having to repay all of the paltry Medicaid payments we received with the additional expense of having to hire lawyers to defend our actions. For me and others it delivers an assault on our:

- Mental Status (I am devastated)
- Careers (I cannot continue to provide at this risk level)
- Pocketbooks (I will have to declare bankruptcy if the total fine is enforced)

- Families (Dentists' families are devastated and discouraged)
- Employees (Office employees are considering looking for other jobs)
- Patients (Abandoned due to a very reduced provider base)
- Health of Indiana's children (Audits do not stop the rising decay rate in the nation's children and scientists do not know the reasons why)
- Expense of hiring an attorney
- Expense of hours researching and preparing information for the audits
- Perception of fairness by this institution, lost.

The stress, size of the penalties and perceived assault seems over the top for what is apparently wanted: better records. Had Providers received a notification from Medicaid that Indiana dentists have too many flaws in their record keeping and it was requiring every Dental Provider to complete certain continuing education units by webinar, regional meetings, or whatever communication method, I have no doubt Providers would have responded positively. I know I would.

Also, the agency has offered no education about its auditing practices. Our attorneys cannot even ascertain if the samples are statistically valid because not enough transparency is present to make an educated analysis of the samples.

Additionally, dentists' medical records are different from medical providers because we rely on x-rays, mapping, and other pictorial methods to chart our diagnoses and treatment. This pictorial charting seems to be disregarded by FSSA's SUR Unit, but they cannot point to their support for this proposition and will not accept this is industry standard to chart this way. We need auditors who are familiar with the service lines which they are auditing.

When the system brings about grave consequences for patients, providers and the system, I do believe that Medicaid officials can and should seek a different way of implementing the correction.

Please consider shifting to education-based reform that we all can participate in together and be proud of versus drastic measures that terrify and disillusion good people who are trying to make the state's program a success and treat a vulnerable population.

Please consider:

- Shortening the audit period to 3 years

  -find and correct problems more quickly to reduce continuing errors

  -produces the desired end—better records

- Keep the experienced Providers in the base

  -easier than recruiting new ones

- Retain prevention for the most widespread and chronic disease of childhood –dental disease-for which no eradication has been devised. (The rate in the U.S. and Canada is rising.) Rotten teeth will be here for the foreseeable future. This disease further debases our population of all ages.
- Retain perception of fairness in the Medicaid institution.

Concluding, I doubt and believe that you also doubt there is intention in non-compliance. The penalties for mere technical violations without good explanations for the method by which you quantify the penalties are hurting we sole practitioners deeply. These audits threaten to leave FSSA without enough dental providers to treat its member base, and in the dental world, what starts as a dental problem can eventually lead to a medical problem if infected teeth are not addressed. We need your help through fair and balanced education, as well as transparent and balanced auditing, to bring good healthcare to disadvantaged Hoosiers.

John R. Roberts, DDS

Good morning. I am John Roberts from Connersville, Indiana, which has just come to the distinction as the poorest city in Indiana. My percentage of Medicaid patients has been approaching to 40%. I used to be able to hold it at 20%, but due to lack of employment in our city and a growing need, I have taken on more. I have been a Medicaid provider all of my 34 years as a dentist. I would like to thank my colleague for her comments.

I am going to talk about 4 major points.

a) All auditors should be trained in dentistry so that they understand what they are reading. We should not be penalized because auditors are not educated.

b) Speaking of the auditors, they do not need to be paid on commission. That is a guarantee that they are going to find *something.* That is their paycheck. They should be paid whether they find something or not.

c) The auditors should not look back over five, six, seven years which gets into the extrapolation of results used to determine the majority of findings. If you look at a few charts and then say, "Well, you have treated this many patients, so it is going to be 100 or 1,000 times what we actually found." That is when you get into the millions of dollars or hundreds-of-thousands of dollars, when it actually should be hundreds *or* thousands.

d) There needs to be a better appeals process. Being found guilty and having to pay, and then having to appeal to get your money back is backwards. That is "typical federal government." I have had to deal with the IRS where they acknowledge they made a mistake, but their solution was to have me pay and then file an appeal to get my money back, which took two years. That is a lot of time and effort.

Those are my main points. I agree that as previously mentioned, Medicaid is going to lose a lot of providers. It is frustrating enough to deal with the sometimes inept administration of the program. There is lots of room for improvement. We would love to work with you to improve the program so that you can gain more providers who can help you get care to the people that need it. This current situation is not the way to go about it.

I do appreciate your time and effort in having this hearing. It is a major step. Thank you.

Jyati Shah, DDS

Good morning. My name is Dr. Shah and I practice here in Indianapolis. 40% to 50% of my patients are Medicaid patients. I have been seeing Medicaid patients since 1998.

I first received a letter from SUR in September 2015. The first letter stated that 134 claims out of the 297 claims were deemed overpayment. The estimated extrapolation was $2.6 million. I provided SUR with all of the paperwork and records and they reviewed all of that. The second time, only six claims out of 297 claims were deemed overpayment. They wanted $230,000.00 that were deemed overpayment. The first time the rate was 45%, then went down to 2%. Out of that, the six claims that were considered erroneous, I provided them with additional information. I am appealing that right now. This has been very, very stressful for me. I feel that I cannot perform dentistry the way that I want to because I am constantly thinking about these audits. I have lost countless weeks of sleep over this. I think it is unfair to a busy practice. It affects the way I do dentistry. Now when I do an extraction, if it is a surgical extraction, I take a picture of the roots, thinking that just in case I am audited, I have this proof to provide, I have these pictures.

I haven't even received a traffic ticket in my entire life, and this is really, really stress for me. I am not a good public speaker, but I just can't take this. If I have to return this much money to the State, I will have to shut down my practice and declare bankruptcy and all that is very stressful. I would like my husband, who is the business manager, to add a few things to this.

My Name is Rajesh Shah and I am the business manager of this practice. . By training, I am an electrical engineer. One of the things I would like to add to this is since we opened the business in 1998, we do a regular backup of all of the

financial records. We have an entire cabinet full of backups since 1998. When we received this letter of audit, we tried to extract all of the records since 1998. This cabinet is full of information from the hard drives and Medias. We were not able to extract because 17 years or 18 years' worth of records is a long time – a lot of data. Some of that information it was requested we extract, we could not, because technology changes rapidly. We tried to contact a vendor and they could not help us because there were so many revisions made since 1998, and we were not able to extract any of this information. She keeps a good record of everything, and we have internal audits to make sure that everything is done according to the requirements. That list you put up earlier, we follow all of that, but they are missing the components to technology. It is difficult because of the development of technology. I suggest you consider the latest technology development in your latest audit process. If you look at the letters that we are receiving, it assumes that we are using the latest technology, and we are not. The audit process is paperless. Please consider that.

I would like to summarize what she said. We have received a letter with 134 claims out of the 292 claims were deemed overpayment. This is a rate of 45% and after we submitted, we spent a lot of time trying to extract all of this information, both electronically and paper charts. Then the second time, six out of 292 claims. They came back to us saying, I don't know what payment. So that is an average rate of 2%. So the average dropped from 45% to 2%, and even that 2% rate is inaccurate because we have the records. So the volume that we see in the audit process is not taking place. There is a lack of communication. We get information, and we send what we think you need, and that is not enough, so you ask for this money. So we invite you to come to our office. We have everything on the record, and we can show you that we have it. And this 2% is too high for us. We have everything on record. It is just a lack of communication from your audit process. So the audit process is at a rate of 95% and we think that is totally inaccurate. That is all.

Jason Rogers, Delaware County EMS

Ladies and gentlemen, my name is Jason Rogers. I am the Director of Emergency Medical Services for Muncie, Delaware County. I have some prepared statements, but I am going to shoot from the hip. We talk about transparency. We talk about frustration.

We are in the midst of an audit. We are a government entity that follows government rules. We follow the Indiana State EMS Commissions rules. We follow the Homeland Security rules. And it seems to me that the FSSA rules and Myers and Stauffer, who is conducting that audit, doesn't follow those rules. So I seriously have my doubts how our audit is going to end up.

I have to applaud the people who have come before me because their plight is much worse than mine. The lack of information I have sent several emails to the FSSA website and I get nothing in return. I called Myers and Stauffer and I can't get people to answer my questions. So if we are going to talk about transparency, we have to talk about ethics. Myers and Stauffer is also the same firm that is conducting, and I am sure that it is on my percentage, Medicare (not Medicaid, but Medicare) reimbursements. So the information that I have sent to Myers and Stauffer for the last 3 years has netted us about $300,000.00 in underpayments. Now you have to understand that my constituents, my commissioners, my counsel, don't understand why, well we are sending all of this information to the auditors, and suddenly we turn around and they want $800,000.00 back. It stinks.

I probably could talk up here for two or three hours, and that is why I am going to shoot from the hip here. I personally feel that it is laughable that you would allow us only seven minutes and here is why. We were given 45 days to provide the information, our trip tickets, our signatures, those types of information that we service on a 911-only basis. I don't take people to the dentist. I don't take people to the doctor. I don't take people to dialysis. Of 160 emergency 911 calls, 106 of those were reported as incorrect for 11 different reasons. You have a definition of what is advance life support, and so does the State. They don't match. You have a definition of what is basic life support, and so does the State in the Indiana Code, and they don't match. It is very frustrating. It has been all-consuming and time-consuming. In fact, to the extent that my 15-year-old child refers to my job now as dealing with the head hunters.

We talk about extrapolation. In my opinion, the greatest game in the world is baseball. It is all about numbers. Not a single person who plays that game extrapolates a thing. Derek Jeter, New York Yankees, is the best Short Stop in the world. He made 524 errors in his career. We are not extrapolating his paycheck for that, are we? I don't think you should extrapolate these.

Let's look at the finite problems. Let's look at the issues at hand. If you want to bill somebody for X amount of miles, then let's bill somebody for X amount of miles that they are provided an EMS service. Let's not take into consideration "this is advance life support this" and "advance life support that." My personal feeling is that Medicaid and Medicare for pre-hospital providers should have the same rules. I don't get to ask, "Are you a Medicaid patient?" whenever anyone calls 911. That would not be a question that I would ask my men and women that respond to these emergencies on a daily basis to ask. In fact, up until a few years ago, we didn't even ask for insurance information. We helped these people without any questions asked. You are causing us to change the way that we do business, and it is very frustrating.

I am not personally going to be at any loss, unlike these ladies and gentlemen that have spoken before me. I feel sorry for them. It is not only disheartening, it does absolutely make me want to get out of the Medicaid business, and we don't have that option. I could go on and on, but I have a feeling that the ladies and gentlemen behind me probably have just about the same thing to say, and the same frustration that we have lived for the last 45 days. Thank you.

Stacy Mantooth, Comfort Dental Care

My name is Stacy Mantooth and I want to give you a perspective from the employees' perspective. I work for Dr. Brad Houston in a dental office. On April 6, 2015, we received a certified letter from FSSA to Dr. Houston stating that we were selected for a Medicaid on-site review.

It stated that Myers and Stauffer would begin conducting this on-site field examination on April 8, 2015. That gave us two days' notice. I personally am in the office on Mondays or Wednesdays, and we received that letter on a Monday. I was not in the office. When I got to the office on Tuesday that was thrown at me.

We operate with a very small staff. We don't have a lot of overhead. We don't have a lot of people. We have people that are there to do their jobs, and that is it. So when they showed up in our office on April 10th, I am sorry, on April 8th that was 2 days. They asked our staff to retrieve all 160 charts ranging from January 21, 2009 through January 4, 2013 for them to scan. Like I said, we don't have a lot of staff, so we had to pull staff away from their duties. We had a doctor that was in the office practicing. We had patients coming in and out. We had the audit team there. We have Operatories in our office and they utilized our Operatories to do their audit. We were down two rooms that we were not able to use for our patients. That was where they set up their space.

They made us pull all of the charts. I want to point out one thing, too, before I forget. Medicaid has an incentive for offices to become digital for EMR. We were in the process of becoming digital paperless. So we have records that are in the computer, and we have paper records. We have x-rays that are digital, and we have analog x-rays. I feel that we were misled. It said in the Administrative Code 405 IAC 51 "Providers must maintain records from the payment of claims for reimbursement. Such medical or other records, including x-rays, shall be maintained for seven years. Then it also goes on to say that the actual date of service to stand alone to support the services that were billed for the claim. That is basically saying two different things. You have to maintain all of these records and charting that would be x-rays. But in the next sentence, it says, only progress notes alone will support your claim. That doesn't make sense.

I also want to point out that we received a certified letter on August 4, 2015 outlining the audit findings. Potential extrapolation of payment was found to be $882,842.84. On August 20th we received another certified letter notifying us of an error on the extrapolation of overpayment. The new number was now $491,994.26. In both letters, the FSSA says that they are within 90% to 100% sure that those numbers are correct, they are accurate. That is our experience that we

have gone through. It has put a lot on our staff. It has put a lot on me to try and get all of this information, coming in on days off, writing letters, and pull all of this documentation. I think that is all I have to add.

Steven Towns, DDS

Good morning. My name is Steve Towns and I am a practicing Periodontist in downtown Indianapolis. I am one of two Periodontists in the state that will presently accept Medicaid patients. Although we have never had a problem with an audit or anything like that, there are some concerns.

We are starting to encourage other Periodontists in the state to help us manage these Medicaid patients and one of the things that are always brought up is the fact that there is a lot of paperwork and there is the audit situation and they have heard all of these horror stories which you have heard already. I am not going to reiterate that.

It is very obvious that the system is broken. It needs to be fixed. I think what we need is to kind of look at what is going on and get some common sense realization of what we need to do to have an audit. No one wants fraud. No one wants to have the system taken advantage of. It is bad for everybody. It is bad for the patients, providers, everybody. We have to figure out a way that we can do this in a fair and equitable way so that everyone benefits from it. There are a lot of problems with confusing codes, confusing payment schedules. All of these things can be documented. We don't need to go through that. We don't have the four hours that it is going to take to do that today. We really need to look at this differently. I hope that some of the things that we have discussed today will kind of bring those things to the forefront.

David R. Holwager, DDS

Good morning. My name is David Holwager. I am a practicing dentist for 34 years in the western part of Wayne County, Cambridge City. I have been a Medicaid provider. I am not currently under an audit. One of the things I have noticed in this procedure is that when you are using an audit, you have no one there who is trained in dentistry. Not a doctor, and not a hygienist or an assistant. It is a procedure in our codes that are different in medicine that needs to have someone there who knows how dentistry is done.

You have heard today earlier about extrapolation limits. Extrapolation does not improve fraud. No one who has come up here before you is interested in approving doctors who commit fraud. What we are interested in is fairness, a level playing field upon which we can act. Audit should be based on history and fraud proven.

Clerical errors does not mean the procedure was not done. You may not like how the doctor writes out his charts. I can guarantee you when I graduated in 1982 the charting is significantly different than what it is in 2016. Notification should come to the provider who takes Medicaid patients on the changes that are being made, not to a general wallboard site which is sometimes difficult to get the information from.

Several states have taken into the process people who are kind enough to be providers for Medicaid to be given individual notification of the changes in the rules and regulations. It is hard enough to practice dentistry without paying attention to every little administrative change. You need to limit the lookback period. Seven years? Two or three! Prove the fraud has been committed. That is what we are asking for. Not the fact that they write lousy, or they don't sign their charts, or they sign it in a way that you can't read it, or it just doesn't fit the auditor's profile of what they think is good.

You need to change the appeals process so that it is fair and level and guarantees due process to the individual who is being audited. Stakeholders need to have involvement. All providers need to have involvement in how the rules are written and the regulations given. Just doing this by people who are not trained in the different fields that you administer only causes the problems that you are facing here today. You shouldn't be fined for administrative errors. If the Administration overpays somebody, and then comes back a few years later and says, "Oh, we made a mistake, but

you have to pay the fine anyway," that is not fair. That is the current practice that has been going on. Retroactive audits. Pass the bill, but look back in years past to see who it offended. That is not correct, either. Continue this particular form of action and what you are going to have, is a fallout of providers.

We treat these people because we want to because it is a service in the community in which we live, and it is the right thing to do for our profession. The current practices that we are facing is going to very much limit how many people you get to enroll as a provider, and especially attract younger doctors to do this, as the older ones of us are going to retire. This form that I mentioned discourages providers from signing up, which we do have a problem with in this state. Because you are signed up and you see one or two patients, it doesn't make you a provider. It is a list that makes you a provider that the State gets. Those of us who treat 20% - 25%, 30%, 40% that you heard. It does affect them, and it does affect the fact that you take the different forms of social service that are offered by the state. I hope this helps to correct some of the situations. We are looking for fairness in how this is done. We are looking for individuals to be involved who are providers, and not just from the administrative side. Thank you very much.

Liz Elias, Hall Render

Good morning. Thank you for the opportunity for us to speak here today. My name is Liz Elias. I am an attorney at Hall Render. My colleagues and I represent a lot of providers with respect to Medicaid. Kind of a summation of my comments can be summarized in one sentence. Providers should be entitled to know the rules of the game for which they are forced to play. Providers are entitled to know the rules by the game they are forced to play. Currently they don't know the rules.

I am going to read to you from 405 IAC 151. The random sample audit should be conducted in accordance with generally accepted statistical matter, and the whenever numbers derived from random sampling generally accepted by the table of random numbers. The commonly accepted ways of recording and reporting accounting information. Well, I am here to tell you that there are a bunch of lawyers who have no idea what generally accepted statistical methods are. I think that method is derived from GAAP, generally accepted accounting principles, but so far we have unable to find generally accepted statistical principles. And we would welcome, if such a body of information exists, we would welcome that published publicly so that providers, and those representing those providers, have the ability to see that information.

The table of random numbers. I am going to have to go down in the weeds for a moment because I am a lawyer, and I spent a lot of time in the weeds helping our clients with this. We don't believe that the audits are statistically valid. The samples, generally speaking, the ones that we have seen are stratified evenly. There will be five or six strata that are singular one code, and not one code. There will be a sample universe of that one particular code. Then at the bottom is a catch-all. And there are usually tens, if not hundreds, of thousands of claims, in the other category. That is where the providers that are getting the huge extrapolations are falling into the most trouble. In that other category. That is where the extrapolations are the most significant. The singular strata where they are focusing on one claim, once they are extrapolated out tend not to be as significant. The providers behind me have testified to audit results in the millions of dollars. Most of those millions of dollars are in this catch-all other claim. And you don't know what is in the other claim. We have no idea what was in that other claim other than to go back and look at every single claim that they have charted for the past seven years. It seems to be that if you are going to have a stratified sample, you either have it all stratified, or just other. The fact that you have this bucket at the bottom where providers are falling into the most trouble. It is where all of the providers are being punished for the most part.

I want to talk about the confidence layer that Stacy Mantooth testified to earlier. Generally speaking, we are seeing 90% to 95% confidence levels, $5 to $10 precision levels. There are variations. We don't know why some levels are 90% confident, and others are 95%. We are not given that information in the audit. Providers don't know why some are 90 and some are 95%. They don't know why the precision levels are $5 or $10. But that precision level means that you guys, when you send those letters, you believe that those samples are within $5 to $10 accurate.

We heard Dr. Shah and others testify that when they got their final overpayment she identified a 95% error rate in the sample. Because her audit went from 192 I think errors, down to six. A 95% error rate. Certainly to have a 95% error rate, does not then still have a prevision level of $5 to $10. Nor does it have a confidence level of 90% to 95% confident. But yet, her final overpayment letter said exactly that. I can't remember if hers was a 90 or 95 or a $5 or $10, through each level of the audit process, the confidence level never changes, and the precision level never changes. As these providers are overcoming these findings of overpayments, it would make sense that the sample confidence level, and as a result the precision levels, would then change. And we would find out if we were conducting these samples statistically valid methods that these providers submitted their additional findings and their additional documentation and charting, then what was once a 90 to 95% sample, is anything but a 90 to 95% confidence level when they are done with it. Yet Dr. Shah still has an extrapolated audit overpayment in the hundreds-of-thousands of dollars for something that is not 90 or 95% confident at this point.

As a continuation of my previous comments, the extrapolation in an uncertain audit environment is patently (inaudible). You have heard all of these providers testify that the extrapolation of something by which they don't know the rules, they don't know the auditing standards, I just explained why the auditing ends up being 90% confident once they are through providing additional information. To extrapolate something that is not 90% confident at that end stage is unfair to the provider population.

In closing, to talk about that seven year statute of limitations, we appreciate the State rule as it differs now from the federal rule. It is a recently published rule saying that on the Medicare side that the statute of limitations with respect to records is now six years, I do acknowledge that they have published a final rule on the Medicaid, but everything else that they have been publishing so far, Medicare, regular Medicare, Medicare Part C, they are all moving to a six year standard, so you should pay close attention, because it appears that the seven year standard may be on its way out the door. And additionally, I don't think that the seven year standard applied where that overpayment is made when you are all the way through the reconsideration process, because we now have providers that have claims that are way more than seven years by the time they actually get to the overpayment determination of the end. Thank you for your time.

David Jose

Stratification is a remarkable problem, particularly in the mental health arena. Payback often exceeds the reimbursement for particular codes. Auditing needs to conform to statistical practices. I would recommend FSSA look at Medicare—and underpayments should be addressed. Indiana law allows for that but OMPP does not do this. Education for providers should be used rather than repayment in most cases. Many errors are administrative, not true errors and don't require 100% repayment. FSSA should use the opportunity to educate providers. There is also a lack of clarity that takes place in the review process. Providers need to know what the rules of the game are. They need to know what the request is for so they can provide the appropriate needed information.

Provider Audit Workgroup Public Hearing
Evansville, Indiana
July 13, 2016

Attendees:

39. Shannon Glass
40. Laura Kelle, SW Healthcare Southwestern
41. Rick Paul, Southwestern Behavioral Health
42. Julie Adams, ECHO
43. Amanda Sempi, Ridgway Eyecare Center
44. Doug Bush, IDA

Doug Bush, Executive Director, Indiana Dental Association

Well, good morning, I'm Doug Bush the executive director of the Indiana dental association. I didn't sign up to testify today because for members of the panel it made no sense to repeat what you have heard on Monday since I was at that hearing as well. But for the benefit of those that came that weren't in Indianapolis on Monday it may be helpful for them to hear an overview. Our organization was behind the original SB364 that was eventually amended to the resolution to hold these hearings. The history on that very briefly; about 2 years ago on the national level we began to receive reports about concerning things happening around audits across the country. Focus was on the RAC audit and what was perceived as unfair tactics being used in these audits. Fast forward to last fall, we began to hear from some of our members that they were being subjected to audits and they were very concerned. It lead us to believe these were in fact RAC audits which prompted us rapidly to enter legislation. It does not appear that these were RAC audits and some dentists were misinformed. Still some concerns which the panel heard on Monday from dentists which shared their experiences. As I'm learning more, I'm being frank in admitting when a dentist calls me and states, "I'm being audited and this is not right, I have not done anything wrong, but I'm being told I owe this much money", we know we are only hearing one side of the story. So we're very cautious and don't take it as complete gospel. It may be that there are aspects that they don't understand. Based on what I heard on Monday, I do think that we will find that while there may be some legitimate concerns that need addressed with policy changes there is some significant miscommunication occurring. I'm very concerned and received a copy. I do hold as highly suspect, the initial letters that go out when a doctor is being audited, I do know that those letters are being perceived by the doctors as a way that is not intended. They are being left with the impression that they owe the states hundreds of thousands if not millions of dollars. If you're a small practice receiving that letters means you're bankrupt as there is no way to pay that back. So the reaction is sheer panic and feel and it's very emotional. That dollar figure constitutes the worst case scenario but I don't think the doctors are reading that far and they're not getting beyond the initial shock of seeing that 6-7 figure number. If we go back and review that than perhaps the communication level can start on a less emotional level. As far as we are concerned providers who are stealing from the Medicaid system are stealing from the poor and we in no way want to see that happen so we want to put a stop to that when it does occur. If there are dentists being driven from the program based on fear and administrative tactics such as extrapolation where we review this many claims and found this many errors, we can extrapolate on total claims, we can collect on all of them. Other concern is the administrative error that did not harm the Medicaid system and there was no attempt to fraud or was it in fact a claim that should not have been paid. Dentists feel like they shouldn't owe money for these small administrative errors such as signature not being eligible or not placing signature in the proper area. Also it seems to me that the emphasis should be based on education, especially if we are going back years. The agency should be telling the doctors what they are doing wrong instead of waiting 7 years and having them repay claims for 7 years. In many cases Medicaid providers have encouraged colleagues to participate. We want to encourage, not discourage participation. We need to not unnecessarily alarming providers. We don't want to scare them away because their colleagues are going to hear about these things.

Provider Audit Workgroup Public Hearing
Mishawaka, Indiana
July 18, 2016

Attendees:

1. Kathy Murzyn, Great Lakes Association; Fair Meadows
2. Ed Popcheff, IDA
3. Susan Schrader, Porter-Starke
4. Gina Zimpelman, Midwest Orthotic Services
5. Mark Pfefferkork, Northeastern Center
6. Rene Villa, Edgewater Systems
7. Tim Thomas, Edgewater Systems
8. Jayme Via, MSLC
9. Amanda Bushey, Truven
10. Dana Guthrie, Hamilton Center
11. Dan Carey, Bowen Center
12. Joe Bader, NE IN Genetics
13. Alle Mertes, Paz, LLC (24 hour dental)
14. Dr. Jay Asdell, IDA
15. Mark Stezel, ISBD
16. Carol Balko, PSS
17. Jodie Wexelberg, HealthLinc
18. Mike Ashley, Delaware Co. EMS

Dr. Asdell- Oral Surgeon, South Bend
I am a Medicaid provider and have been since day one and currently the president of the Indiana Dental Association and that is why I am here today. To thank you guys for having these hearings and taking the time to do these. I'm sure this has been discussed previously- dentistry isn't a real big part of the Medicaid dollar and we are a small business and an overwhelming audit is harmful to the dental community. As audits go on and rumor fly it discourages providers to be part of the IHCP. Its key and I truly agree that there are people out there that are not playing by the rules that need to be audited. It needs to be done in a proper way, a way that auditors should have some dental training. Need to be exemptions for clerical errors. Need specific beginning and end dates. Agree that there are some people that don't always play by the rules. Needs to be fair and not an onerous process. Thank you.

Dan Carey- Bowen Center
Good Morning. I just want to talk just a little bit about the process as Bowen Center went through. We are in the middle of administrative consideration from a June 2015 audit. Were sent a list of 21 different types of documents that were expected to be sent to the state and it was a total of 151 claims. Our audit covered Jan 1, 2009-June 30, 2010. The claims were 5 years old. Private nonprofit Community Health Organization. Have an active corporate compliance plan and program. We make multiple refunds to the state as they are found and have had a couple that were over a hundred thousand dollars for things that were found. These audits should identify fraudulent organizations but we don't believe we are one of them. Medical records manager spent over 100 hours pulling audit together. State did grant an extension and the majority was already in the archives department from when they were still paper based. It was part of an old electronic billing system and have since gone to a new electronic health record system and all new information is in that system. Going back into archives pulling out papers trying to find all documentation in paper forms, including staff that has long since left the organization, was quite difficult. Even with the extension, we almost couldn't get it done. We were going up to the last minute. 151 claims and 19 claims were potentially in error and are in the middle of administrative reconsideration process. Potential sample over payment, so the actual claims identified as overpayments was only $848.05 and after extrapolation, $1,269,890.87. For a nonprofit CMHC that is quite a bit of money. The interesting thing is that our audit also identified under billing. But accordingly to the letter the state does not have any

method of refunding underpayment. We had some administrative errors that resulted in overpayment, and administrative errors that resulted in underpayment but no credit for administrative error that identified underpayment. The time period made the audit not relevant across the course of 5-6 years due to change in policies. If you're talking about integrity audits should be more current information and there is also some communication issues. Communication could have gone better. There was an intermediary agency that all information needed to go through which made that more difficult. The other thing is there were some items within the audit that were educational based but I feel like for providers that are doing the best they can with the resources they have this audit didn't feel collaborative but rather punitive and I hope that in the future there can be more communication and education and potentially even more collaboration to ensure this doesn't happen in the future. The services that were found non-compliant or overpaid were actually services that did occur but because we couldn't find the documentation going back six years we will be penalized.. I don't know what you'll do to make it better but hopefully there will be some consideration for those administrative mistakes that identify the underpayments as well. That's all I have. Thank you.

Joe Bader –Northeast Indiana Genetics

Good Morning. I also commend you very much for taking the time to be here. Have an open mind and to listen to providers about ways to improve the process. Furthermore I fully agree that the integrity and continuous improvement is essential. I agree with everything that has been said. I hear that all providers are supposed to have the same level of expectation and it should be in writing and it would be wonderful if that happens. Providers are upset about things that are unwritten such as pre-payment review that is supposed to help educate providers. It would be wonderful if they answered questions for providers and they are consistent with written expectations.