Provider Audit Workgroup

June 8, 2016

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning

Agenda

- *Welcome and Introductions*
- *SEA 364 and Background Information*
- *Presentation on Federal Requirements*
- *FSSA Program Integrity Overview*
- *Overview of Process and Scheduled Public Hearings*
- *Facilitated Group Discussion*
- *Public Comments*

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Federal Program Integrity Requirements

June 8, 2016

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Utilization Control

- 42 USC § 1396a(37)(B): Prepayment and Postpayment review of all claims.
- 42 CFR § 456.3: All Medicaid agencies must have a surveillance and utilization review program.
- 42 CFR § 456.21-456.23: All State plan services must be monitored utilizing a sample based evaluation and post payment review.

Payment Issues

- 42 CFR § 447.15: Providers must accept payment as payment in full if enrolled in program.
- 42 CFR § 447.52(e): Providers may not deny services for failure to pay cost sharing/copayment amount unless individual meets requirements of (e)(1).
- 42 CFR § 447.20(a)(2)(ii)(b): Providers may not refuse services due to potential third party liability.

Fraud Detection and Investigation 42 CFR § 455.12-455.23

- 42 CFR § 455.13: Agency must have method for investigation of allegations.
- 42 CFR § 455.20: Agency must have means of beneficiary verification of services paid on their behalf.
- 42 CFR § 455.21: Agency must refer suspected from to Medicaid Fraud Control Unit.
- 42 CFR § 455.23: Agency must suspend payments when it has determined a credible allegation of fraud exists.
- 42 CFR § 1001.1301: Agency must be given immediate access to records of a provider at the time the request is made.

State Refund of Overpayment to CMS

- Federal Register – CMS just announced is expanding it's look back period for Managed Care audits to 10 years.
  - https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-09581.pdf

- 42 CFR § 433.320 (a)(1) - The Agency must refund the federal share of all identified overpayments within one year of discovery, even if discovered by federal auditors.

Enrollment Disclosures
42 CFR § 455.100-455.106

- Providers and fiscal agents must disclose certain ownership, control and business transaction information. Threshold for ownership interest is **5%** as explained in 42 CFR § 455.101.

- Certain criminal convictions must also be disclosed related to crimes against government funded programs.

Provider Enrollment
42 CFR § 455.400-455.470

- All providers must be screened utilizing federal websites, licensure databases and criminal backgrounds (where applicable).
- All provider information must be revalidated at least every **5 years** for all providers (42 CFR § 455.414).
- Site visits are required for all providers in moderate and high risk categories (42 CFR § 455.432 see http://provider.indianamedicaid.com/become-a-provider/provider-enrollment-risk-levels-and-screening.aspx).
- States are required to collect application fee from providers (42 CFR § 455.460).

Medicaid Recovery Audit Contractors
42 CFR § 455.500-455.518

- RAC contracts must be entered into by states (42 CFR § 455.502).
- There must be coordination between RACs and other auditing activities and must be a set limit on number and frequency of claims reviewed (42 CFR § 455.506).
- RACs must be paid on a contingency fee from the collected overpayment and established by the State. RACs must identify underpayments and the State must notify providers of identified underpayments. (42 CFR § 455.510)
- Appeals of RAC audits are governed by applicable State administrative procedures (42 CFR § 455.512).

Other Provisions
42 CFR § 455.200-455.304

- Federal government established Medicaid Integrity Program contractors to audit state's Medicaid programs (42 CFR § 455.200-455.240). These are better known as Audit MICs.

- States must have independent audit of Disproportionate Share Hospital Payments (42 CFR § 455.300-455.304).

Provider Audit Workgroup

Indiana Medicaid Program Integrity (PI) Audit Requirements

June 8, 2016

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Agenda

- Program Integrity Overview
  - Who is Program Integrity?
  - Audit-related Indiana guidelines, rules & statutes
- Who else audits Indiana Medicaid?
- Voluntary Self Disclosure
  - Self-audit
  - Reporting / Returning Overpayment
  - Compliance

Who or What is Program Integrity?

- Medicaid Program Integrity works to ensure that all aspects of the Indiana Medicaid program are strong and functioning well.
- FSSA Program Integrity (PI) is composed of three collaborative groups:
    1. Investigations & Coordination
    2. Prepayment Review
    3. Surveillance & Utilization Review (SUR) - *Audit*

Who or What is Program Integrity?
(con't.)

- Investigations & Coordination
  - Respond to complaints from members, providers, other state agencies
  - Conduct preliminary investigations to establish a Credible Allegation of Fraud CAF)
  - Coordinate with other State agencies and/or divisions
- Prepayment Review
  - Potential concerns with provider billing practices
  - Provider submission of supporting documentation with claim forms
  - Must meet 85% accuracy rate in claims submission for three (3) consecutive months
- Surveillance & Utilization Review (SUR) - *Audit*
  - Retrospective review of provider billing compliance
  - Algorithmic approach vs. provider-specific reviews
  - Recovery of overpayments – Federal share of all Medicaid recoveries must be repaid to CMS
  - Fraud & Abuse Detection System (FADS) Team – PI; Truven Health Analytics; Myers & Stauffer, LC; HMS

How are Indiana Medicaid providers selected for review?

Healthcare providers enrolled in the Indiana Medicaid program can be selected for review through one of the following ways:

- Ranking as an outlier when compared to providers of like specialty
- Concern or complaint relayed to PI through the Concerns Hotline or PI email box – result in Preliminary Investigation or Credible Allegation of Fraud Assessment
- Request or recommendation from other State or Federal agencies

Two Types of Audit Approach

- Provider-specific Audit
  - Individual practitioner or group
  - Risk Assessment completed to look for areas of potential concern
  - Focus on all aspects of provider's billing practices

- Algorithm-driven Audit/Project
  - Focus on a specific issue or concern, including, but not limited to; procedure code; diagnosis code; proc. code/modifier combination; services after death; DME during LTC
  - Several to hundreds of providers involved
  - Based on Indiana Medicaid policies/regulations, coding regulations, etc.

Types of Audits

- Desk Audit
  - Records requested to be sent to audit staff
  - Paper records or electronic records
  - Conducted at audit staff office, with on-going communication with provider
- Provider Self-Audit
  - List of claims to be reviewed submitted to provider
  - Review conducted by provider/staff, with results submitted to FADS team upon completion
  - Documentation of select claims submitted with results to allow FADS team to validate provider results
- On-Site Audit
  - May be announced or un-announced
  - Copies of documentation for selected claims obtained while on-site
  - Allows direct communication with provider
  - Provider able to submit later any documents unavailable during on-site process.

Audit Claim Selection

- Claim-by-Claim
  - Individual claims are selected for review
  - Any identified overpayments are tied to individual claims
  - Interest assessed on overpayment from claim paid date to date of audit.
- Statistically-Valid Random (SVR) Sample – Extrapolation
  - Universe of claims identified for a specific period of time
  - From this claims universe, a SVR sample is pulled, giving each claim in universe an equally same chance of being chosen for review
  - Total amount of overpayment identified for all claims in sample is divided by # claims in sample, then multiplied by the total number of claims in the universe
  - Interest assessed from the end-date of the review period to date of audit.
  - Stratified vs. full random sample selection

405 IAC 1-5-1 – ***Medical records; contents and retention***

Sec. 1. (a) Medicaid records must be of sufficient quality to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program.

(b) All providers participating in the Indiana Medicaid program shall maintain, for a period of seven (7) years from the date Medicaid services are provided**,** such medical or other records, or both, including x-rays, as are necessary to fully disclose and document the extent of the services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program. A copy of a claim form that has been submitted by the provider for reimbursement is not sufficient documentation, in and of itself, to comply with this requirement. Providers must maintain records that are independent of claims for reimbursement.

Such medical or other records, or both, shall include, at the minimum, the following information and documentation:

(1) The identity of the individual to whom service was rendered.

(2) The identity of the provider rendering the service.

(3) The identity and position of the provider employee rendering the service, if applicable.

(4) The date on which the service was rendered.

(5) The diagnosis of the medical condition of the individual to whom service was rendered, relevant to physicians and dentists only.

(6) A detailed statement describing services rendered.

(7) The location at which services were rendered.

(8) The amount claimed through the Indiana Medicaid program for each specific service rendered.

(9) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs.

405 IAC 1-5-2 – ***Disclosure of Medical Records***

Sec. 2. Records maintained by providers under section 1 of this rule shall be openly and fully disclosed and produced to the office of Medicaid policy and planning or any authorized representative, designee, or agent thereof, forthwith, upon reasonable notice and request. Such notice and request may be made in person, in writing, or by telephonic means. Failure on the part of any provider to comply with this section shall constitute an abuse of the Medicaid program under IC 12-15-22 and applicable federal law.

405 IAC 1-1-5(a) – ***Overpayments made to providers; recovery***

Sec. 5. (a) Under IC 12-15-21-3(5) and IC 12-15-21-3(7), the office of Medicaid policy and planning (office) may recover payment, or instruct the fiscal contractor to recover payment, from any Medicaid provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:

(1) the services paid for cannot be documented by the provider as required by 405 IAC 1-5-1;

(2) the amount paid for such services has been or can be paid from other sources;

(3) the services were provided to a person other than the person in whose name the claim was made and paid;

(4) the service reimbursed was provided to a person who was not eligible for medical assistance at the time of the provision of the service;

(5) the paid claim arises out of any act or practice prohibited by law or by rules of the office;

(6) overpayment resulted from:

(A) an inaccurate description of services or an inaccurate usage of procedure codes;

(B) the provider's itemization of services rather than submission of one (1) billing for a related group of services

provided to a recipient (global billing) as set out in the office's medical policy;

(C) duplicate billing; or

(D) claims for services or materials determined to have been not medically reasonable or necessary; or

(7) overpayment to the provider resulted from any other reason not specified in this subsection.

405 IAC 1-1-5(b) – ***Overpayments made to providers; recovery*** ***(con't.)***

(b) Under IC 12-15-21-3(5), the office may determine the amount of overcharges made by a Medicaid provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana Medicaid program. The following criteria apply to random sample audits:

(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.

(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must:

(A) be completed within one hundred eighty (180) days of the date of appeal; and

(B) demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law.

The provider must submit supporting documentation to demonstrate this compliance.

Who else may audit Indiana Medicaid?

Reviews can be initiated by other external entities in conjunction with IN Program Integrity, including, but not limited to:

CMS

- Payment Error Rate Measurement (PERM) audit
  - 3-year cycle
  - Establish state-wide error rate from sample audit
  - **A+ Gov't. Solutions and The Lewin Group** (vendors)
- Medicaid Integrity Contractor (MIC)
  - Audit contractor directed to assist State PI efforts – CMS approves audits
  - Indiana contractor - **Health Integrity (HI)**
  - Works collaboratively with IN PI
- Recovery Audit Contractor (RAC)
  - Indiana contractor – **HMS**
  - Focused on credit-balance audits and reviews of LTC providers

Who else may audit Indiana Medicaid?
(con't.)

Department of Health & Human Services – Office of Inspector General

- Issue-specific reviews
- Contact State PI to pull claims data to review
- Findings of issue directed to State Medicaid program to pursue recovery and develop a Corrective Action Plan (CAP), if warranted
- Recent examples:
  - *"Questionable Billing for Medicaid Pediatric Dental Services in Indiana"*
  - *"Indiana Made Incorrect Medicaid Payments to Providers for Full Vials of Herceptin"*
  - *"Indiana Claimed Medicaid Reimbursement for High-Dollar Inpatient Services That Were Unallowable"*
- State PI works to validate audit results, then utilize standard State process to recover overpayments

Who else may audit Indiana Medicaid?
(con't.)

Indiana Medicaid Fraud Control Unit (MFCU)

Fraud is an intentional deception or misrepresentation, made by the provider or member, which could result in an unauthorized benefit, such as an improper payment being made to an IHCP provider. The following list contains examples of fraud:

- Altering a member's medical records to generate fraudulent payments
- Billing for group visits, such as a provider billing for several members of the same family in one visit, although only one family member was seen or provided medically necessary services
- Billing for services or supplies that were not rendered or provided
- Misrepresenting services provided (for example, billing a covered procedure code and providing a non-covered service)
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Submitting claim forms that have been altered or manipulated to obtain higher reimbursement

Provider Voluntary Self-Disclosure

Mandatory reporting 42 U.S.C. § 1320a-7k(d)

- Provider Self-Disclosure packet located on the State PI website
  - **http://provider.indianamedicaid.com/about-indiana-medicaid/program-integrity.aspx**

42 U.S.C. § 1320a-7k(d)

"(d) Reporting and Returning of Overpayments – (1) in general, - If a person has received an overpayment, the person shall -

A.) Report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

B.) Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment."

Report and Return to Correct Address

Standardized tool for reporting overpayments

Notify with reason for overpayment

In Indiana, overpayments should be returned, reported and explained to the PI Unit at the following address:

IHCP Program Integrity Department
ATTN: SUR Audit Overpayment
P. O. Box 636297
Cincinnati, OH 45263-6297

42 U.S.C. § 1320a-7k(d)

"(2) Deadline for reporting and returning overpayments. - An overpayment must be reported and returned under paragraph (1) by the later of -

A.) The date which is 60 days after the date on which the overpayment was identified; or

B.) The date any corresponding cost report is due, if applicable."

Federal Exclusion from Program Participation

- Excluded Individuals
  - **http://www.oig.hhs.gov/fraud/exclusions.asp**
  - **https://www.sam.gov/portal/public/SAM/**
  - The Online Searchable Databases enable users to enter the name of an individual or entity and determine whether they are currently excluded. If a name match is made, the database can verify the match using a Social Security Number or Employer Identification Number.
  - Any claims involving excluded individuals or business **will be recouped in full as overpayments**
- Also refer to IHCP Provider Bulletin BT200715 (Federal Health Care Exclusions Program)

Federal Exclusion from Program Participation (con't)

The following is from the DHHS OIG ***Special Advisory Bulletin***, *The Effect of Exclusion from Participation in Federal Health Care Programs (September 1999), C. Exclusion from Federal Health Care Programs,* available at oig.hhs.gov:

Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs [including Medicaid]. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner, or supplier that is not excluded.

The prohibition against Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries. This prohibition continues to apply to an individual even if he or she changes from one health care profession to another while excluded. In addition, no Federal program payment may be made to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care.

False Claims and Whistleblower Regulations

- Indiana enacted State False Claim and Whistleblower statute: **Indiana Code 5-11-5.7**
- Federal False Claims Act: **31 USC § 3729-3733**
- Report Medicaid Fraud to Attorney General: **http://www.in.gov/attorneygeneral/2453.htm**
- False Claims and Whistleblower education: **http://www.in.gov/attorneygeneral/2807.htm**

False Claims and Whistleblower Regulations (con't.)

42 USC §1396a (a):

- (68) provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall-
  - (A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1320a–7b(f) of this title);
  - (B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and
  - (C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse

THANK YOU

Questions?