Disclaimer

Only formal responses to questions asked through the [www.in.gov/fssa](http://www.in.gov/fssa) inquiry process will be considered official and valid by the State. No participant shall rely upon, take any action, or make any decision based upon any verbal communication with any State employee including responses in today’s presentation.

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Agenda

Program Integrity

- PI Organization Chart
- Auditing
- Voluntary Self Disclosure
- Investigations & Coordination
- Prepayment Review
- Estate Recovery
- Contact Information
Surveillance & Utilization Review (SUR)

- Retrospective review of provider billing compliance
- Review of Fee-for-Service (FFS), Managed Care, and Waivers
- Utilize provider peer comparison to identify outliers from peers
- Audit Approach

*Algorithms vs. provider-specific*

- Can utilize statistically-valid, random-sampling & extrapolation
- Recovery of overpayments

**NOTE:** Federal share of all Medicaid recoveries must be repaid to CMS within 365 days of overpayment notification
Steps involved in PI Audit retrospective review process:

1. Preliminary review of provider billing, payment, and audit history
2. Request of medical records from provider (if applicable)
3. On-site or in-house medical record audit
4. *Draft Audit Findings* (DAF) letter of preliminary audit results
5. Request for administrative reconsideration (optional)
6. *Final Calculation of Overpayment* (FCO) letter or *Final Audit Findings* (FAF) letter
7. Administrative appeal process (optional)
8. Recoupment of overpayment (if applicable)
Example 1
Provider A billed Medicaid for E/M code CPT 99201 (new patient code) for an established patient seen by the same provider within the last 3 years.

**Outcome:**
State recouped the different amount between what was reimbursed for CPT 99201 and CPT 99211 (established patient code) which should have been billed instead.

Example 3
The state arrived at Provider C’s office for an onsite audit of medical records for specific set of claims. The state found that Provider C never documented any of the services billed by the provider.

**Outcome:**
All reimbursement for claims without medical record documentation present was recouped. The IN MFCU was contacted about the issues noted during the onsite audit.

Example 2
Provider B was found to be billing modifier 59 on every claim in order to bypass the claim system edits in order to receive extra reimbursement for two or more non-distinct services on same date of service and lacked the documentation to support that they were performed separately.

**Outcome:**
State paid the first service rendered that was medically necessary and had documentation, but recouped the rest of the services on that same date of service. The provider’s billing practice was discussed with the PI Investigations & Coordination team regarding a possible referral to the IN Medicaid Fraud Control Unit (MFCU).
Other Auditing Entities

- Health and Human Services (HHS)
- HHS Office of Inspector General (OIG)
- Centers for Medicare and Medicaid Services (CMS)
- Unified Program Integrity Contractor (UPIC)
- Payment Error Rate Measurement (PERM) Audit
- Indiana Attorney General
- Indiana Medicaid Fraud Control Unit (MFCU)
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
Under federal law (§Section 6402(d) of the Patient Protection and Affordable Care Act (PPACA) of 2010, Pub. L. 111-148, title VI, Mar. 23, 2010, 124 Stat. 753), a provider that identifies an overpayment must report the overpayment and return the entire amount to a Medicaid program within 60 days after the overpayment is identified. See 42 U.S.C. § 1320a-7k(d) – Reporting and returning of overpayments. A provider that retains an overpayment after the 60-day deadline incurs an obligation under the federal False Claims Act and may be subject to criminal and civil liability, including civil monetary penalties, treble damages, and, potentially, exclusion from participation in federal health care programs. A provider that fails to make the repayment within 60 calendar days of identification may also be at risk from a “whistleblower” lawsuit.

Provider shall report and return all overpayments within 60 days of discovery

IHCP requests the self-disclosure protocol be utilized in the following scenarios:
• To self-report overpayments involving specific compliance issues
• To self-report overpayments involving cumulative amounts greater than $1000
• To self-report overpayments involving fraud or violations of law
Voluntary Self-Disclosures (continued)

Benefit of Voluntary Self-Disclosure
- Results in a better outcome for the provider
- Provider will be in compliance with the law
- Interest will not be assessed on the disclosed overpayment

Potential consequences if IHCP discovers the matter independently
- Recoupment of improper reimbursements with interest
- On-site or in-house audit of medical records
- Placement in Prepayment Review
- Referral for administrative sanctions
- Referral to MFCU

Statistically-valid Random Sampling and Extrapolation
- If a provider chooses to utilize the providers should submit an explanation of the extrapolation process utilized and how the overpayments were discovered
- If a provider audits or reviews their Medicare claim population, providers cannot use Medicare error rate on their Indiana Medicaid claim population
The Role of Investigations & Coordination

- Responds to complaints from many sources
- Conduct preliminary investigations to establish a **Credible Allegation of Fraud (CAF)**
- Makes referrals to and collaborates with **MFCU** on provider investigations
- Coordinate with FSSA operating divisions (DDRS, DA, DMHA, DFR)
- Oversee the Managed Care Entities (MCE’s) to monitor their Special Investigation Units (SIU) and referrals of provider fraud allegations
Prepayment Review

- Contracted through the FADS contractor, IBM Watson Health
- Providers placed on prepayment review due to concerns with billing or documentation practices
- Provider submits supporting documentation with every claim
- Claims will suspend for review prior to payment
- The Provider must meet 85% accuracy rate in claims submission for three (3) consecutive months within the initial six (6) month review period
Example 1
A member calls the concern line to report that they suspect that their dentist billed Medicaid for an exam and a cleaning they did not render to them.

Outcome:
The State checks the claims data and determines that the provider did not bill Medicaid for the disputed services. The State closes the matter without taking any further action.

Example 2
An employee of a mental health clinic calls the concern line to report that the clinic that they work for is upcoding a time based behavioral health code.

Outcome:
The State performs a preliminary investigation on the provider (which includes performing a limited documentation review and a provider peer comparison) and substantiates the allegation. The State performs an audit of the provider’s usage of the time based behavioral health code.

Example 3
A member calls the concern line to report that they suspect that their home health provider billed for home health services that they did not render to them.

Outcome:
The State performs a preliminary investigation on the provider and finds that a credible allegation of fraud exists. The State refers the case to the MFCU and requests that the provider be placed on payment suspension.
What is Estate Recovery?

1965 – Medicaid signed into law. Congress gives states the option to recover costs for care for individuals age 65 and over. Some states pass estate recovery laws.

1982 – TEFRA (Tax Equity & Fiscal Responsibility Act) - first federal estate recovery law; not mandatory so many states still didn’t pass their own estate recovery laws however, states did lose certain federal funding for failing to do so

1993 – OBRA (Omnibus Budget Reconstruction Act) - mandated recovery for all states for individuals age 55 and over
What Expenses Can Be Recovered by Medicaid?

- Medical expenses paid on behalf of an individual's age 55 and over
- Medical expenses paid on behalf of an individual under age 55 who was a resident of a Long Term Care facility and who was not reasonably expected to return home
Are There Exceptions to Estate Recovery?

• Real and personal property when necessary for the support of a surviving spouse, a dependent child or a dependent who is non-supporting due to blindness or disability
• Personal effects, ornaments, keepsakes
• Assets of any recipient who purchased a qualified Long Term Care policy
• When there is a minor child, no recovery is made while the child is under 21 or who is blind or disabled
What Can Be Paid From an Estate Before Paying Medicaid?

- If no prepaid funeral, can exempt $2,150 for funeral and burial expenses.
- Debts & taxes having preference under US law
- Debts & taxes having preference under Indiana law (Medicaid is here)
- Nothing else can be paid prior to satisfying Medicaid
What About Hardships or Exceptional Circumstances?

- Undue Hardship Waivers may be granted if pursuing the Medicaid claim would result in:
  - causing a beneficiary becoming eligible for public assistance
  - causing a beneficiary to remain dependent on public assistance
  - loss of income producing assets where there is no other income and income does not exceed 100% of poverty level
  - other compelling circumstances
- Undue Hardship determined on a case-by-case basis
- Only immediate family may qualify (spouse, child, grandchild, great-grandchild, parent, grandparent, sibling)
  - Others might qualify in exceptional circumstances with good cause shown
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